Warrington and Halton Teaching Hospitals NHS Foundation Trust

TRUST BOARD
Supplementary Agenda

MAIN AGENDA

ITEMS FOR APPROVAL

ITEMS FOR NOTING FOR ASSURANCE

Classification: Official

Publication approval reference: PAR772

Respiratory syncytial virus 2021 preparedness

Children's safer nurse staffing framework for inpatient care in acute hospitals

August 2021

Contents

1. Introduction

This guidance supports the redeployment planning processes to respond to the anticipated earlier and greater than usual increase in respiratory syncytial virus (RSV) and other respiratory illnesses in children, which will increase pressure on paediatric critical and inpatient care.

Through appropriate workforce planning, aim to maintain nationally recommended nurse-to-patient ratios using mutual clinical aid[1] options including system working. Should such mutual aid arrangements be exhausted, strategies to increase the clinical workforce to meet staffing requirements at times of exceptional demand need to be planned in advance being cognisant of the impact deployment decisions have on other services.

Organisations will vary in their staff skill mix, staff availability and the services they have on site, so we emphasise that this document has been prepared as guidance to support local decision-making.

National, regional and local collaboration will be needed when deciding which of the measures outlined here should be enacted and the timing of their implementation.

We include example phased staffing plans for levels 2 and 3 paediatric critical care in a tertiary care setting and levels 1 and 2 in a secondary care setting.

We are grateful to the following for contributing to this guidance:

- Association of Chief Children's Nurses (ACCN)
- British Association of Critical Care Nurses (BACCN)
- Critical Care National Network Nurse Leads Forum (CC3N)
- Health Education England (HEE)
- Intensive Care Society (ICS)
- Nursing and Midwifery Council (NMC)

[1] Mutual aid is system wide redeployment of staff, equipment, transfer of patients where clinically appropriate and safe to do, services and supplies to mitigate risks to patient safety.

- Paediatric Critical Care Society (PCCS)
- Public Health England (PHE)
- Royal College of Nursing (RCN)
- UNISON.
- Unite the Union.

1.1 Principles

The guidance is based on the following principles:

1.	A flexible, pragmatic and staged approach with an emphasis on team working should be followed.
2.	Through appropriate workforce planning, aim to maintain nationally recommended nurse-to-patient ratios using mutual clinical aid options including system working.
3.	Should such mutual aid arrangements no longer be viable, strategies to increase the clinical workforce to meet staffing requirements at times of exceptional demand need to be planned in advance being cognisant of the impact deployment decisions have on other services.
4.	Nursing staff identified as able to support the requirement for an increased paediatric critical care workforce in response to exceptional demand are categorised into four groups: paediatric critical care trained nurses and category A, B and C staff.
5.	Identification of staff to support the paediatric workforce should consider the actual and potential requirements of other services.
6.	Redeployment of staff into paediatric critical care areas or children's and young people's wards from another service should be on a voluntary basis. Redeployed staff should receive regular check-ins both during and after redeployment regarding their health and wellbeing. These should include discussion of their return to their usual role and the timing of this.
7.	Following conversations with the identified staff, individualised training needs analysis should be completed. Staff must receive appropriate training,

induction and familiarisation with the new work environment and processes. Health Education England e-Learning for Healthcare (HEE e-LfH) has created an e-learning programme to support the cross-skilling of the NHS workforce available.
8. Organisations should ensure that staffing plans are reviewed and signed off by the chief nurse, with staffing decisions including redeployment and daily deployment of staff led by the senior clinical leadership teams. Discussions about staffing at meetings to agree mutual aid and how to address system challenges – at hospital cell/situation report (SitRep) meetings, local system resilience meetings and regional Emergency Preparedness, Resilience and Response (EPRR) calls – should be documented.
9. The trust board should review its risk appetite in relation to quality and workforce risks associated with potential future spikes in demand for children's services as a result of RSV and other respiratory illnesses and be clear about the tolerances it is willing to accept. The trust board should be assured that appropriate measures are in place to mitigate any identified risks.

Although this guidance focuses on the clinical nursing workforce, the response to increased demand must be agile and multiprofessional, based on holistic person-centred need. Trusts will need to employ the skills of the full multiprofessional team appropriately to ensure the clinical environment is as safe as it can be for patients, staff and their respective families. As maternity services are outside this scope, they are not considered in this document.

1.2 Guidance on self-isolation for essential staff

Government updated its guidance on 19 July 2021.

Accountability for trigger thresholds to release staff from self-isolation is locally determined and risk assessed in a local context. The trust board is accountable for increasing and/or consistently applying infection prevention and control (IPC) mitigation measures. The IPC guidance allows for risk-based decisions to ensure safe systems of work. An established system is in place for lateral flow test access and staff will continue to order their tests online.

2. Roles, responsibilities, and accountabilities

The supportive structures and processes set out in the National Quality Board (NQB) Safe, sustainable and productive staffing (2016) and the regulatory mechanisms in Developing workforce safeguards (2018) provide the framework for safe staffing at all times. However, these need to be applied within the context of the current challenges.

2.1 Trust boards

The trust board is accountable for ensuring that high quality care is consistently delivered. Boards should seek assurance that the systems and processes in place enable the identification and resolution of staffing risks. Robust mechanisms for escalation from point of care delivery to the trust board should be in place. This includes ensuring a supportive culture is embedded in the organisation. Clear and effective processes should allow clinical staff to readily raise concerns about staffing through a variety of routes, including huddles and risk and incident reporting processes. These processes should be available to substantive and temporary staff. Leaders should also ensure there is regular communication with staff-side representatives and Freedom to Speak Up guardians, so they can channel the concerns raised with them.

Boards should ensure that their local system (via the local resilience forum) and NHS England and NHS Improvement regional leadership teams are kept abreast of any major changes or challenges through the EPRR management systems. This will enable system and regional support to mitigate staffing risks where necessary.

2.2 NHS England and NHS Improvement regional leadership teams

NHS England and NHS Improvement regional leadership teams are collectively responsible for supporting and enabling provider leadership teams to respond to local escalation of demand and concerns. They will support the deployment of mutual aid within the regional systems and keep the NHS England and NHS Improvement executive informed of the unfolding demand for services and staffing challenges.

2.3 NHS England and NHS Improvement executive team

The team are collectively responsible for supporting and enabling inter-regional responses to escalation of demand and staffing concerns, and keeping the Department of Health and Social Care (DHSC) updated to support and review the national response.

3. Principles of clinical nursing workforce redeployment

There are three defined levels of paediatric critical care, with levels 1 and 2 mapping to high dependency care and level 3 to intensive care. The Paediatric Critical Care (PCC) Healthcare Resource Group (HRG) classifies the three levels of paediatric critical care:

- level 1 critical care: basic critical care provided in all district general hospitals which provide children and young people's in-patient facilities
- level 2 critical care: intermediate critical care provided in tertiary hospitals and a limited number of District General Hospitals
- level 3 critical care: advanced critical care provided in tertiary and specialist hospitals

Children and young people requiring level 1 critical care may be admitted to and cared for in designated beds within children's and young people's inpatient wards. The PCCS Quality Standards for the Care of Critically Ill Children states that with Paediatric Critical Care Network agreement, CPAP for bronchiolitis may be initiated or continued in a number of Level 1 Paediatric Critical Care Units. Patients needing an enhanced level of observation, monitoring or intervention will need to be admitted to a paediatric critical care unit (PCCU) that provides this level of care.

3.1 Categories of staff who can potentially be redeployed

PCCU trained nurses	Paediatric critical care trained nurses – nurses with appropriate competencies in levels 1, 2 and 3 paediatric critical care/successful completion of foundation programme
Category A staff	Registered children's nurses with appropriate competencies in levels 1 and 2 paediatric critical care
Category B staff	Registered children's nurses and nursing associates with recent/previous paediatric critical care experience or some transferable skills Registered adult critical care trained nurses Registered adult trained nurses with recent/previous critical care experience or some transferable skills
Category C staff	Registered children's nurses with no critical care skills Adult registered nurses with no critical care skills Nursing associates with no previous paediatric experience Allied health professionals (AHPs) and nursing support staff

Where possible, PCCUs should maintain the national recommended nurse-to-patient ratios through redeployment, appropriate escalation and use of mutual clinical aid options, including system working. Once these strategies are exhausted, it may be appropriate to move to a team-based approach using non-critical care trained paediatric staff or non-paediatric staff to deliver nursing care under the supervision of paediatric critical care trained nurses or Category A nurses in PCCU areas.

To support redeployment of registered children's nurses into PCCU areas, non-paediatric staff may be required to be redeployed to children's and young people's wards to deliver nursing care as part of a team-based approach under the supervision of registered children's nurses.

Moving to work in an area that is not their normal practice area may mean that those redeployed will need to be supported to ensure safe practice, safe patient care, staff wellbeing, appropriate supervision and appropriate delegation of care. A quality impact assessment to determine any risks and identify mitigations should be completed prior to staff redeployment – see Appendix 2.

3.2 Staffing provision

Throughout the changing situation, staffing arrangements should:

1.	Be based on a multiprofessional team approach to caring for patients.
2.	Ensure each clinical area is supervised by a senior clinical leader, recognising their vital role in staffing arrangements and support.
3.	Be based on an assessment of the patients' needs, with consideration for and account of acuity[2] and dependency[3] as well as environmental aspects.
4.	Always ensure clinical leaders' **professional judgement** is part of all staffing decisions.
5.	Consider the skills required to meet the patients' needs and deploy the most appropriate staff/organise the team around them accordingly.
6.	Ensure that clinical staff know how to escalate any concerns regarding staffing and are given appropriate support.
7.	Ensure IPC teams are appropriately resourced and enabled to work efficiently and effectively.
8.	Continually enable redeployed staff to increase their confidence and skills in paediatric ward/department-based nursing.
9.	Ensure that all staffing plans are reviewed and signed off by the chief nurse. Staffing decisions including redeployment and daily deployment of staff are led by the senior clinical leadership teams and are documented according to local reporting policy.

[2] Acuity is the level to which the patient is dependent on nursing care to support their physical and psychological needs and activities of daily living, such as eating and drinking, personal care and hygiene, mobilisation (NICE, 2014).
[3] The level to which the patient is dependent on nursing care to support their physical and psychological needs and activities of daily living, such as eating and drinking, personal care and hygiene, mobilisation (NICE, 2014).

10.	Ensure that all staffing plans are reviewed on a weekly basis or more frequently if required/indicated.

4. Phased staffing plans for expansion of critical care capacity

Individual units are responsible for determining an appropriate mix of staffing that aligns to their service, eg staffing skill set, geographical layout.

4.1 A phased approach

Local, system and regional escalation plans should demonstrate how staffing levels will be adjusted to respond to fluctuations in the number, acuity and dependency of patients and staff availability across their services. Providers' plans for expanding the paediatric critical care nursing workforce as demand increases should take a flexible, pragmatic and phased approach that emphasises teamworking. The Paediatric Critical Care Society (PCCS) Quality standards for the care of critically ill children (2015) align as follows to the operations pressure escalation levels (OPELs):

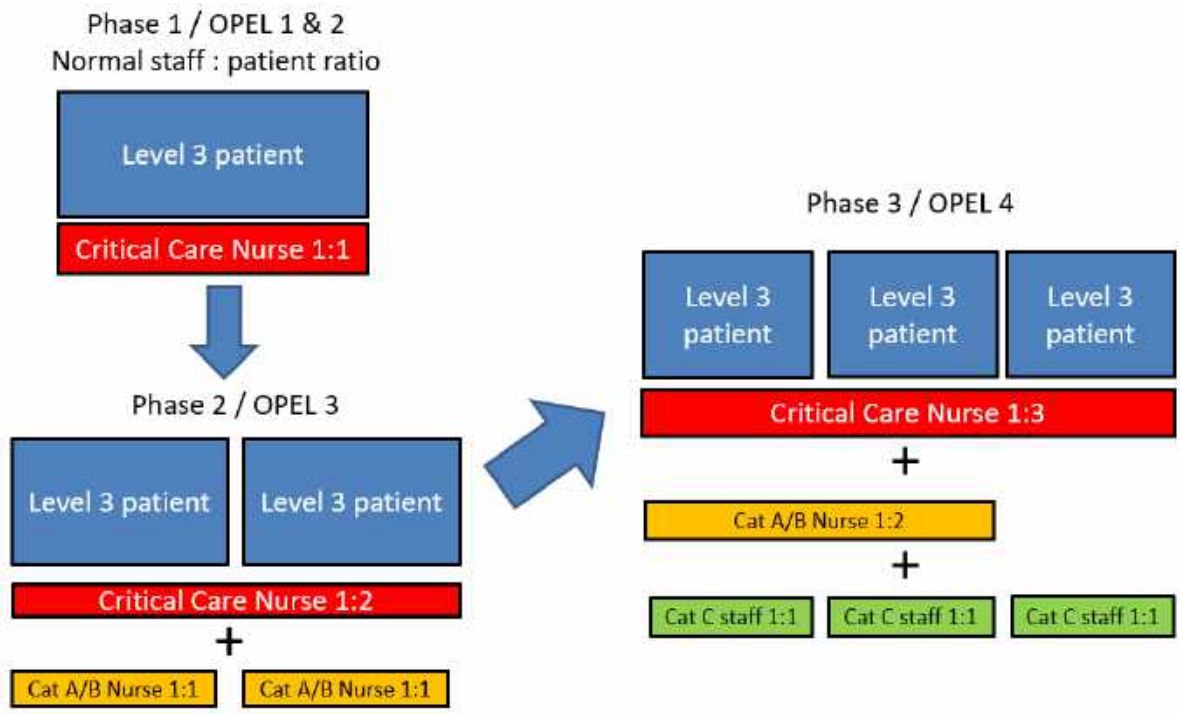
OPEL level	PCCS nursing ratio guidance
OPEL 1 and 2	Usual PCCS nursing ratio standard applies
OPEL 3	Usual PCCS nursing ratio standard applies, but nurses skilled in other areas of critical care, or nurses with historical critical care skills, can be utilised as appropriate
OPEL 4	A flexible and pragmatic approach will need to be taken, using such staff as are available under the supervision of PCCU nurses

4.2 Paediatric critical care units (PCCUs): levels 2 and 3 PCCU in a tertiary setting

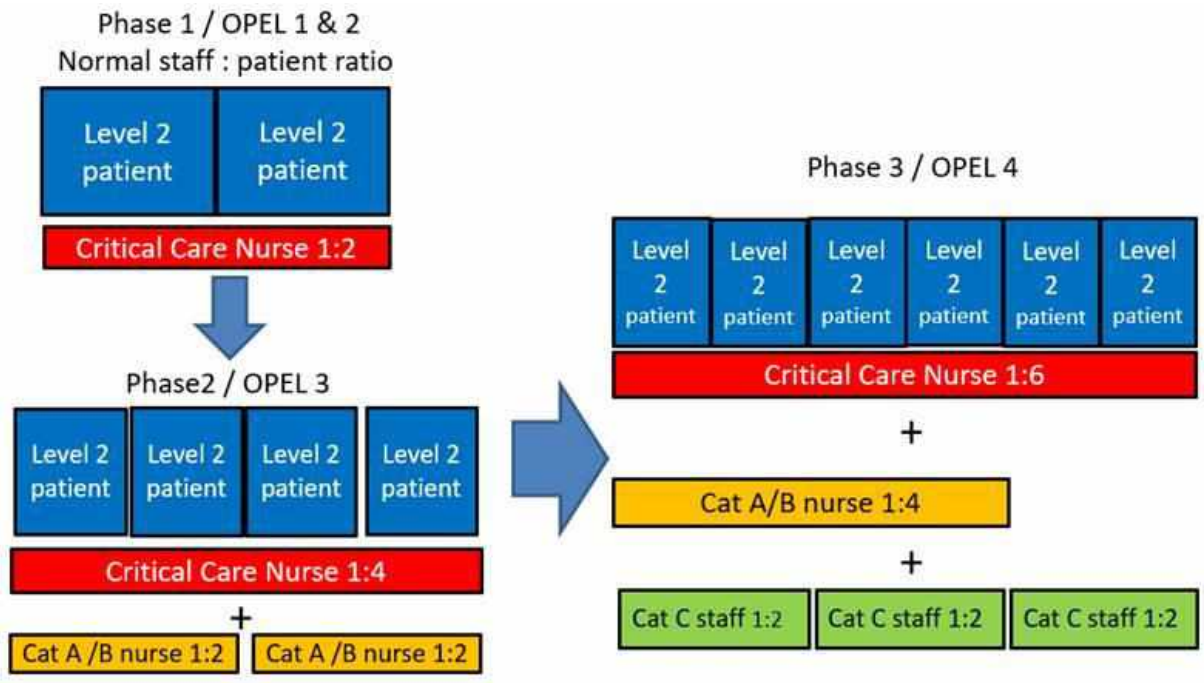
The example phased nursing workforce plan below outlines the three phases of response to rising demand. Ratios are provided to guide workforce requirement planning, but a flexible team-based approach will be required.

	Staff-to-patient ratio Level 3 PCCU patient	Staff-to-patient ratio Level 2 PCCU patient
Phase 1 (OPEL 1 and 2) – Initial local increase in demand; maintain current paediatric critical care trained nurse-to-patient ratios using mutual clinical aid across the system.		
PCCU trained nurse	1:1	1:2
Phase 2 (OPEL 3) – increasing demand across the system		
PCCU trained nurse	1:2	1:4
Category A and B staff	1:1	1:2
Phase 3 (OPEL 4) – exceptional increase in demand across the system		
PCCU trained nurse	1:3	1:6
Category A and B staff	1:2	1:4
Category C staff	1:1	1:2

Example: Staffing for level 3 PCCU patients in a tertiary care setting



Example: Staffing for Level 2 PCCU patients in a tertiary care setting



Units may not move sequentially through the three phases of response.

The following minimum nurse staffing levels should be achieved:

- at least one nurse with up-to-date advanced paediatric resuscitation and life support competencies on each shift
- at least two registered children's nurses on duty at all times
- at least one nurse per shift with appropriate level competencies in paediatric critical care
- at least one nurse per shift with competencies in care of children with tracheostomies and those requiring non-invasive or tracheostomy ventilation
- at least one supernumerary co-ordinating nurse on each shift
- access to an educator for the training, education and continuing professional development of staff.

In addition, other support staff should be available to assist with delivering and supporting the delivery of patient care.

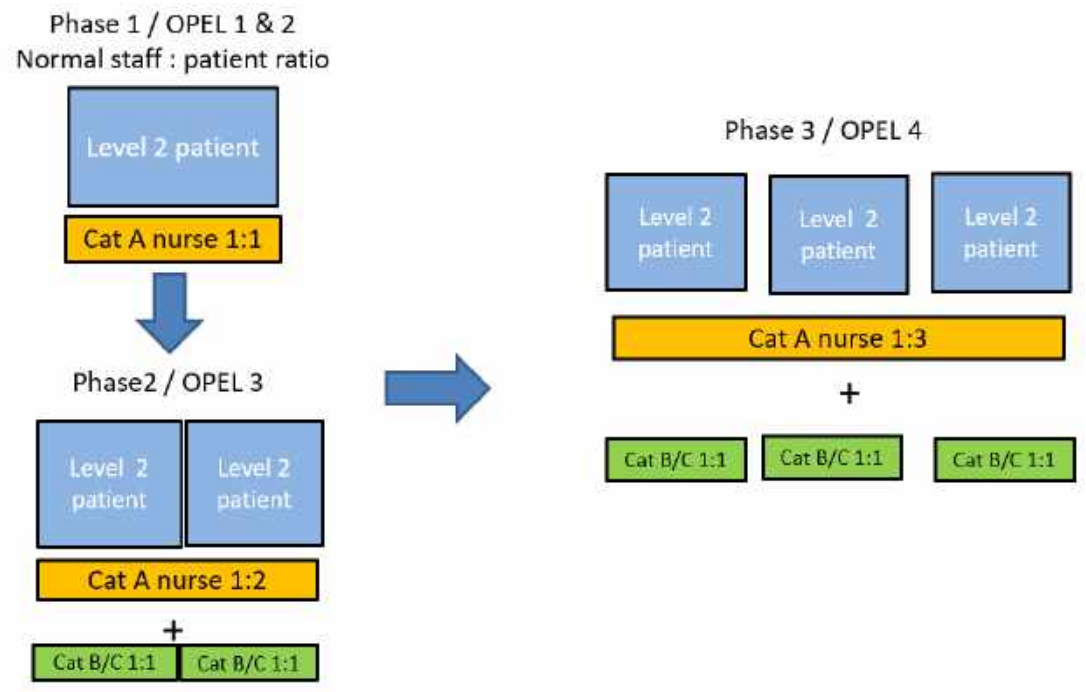
4.3 Levels 1 and 2 PCCU in a secondary care setting

The example phased nursing workforce plan below outlines the three phases of response to rising demand. Ratios are provided to guide workforce requirement planning, but a flexible team-based approach will be required.

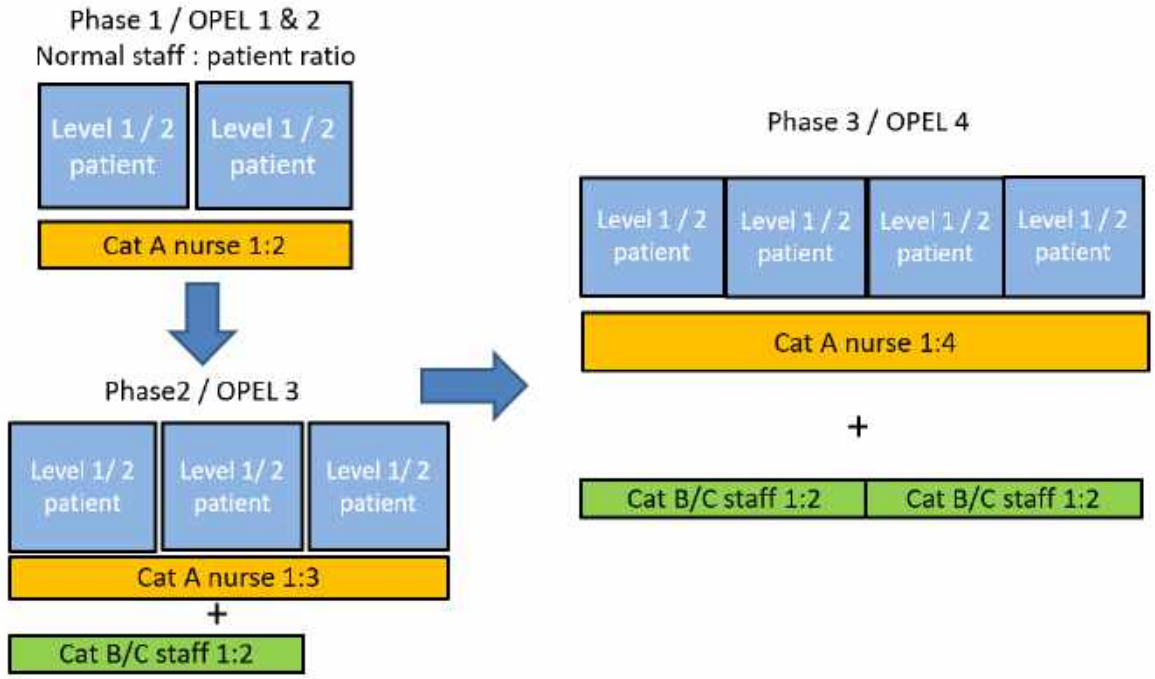
	Staff-to-patient ratio Level 2 PCCU patient in a side room	**Staff-to-patient ratio Level 1 PCCU patient and level 2 PCCU patient in a bay**
Phase 1 (OPEL 1 and 2) – Initial local increase in demand; maintain current Category A nurse-to-patient ratios using mutual clinical aid across the system.		
Category A	1:1	1:2
Phase 2 (OPEL 3) - increasing demand across the system		
Category A	1:2	1:3
Category B and C staff	1:1	1:2

Phase 3 (OPEL 4) - exceptional increase in demand across the system		
Category A	1:3	1:4
Category B and C staff	1:1	1:2

Example: Staffing for level 2 PCCU patients in a side room in a secondary care setting



Example: Staffing for levels 1 and 2 PCCU patients in a secondary care setting



Units may not move sequentially through the three phases of response.

The following minimum nurse staffing levels should be achieved:

- at least one staff member with up-to-date advanced paediatric resuscitation and life support competencies on each shift
- at least two registered children's nurses on duty at all times
- at least one nurse per shift with appropriate level competencies in paediatric critical care
- at least one nurse per shift with competencies in care of children with tracheostomies and those requiring non-invasive or tracheostomy ventilation in level 2 PCCUs
- a co-ordinating nurse on each shift who is supernumerary where possible
- access to an educator for the training, education and continuing professional development of staff.

In addition, other support staff should be available to assist with delivering and supporting the delivery of patient care.

A system-wide approach should be taken regarding staffing planning with consideration of prompt identification and early transfer of patients requiring critical care to a tertiary centre as demand increases.

5. Key considerations for redeployment of the clinical nursing workforce

Trusts and regions should estimate the number of surge beds they will provide and then in advance identify how many suitable staff they will need to deploy.

Local paediatric critical care networks will offer mutual aid. Staff or patients (where clinically appropriate) may be relocated between critical care sites to balance supply and demand. The digital staff passport helps staff move temporarily to another organisation to provide mutual aid.

However, we envisage that non-critical care trained paediatric and adult staff will be required to deliver nursing care under the supervision of PCCU trained nurses in tertiary PCCUs or category A staff in secondary care.

5.1 Identifying staff for redeployment

Nursing staff

Trusts should identify the surge workforce as early as possible. This may consist of registered children's nurses, specialist nurses, nursing associates, adult critical care nurses and adult nurses. Early identification provides adequate time and access to resources for training and preparation, with the aim of achieving the best possible patient outcomes and support to staff.

Working patterns may need to be redesigned to support increased staff presence at night and out of hours. This should where possible be discussed and planned in advance with staff-side representatives and trade unions.

Before their redeployment into paediatric critical care areas or children's and young people's wards, staff should be given, and time allowed for, both formal training and

the opportunity for supernumerary work shadowing either PCCU trained nurses or registered children's nurses with the appropriate level competencies, depending on proposed redeployment area.

Nursery nurses

Nursery nurses make sure that children are safe, stimulated and supported during clinical procedures. They also promote public health, provide key parental and carer support and act as a liaison between clinicians and families. Nursery nurses can be considered for redeployment into paediatric critical care areas and children and young people's wards working as part of a team under the supervision of PCCU trained nurses or registered children's nurses. Prior to redeployment they should receive appropriate training and induction alongside ongoing supervision.

Healthcare support workers

Healthcare assistants and clinical support workers may be redeployed to assist clinical staff in a range of settings and in a variety of ways, including transporting patients, assisting with clinical recording, and arranging and following up diagnostics. Healthcare support workers can be considered for redeployment into paediatric critical care areas and children and young people's wards working as part of a team under the supervision of PCCU trained nurses or registered children's nurses. Prior to redeployment they should receive appropriate training and induction alongside ongoing supervision.

Neonatal nurses

Their redeployment should be considered with caution. While neonatal nurses have many transferable skills to support PCCU areas, over-reliance on neonatal critical care staff may negatively impact on the ongoing requirements for this essential service.

Operating department practitioners (ODPs)/recovery staff

While ODPs and recovery staff have many transferable skills to support PCCU areas, over-reliance on anaesthetics/theatre staff for surge capacity should be avoided while elective surgical activity continues.

Public health nurse workforce

Health visitors and school nurses (and their teams) may have specific skills and expertise within PCCU, high dependency and paediatric care. However, their role

should focus on supporting children and families from a public health and prevention perspective to ensure delivery of the Healthy Child Programme (HCP). Health visitors are autonomous practitioners who lead and deliver crucial and technical services. Their role supports awareness raising with parents and early identification of vulnerable groups. Redeployment of public health nurses will require negotiation between local authority directors of public health, HCP commissioners and chief nurses within provider trusts.

Student nurses

Student nurses from all branches of nursing should continue with their planned clinical practice placements across all years. This will ensure they can continue their educational programme while also contributing to clinical services during the anticipated surge in paediatric demand as a result of RSV and other respiratory illnesses. Local arrangements with students on paediatric placement should be reviewed with the higher education institution (HEI). Increasing student placements in PCCU settings may be considered where there is a sufficiently safe and supportive environment for learning. Collaborative working with HEIs should continue to ensure there is appropriate health and wellbeing support for the students as well as learning opportunities. Any interventions offered to substantive and temporary staff should also be made available to students, including debriefing or interventions to support mental health issues as in the initial COVID-19 response.

Allied health professionals

The 14 distinct allied health professions have a huge range of transferable skills. AHPs work as autonomous practitioners and may be redeployed to lead and deliver crucial therapy, clinical and technical services. AHPs subdivide into two areas of expertise: therapy/rehabilitation and science/technical. The former can lead and deliver the crucial cross-system rehabilitation services that drive hospital flow, minimise admission and optimise early discharge and recovery at home. The science/technical AHPs can maximise imaging capacity and build critical care and ambulance service capacity. AHPs may also play a significant role in maintaining existing services across a range of systems where access to wider team members is reduced. These roles can be considered for redeployment into paediatric critical care areas and children and young people's wards working as part of a team under the supervision of PCCU trained nurses or registered children's nurses. Prior to

redeployment they should receive appropriate training and induction alongside ongoing supervision.

Pharmacists and pharmacy technicians

Hospital pharmacists play significant clinical roles in most specialty teams, including paediatrics. Pharmacy technicians manage areas of medicines supply, usually under the supervision of a pharmacist, and are also involved in the production of medicines in hospitals. These roles could be considered for redeployment to support the optimisation of the provision, preparation and administration of medicines. Prior to redeployment they should receive appropriate training and induction alongside ongoing supervision.

Play specialists/activity co-ordinators

Play specialists provide therapeutic play interventions for sick infants, children and young people, service users, carers and families. They develop and implement complex communication plans with children and families and provide key parent and carer support, acting as a liaison between clinicians and families. These roles can be considered for redeployment into paediatric critical care areas and children and young people's wards working as part of a team under the supervision of PCCU trained nurses or registered children's nurses. Prior to redeployment they should receive appropriate training and induction alongside ongoing supervision.

Volunteers

Volunteers can give extra support to patients, their families and carers, and staff and the public. The roles they undertake will be determined jointly by the volunteers and the local NHS organisation in accordance with local arrangements.

5.2 Professional regulation

The NMC recognise that these unprecedented times will present challenges to nurses working in different circumstances. These include:

- Those nurses who may not have worked in paediatric settings previously and are unfamiliar with caring for children and young people
- Those asked to provide critical care in paediatric settings
- Experienced nurses who are accountable for delegation of care to colleagues

Nurses will need to exercise their professional judgement and act in the best interests of their patients when delegating duties to colleagues, and be able to provide a rationale for their decisions.

The NMC encourage nurses who carry out delegated care and duties to work in partnership with nursing colleagues and the wider multidisciplinary team, to ensure that risk assessment and decision making is shared and informed by relevant professional guidance, and the values and principles set out locally.

The NMC recognise that the individuals on their registers may feel anxious about how context is taken into account when concerns are raised about their decisions and actions in these very challenging circumstances. Where a concern is raised about a registered nurse, the NMC will always consider the specific facts of the case, taking into account the factors relevant to the environment in which the nurse was working. The NMC would also take account of any relevant information about resource, guidelines or protocols in place at the time.

5.3 Preparing staff for redeployment

Planned redeployment of staff into paediatric critical care and children and young people's wards from another service should be on a voluntary basis. They should be appropriately trained in processes and inducted and familiarised with the new work environment. Appropriate preparation and voluntary redeployment can promote growth and resilience.

Staff redeployed into paediatric critical care and children and young people's wards will require close supervision for both patient safety and personal safety/welfare reasons. They should receive regular check-ins during and after redeployment regarding their health and wellbeing, with plans for their return to their usual role discussed. Ideally, supervisors should be trained in active listening.

Training resource

Health Education England e-Learning for Healthcare (HEE e-LfH) has created an e-learning programme to support the cross-skilling of the NHS workforce to manage:

- existing demand in children's services

- future spikes in paediatric demand as a result of RSV and other respiratory illnesses
- longer term, increases in paediatric acuity and demand within children's services.

This programme is free to access and appropriate for the various settings where a child can present with respiratory illness, including home, primary and community care, and across the acute hospital environment. New content is regularly added.

Before being redeployed staff should undertake a skills and competency assessment to identify learning requirements. Clinical competence is context-specific and is not the same as confidence, or necessarily related to seniority. The HEE e-LfH programme includes a downloadable interprofessional skills matrix appropriate to all professions. This maps key educational content to skills, by domain (eg recognition, management and escalation: care of the sick child) and level of paediatric care required in primary, secondary or tertiary care. The content aligns with The Royal College of Paediatrics and Child Health (RCPCH) and the RCN/NMC professional competencies, to support revalidation with the NMC as well as annual presentation for revalidation and appraisal.

Paediatric life support

All clinical staff working in children's and young people's areas should have completed paediatric basic life support training. In addition, areas providing levels 1, 2 and 3 paediatric critical care should have at least one staff member with up-to-date advanced paediatric resuscitation and life support competencies on each shift.

Local induction

All substantive and temporary staff redeployed to a new clinical area should receive a focused local induction. This should concentrate on the delivery of safe patient care, communication with children and families/carers, paediatric life support, paediatric safeguarding and how to raise concerns regarding scope of practice. Organisations need to maintain robust training and orientation records for all staff members including bank and agency staff.

Although not exhaustive, local induction should include the following:

- welcome to the team: a place and person to contact on arrival

- orientation in the environment and equipment including personal protective equipment (PPE)
- local guidelines/standard operating procedures (SOPs) and training materials
- information technology access and orientation
- pass cards and access
- key team members for escalation and support
- breakrooms/rota/shift times/handover
- ward/unit routine and culture/values.

Supervision

Staff should receive clinical supervision to enhance safety, mitigate workplace stress and provide support. It can help staff manage the personal and professional demands of their work. When redeployed staff return to their normal roles, they should be given the opportunity to reflect on their work, be thanked properly and have their mental wellbeing actively monitored by their receiving supervisors.

Staff identification

Staff should be issued with and wear – outside of any PPE – identification badges that clearly state their name, professional background and the role they are now performing, to inform new members of staff and support safe team working. Redeployed staff will often be moving into unfamiliar teams and settings with the risk that colleagues make assumptions about their levels of experience and expertise

5.4 Health and wellbeing

Local support, including from professional nurse advocates who are trained to provide confidential restorative clinical supervision and support nurses in clinical practice, should be readily available, in addition to access to regional health and wellbeing hubs. All resources and tools to support the needs of staff should be regularly reviewed and refreshed. A range of staff wellbeing guides, apps and resources are available at www.england.nhs.uk/people.

Rostering

Working patterns may need to be redesigned for some staffing groups; for example, to increase their presence at night and out of hours and/or to run seven-day

services. The impact of such changes on staff morale should be considered and plans to support staff should be prioritised. Rostering should ensure staff do not exceed recommended working hours and that they have sufficient time to rest and recover between runs of shifts. The principles of good rostering apply.

Staff skills recorded within the e-rostering system must be kept up to date and consistent terminology used to do this across the organisation. This will help with the identification of staff who have the relevant skills for redeployment and aid system-wide planning processes.

Organisations should have a clear process for confirming shifts with staff. This is particularly important for staff moving to new areas or changing their usual work patterns.

Staff need to be coded appropriately so that rosters can be drawn up that give an acceptable ratio of PCCU trained, category A, category B and category C staff. This categorisation also enables redeployment decisions that balance clinical leadership and supervision across the service. Organisations should consider creating separate rosters for redeployed staff to increase their visibility and aid staffing decisions.

Organisations need robust measures to ensure all staff are identified and contactable, and their attendance/absence is tracked appropriately and recorded in the Electronic Staff Record. This will require significant administrative support within each department.

5.5 Other inpatient services

Critical care outreach services

Paediatric critical care outreach services, where available, should support rapid escalation of care according to carefully considered admission and discharge criteria. Adult critical care outreach services where available may be required to support the stabilisation of paediatric patients awaiting transfer to tertiary PCCUs.

Paediatric and adult critical care outreach services where available may be required to lead/support expert transfer of critically ill patients within the hospital.

As paediatric critical care demand increases, outreach services may need to be strengthened.

Paediatric critical care (PCC) transport services

PCC transport services provide critical care decision support to referring hospitals, triage patients who need transport, find appropriate beds and safely transport patients to critical care units. They are consultant-led, with at least one duty consultant on each shift who supervises transport teams and referrals, co-ordinates transport and provides decision support. Transport teams consist of at least two appropriately trained and experienced staff (consultant, middle-grade doctor or advanced nurse practitioner + critical care nurse) and an ambulance technician/driver. Some lower-risk transports (such as repatriations from critical care units, which only some transport teams perform) can be delivered by a trained nurse and ambulance technician/driver only.

Due to the nature of the transport environment, a transport team cannot usually care for more than one patient at a time. During periods of surge in demand, extra transport teams will need to be established. Delays in responding to request for transport may occur and contingency for maintaining safe care while awaiting transfer needs to be built into local plans.

Emergency departments (EDs)

ED plan triggers should be based on community and hospital levels of disease/demand, paediatric critical care capacity, staff availability and acute bed occupancy. RCN and the Royal College of Emergency Medicine (RCEM) have jointly outlined nursing workforce standards for type 1 emergency departments. The RCPCH recommends that EDs treating children must at all times be staffed with two registered children's nurses with recognised post-registration training in emergency nursing. EDs may require staff to be redeployed from children's services as well as other acute services.

Children's and young people's inpatient wards

All children's and young people's inpatient units should have seasonal workforce plans whose triggers are based on community and hospital levels of disease/demand, acute bed occupancy, PCCU capacity and staff availability. The age, acuity and dependency of the children and young people being cared for should be factored in when considering safe staffing.

Levels 1 and 2 PCCU patients may be admitted to and cared for on children's and young people's inpatient wards. Advanced staffing planning for these patients should follow this guidance: Level 1 and level 2 PCCU in a secondary care setting.

Further ward staffing for non-PCCU patients should be kept at a level that maintains patient safety and optimises patient flow. These staffing levels should be regularly reviewed in relation to activity and patient acuity and dependency, with input from senior clinical decision-makers and support from a comprehensive wider professional team. Staffing should be flexed in line with demand, allowing for levelling and redeployment of staff as required.

The RCN's Defining staffing levels for Children and young people's services: RCN Standards for clinical professionals and service managers states there should always be a minimum of two registered children's nurses per shift (day and night).

Adult critical care units

Children and young people may need to be admitted to an adult critical care unit to be stabilised before they are transferred to a dedicated PCCU facility. They should where possible be nursed in a side room by an adult critical care nurse with the support of a registered children's nurse. However, if cubicle capacity is limited, a risk assessment is required to prioritise cubicle use.

Adult inpatient wards

Some adult inpatient wards may be converted into children's and young people's wards to support increased capacity. Adult nurses from those wards may be redeployed to care for children and young people. Registered adult nurses will have many transferable nursing skills and knowledge but caring for children and young people is different from caring for an adult. Trusts should ensure that staff have the necessary skills and knowledge to undertake the duties required. Staff competencies and limitations should be carefully examined before redeployment and delegation of tasks. Adequate provision to support these areas should be the direct responsibility of paediatric teams and a minimum of two registered children's nurses should be available on every shift in these areas.

Children and young people admitted to an adult ward have the right to a parent or carer staying with them, so somewhere for the parent to sleep (inpatients) and to make refreshments is required.

Children and young people should not be nursed alongside acutely ill adult patients as they are more vulnerable emotionally than adults; ideally the child/young person should be admitted to a side room. However, if cubicle capacity is limited, a risk assessment is required to prioritise cubicle use.

All children and young people who are admitted to adult areas should be managed by the paediatric team and discussed at the daily staffing meetings to review the need for ongoing inpatient care. They should be repatriated to children's area as soon as feasibly possible.

Safeguarding children and young people

To protect children and young people from harm and improve their wellbeing, all healthcare staff must have the competencies to recognise child maltreatment and opportunities to improve childhood wellbeing, and to take effective action as appropriate to their role. All clinical staff caring for children require a minimum of level 2 safeguarding children training, as per the intercollegiate document on child safeguarding. In addition, they should always have access to colleagues trained in level 3 safeguarding.

The provider safeguarding team must be made aware of anyone under the age of 18 who is admitted to a non-paediatric area. At a local level there must be clear processes in relation to seeking support, advice and escalating concerns to the safeguarding children team.

6. Governance around staffing decision-making and redeployment

Good governance is vital in ensuring that safe, high-quality care is delivered. In its simplest terms, governance is a framework of systems and processes, eg risk management, incident reporting, safeguarding, that gives boards and local leaders confidence about the delivery and quality of their services. Effective governance:

- gives timely insight into the issues that need to be addressed and escalated
- provides positive assurance that statutory functions in relation to the quality of care are being delivered
- ensures that potential risks and issues have been addressed effectively and escalated where necessary.

In the context of workforce, governance processes should already be in place to ensure that the requirements set out in Developing workforce safeguards are complied with in full. This includes regular reporting to the board and the requirement for bi-annual staffing assessments. Although these requirements remain, we anticipate the paediatric clinical workforce will be impacted by increased demand, for which providers need to plan and act. Boards need to be assured that plans to expand the paediatric workforce are sufficiently robust and that risks associated with increased demand are mitigated as far as possible. Boards should also review their risk appetite in relation to quality and workforce when demand for paediatric care increases as a result of RSV and other respiratory illnesses in children, and communicate the level of risk they are prepared to tolerate.

We recognise that providers have been operating under significant pressure as a result of the Covid-19 pandemic for some time and there is a risk that difficult and exceptional decisions around staffing could become normalised. Through existing safer staffing systems and processes, boards should continue to seek assurance that all wards and departments, including paediatric wards and clinical areas, have sufficient staff with the right qualifications, skills and training to safely care for patients and that any shortfalls and risks are escalated so that timely action can be taken.

Reporting should be triangulated and include quality metrics, including incident data and complaints along with NICE red flags,[4] so that the consequence of staffing decisions can be understood, and learning maximised. Boards should also gain assurance that effective leadership at a local level is supporting staff wellbeing.

A safe staffing assurance framework template is attached at Appendix 4. This can be used to support leadership decisions and prompt consistent discussion around staffing assurance during challenging times. Key questions raised by the framework can help the board maintain a spotlight on staffing risks and their associated potential impact on patient care.

We also reiterate the importance of decisions being made at the right level being clearly documented. This includes decisions taken at hospital cell/situation report

[4] These are indicators that action needs to be taken to ensure that the fundamental needs of patients are being met.

(SitRep) meetings, local system resilience meetings and regional EPRR calls where mutual aid is agreed and system challenges are discussed.

Useful tools

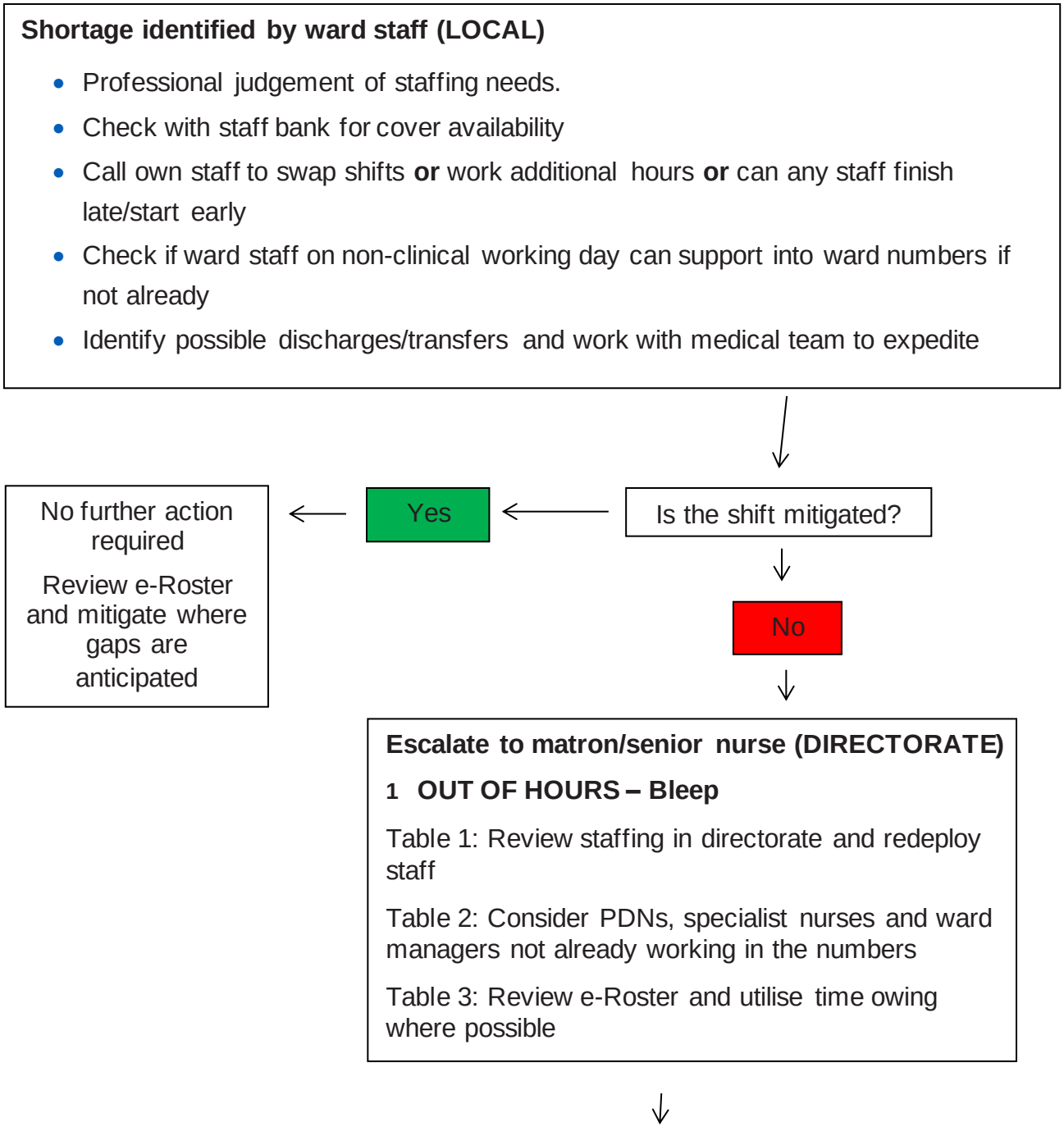
We expect providers already have embedded tools, templates and meetings to support and evidence decision-making and risk mitigation, but we include examples in the appendices, covering point of care to board approach, and ranging from the daily discussions and decision-making around filling shifts, the assessment and quality impact of changing the function and staffing of a ward, right up to the assurance that boards need to seek to ensure that decisions are robust, evidence-based and that any risks are mitigated as far as possible.

The tools are:

- decision and escalation framework tool, used to support nurse in charge and matrons on a shift-by-shift basis (Appendix 1)
- quality impact assessment, for clinical and service leads to plan changes in ward or staffing configuration (Appendix 2)
- staffing communication tool using SBAR (Situation, Background, Assessment, Recommendation) principles to ensure critical staffing issues are received, reviewed and actioned (Appendix 3)
- assurance framework for boards to use to support discussion around the staffing challenges faced and the potential impact they may have on patients (Appendix 4).

Appendix 1: Decision and escalation framework tool

Flowchart for resolution of staff shortages (Oxford University Hospitals NHS Foundation Trust)



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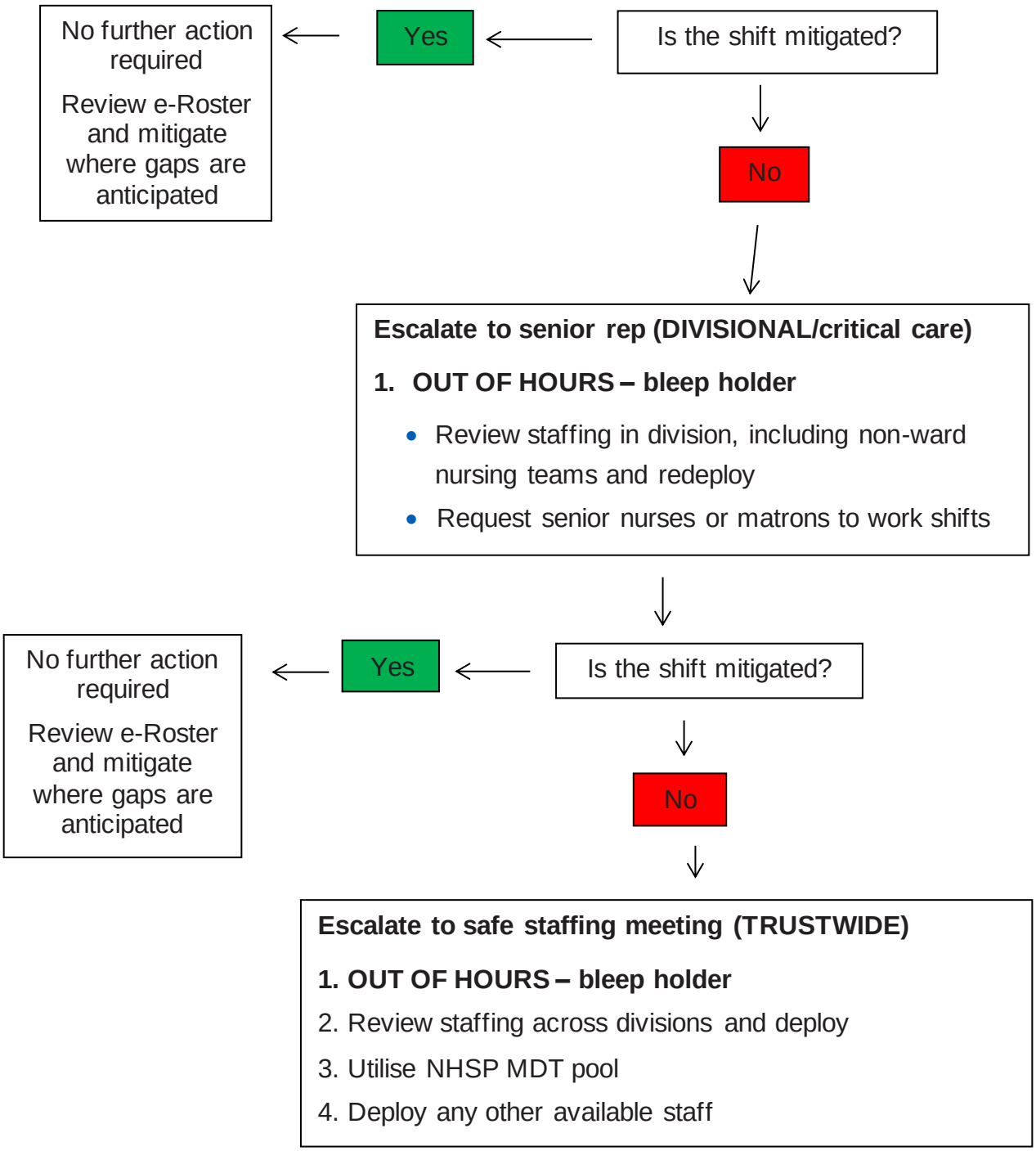
Is the shift mitigated?
Yes
No further action required
Review e-Roster and mitigate where gaps are anticipated
No
Escalate to senior rep (DIVISIONAL/critical care)
1. OUT OF HOURS – bleep holder
Review staffing in division, including non-ward nursing teams and redeploy
Request senior nurses or matrons to work shifts
Is the shift mitigated?
Yes
No further action required
Review e-Roster and mitigate where gaps are anticipated
No
Escalate to safe staffing meeting (TRUSTWIDE)
1. OUT OF HOURS – bleep holder
2. Review staffing across divisions and deploy
3. Utilise NHSP MDT pool
4. Deploy any other available staff

Appendix 2: Quality impact assessment

Ward/Clinical Area	
Sister/Charge Nurse	
Matron	
Divisional Nurse sign off	

Consequence	Likelihood 1 Rare	2 Unlikely	3 Possible	4 Likely	5 Almost certain
5 Catastrophic	5	10	15	20	25
4 Major	4	8	12	16	20
3 Moderate	3	6	9	12	15
2 Minor	2	4	6	8	10
1 Negligible	1	2	3	4	5

Extreme risk	0
High risk	0
Moderate risk	0
Low risk	0

	Brief description of potential impact	Risk rating: Consequence score	Likelihood score	Total risk score	Possible mitigation	Mitigated consequence score	Mitigated likelihood score	Mitigated risk score	Quality indicators	Actions taken when negative impact on quality
		On a scale of 1 to 5 - what is is the impact of the risk occurring?	*On a scale of 1 to 5 - what is is the likelihood of the risk occurring?*	***Corresponding total rating on the matrix above.***	*Detail what action will be taken to reduce any negative impact.*	*What is your adjusted consequence score post mitigation?*	*What is your adjusted likelihood score post mitigation?*	***Corresponding total rating on the matrix above.***	*How will you measure the impact on quality? What can indicate a change in the quality?*	
Patient safety										
Clinical effectiveness										
Patient experience										
Staff Experience										
Equality & diversity										

Maximum risk score (overall)	

	Date	Comments
Approval and comments -		
Chief Nurse		

Example quality indicators
Infection rate e.g MRSA
Medication errors
Slips, trips and falls
Adverse events e.g SUIs
Readmission rate
Mortality rate
Average length of stay
Patient satisfaction (discharge survey)
Patient complaints
Waiting times
Sickness and absence levels

Appendix 3: Staffing escalation (SBAR)

Situation

Ward:

Date, shift and Band that require covering:

Number of beds:

Acuity and dependency score:

Describe your concern, include safety/quality concern:

Background

Current problem:

Reason for problem on shift:

How long has the shift been out to the hospital nurse bank:

How long has the shift been out to the framework agency:

Assessment

My assessment of the situation is:

Current concern:

Describe actions that have been taken to solve current concern:

Recommendation

Based on my assessment I request that you approve:

Things to consider:

Explain what you need:

Appendix 4: Safe staffing assurance framework

Ref	Details	Controls	Assurance (positive and negative)	Residual risk score/ risk register reference	Further action needed	Issues currently escalated to local resilience forum/regional cell/national cell	Ongoing monitoring/ review
	Guidance notes	Outline the current controls (actions that mitigate risk, including policies, practice, process and technologies)	Detail the current positive and negative assurance position to give a balanced view of the current position Assurance is evidence that the control is effective – or conversely that a control is ineffective/ there are still gaps Recurrent forms of assurance are audit results, key performance indicators, written reports, intelligence and insight Effective assurance should be a triangulated picture of the evidence (staff shortages, sickness absence,patient outcomes, complaints, harm reviews)	What is the remaining risk score (using the trust's existing risk systems and matrix)? Are these risks recorded on the risk register?	Where gaps are identified in either control or assurance, outline the additional action to take to mitigate the risk. Where the organisation is unable to mitigate fully, this should be escalated to the local resilience forum/region/ national teams and outlined in the column immediately to the right	Provide the board with oversight of the current significant gaps are Outline the risks that are currently not fully mitigated/needing external oversight and support	Due to the likely prevailing nature of these risks, outline how these active risks are being monitored and through what operational channels (eg daily silver meetings via safe staffing heatmap)
1.0 Staffing escalation/planning for increased and exceptional demand across the system							

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Ref	Details	Controls	Assurance (positive and negative)	Residual risk score/ risk register reference	Further action needed	Issues currently escalated to local resilience forum/regional cell/national cell	Ongoing monitoring/ review
1.1	Staffing escalation plans have been defined to support increased and exceptional demand across the system. They include triggers for escalation at each phase and the corresponding redeployment approaches for staff Plans are detailed enough to evidence delivery of additional training and competency assessment, and expectations where staffing levels are contrary to required ratios (ie paediatric critical care) or as per the NQB safe staffing guidance[5]						
1.2	Staffing escalation plans have been widely consulted on and						

[5] National Quality Board guidance on safe staffing - https://www.england.nhs.uk/publication/national-quality-board-guidance-on-safe-staffing/

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Ref	Details	Controls	Assurance (positive and negative)	Residual risk score/ risk register reference	Further action needed	Issues currently escalated to local resilience forum/regional cell/national cell	Ongoing monitoring/ review
	agreed with trust staff-side committee						
1.3	Quality impact assessments are undertaken where estate or ward function or staff roles (including base staffing levels) change and these are signed off by the chief nurse/medical director						
2.0 Operational delivery							
2.1	There are clear processes for review and escalation of an immediate shortfall on a shift basis, including a documented risk assessment which includes a potential quality impact Local leadership is engaged and where possible mitigates the risk						

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Ref	Details	Controls	Assurance (positive and negative)	Residual risk score/ risk register reference	Further action needed	Issues currently escalated to local resilience forum/regional cell/national cell	Ongoing monitoring/ review
	Staffing challenges are reported at least twice daily via bronze						
2.2	Daily and weekly forecast position is risk assessed and mitigated where possible via silver/gold discussions Activation of staffing redeployment plans are clearly documented in the incident logs and assurance is gained that this is successful and that safe care is sustained						
2.3	The nurse in charge who is handing over patients is clear about their responsibilities to check that the member of staff receiving the patient is capable of meeting their individual care needs						

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Ref	Details	Controls	Assurance (positive and negative)	Residual risk score/ risk register reference	Further action needed	Issues currently escalated to local resilience forum/regional cell/national cell	Ongoing monitoring/ review
2.4	Staff receiving the patient(s) are clear about their responsibility to raise concerns if they do not have the skills to adequately care for the patients being handed over						
2.5	There is a clear induction policy for redeployed and temporary staff There is documented evidence that redeployed and temporary staff have received a suitable and sufficient local induction to the area and patients they will be supporting						
2.6	The trust has clear and effective mechanisms for reporting staffing concerns or where the patient needs are beyond an individual's scope of practice						

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Ref	Details	Controls	Assurance (positive and negative)	Residual risk score/ risk register reference	Further action needed	Issues currently escalated to local resilience forum/regional cell/national cell	Ongoing monitoring/ review
2.7	The trust can evidence that the mechanisms for raising concerns about staffing levels or scope of practice is used by staff and leaders have taken action to address these risks to minimise the impact on patient care						
2.8	The trust can evidence that there are robust mechanisms in place to support staff physical and mental wellbeing The trust is assured that these mechanisms meet staff needs and are having a positive impact on the workforce and therefore on patient care						
2.9	The trust has robust mechanisms for understanding the current staffing levels and their potential impact on patient care						

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Ref	Details	Controls	Assurance (positive and negative)	Residual risk score/ risk register reference	Further action needed	Issues currently escalated to local resilience forum/regional cell/national cell	Ongoing monitoring/ review
2.10	Staff are encouraged to report incidents in line with normal trust processes The trust considers novel mechanisms outside incident reporting for capturing potential physical or psychological harm resulting from staffing pressures (eg use of arrest or peri-arrest debriefs and outreach team feedback) and learns from this intelligence						
3.0 Daily governance via EPRR route							
3.1	Where necessary the trust has convened a multidisciplinary clinical and/or workforce/ wellbeing advisory group who inform the tactical and strategic staffing decisions via silver and bronze to						

Ref	Details	Controls	Assurance (positive and negative)	Residual risk score/ risk register reference	Further action needed	Issues currently escalated to local resilience forum/regional cell/national cell	Ongoing monitoring/ review
	provide the safest and sustained care to patients. Their decision-making is clearly documented in incident logs or notes of meetings						
3.2	Immediate and forecast staffing challenges are discussed and documented at least daily via the internal incident structures (bronze, silver, gold)						
3.3	The trust ensures system workforce leads and executive leads within the system are sighted on workforce issues and risks as necessary The trust uses local/ system reliance forums and regional EPRR escalation routes to raise and resolve staffing challenges to						

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Ref	Details	Controls	Assurance (positive and negative)	Residual risk score/ risk register reference	Further action needed	Issues currently escalated to local resilience forum/regional cell/national cell	Ongoing monitoring/ review
	ensure patients are provided with safe care						
3.4	The trust has sufficiently granular, timely and reliable staffing data to identify and, where possible, mitigate staffing risks to prevent harm to patients						
4.0 Board oversight and assurance (business as usual (BAU) structures)							
4.1	The quality committee (or other relevant designated board committee) receives a regular staffing report that evidences the current staffing hotspots, the potential impact on patient care and the short- and medium-term solutions to mitigate the risks						
4.2	Information from the staffing report is considered and triangulated alongside						

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Ref	Details	Controls	Assurance (positive and negative)	Residual risk score/ risk register reference	Further action needed	Issues currently escalated to local resilience forum/regional cell/national cell	Ongoing monitoring/ review
	the trust's Serious Incident (SI) reports, patient outcomes, patient/carer feedback and clinical harms process						
4.3	The trust's integrated performance dashboard has been updated to include paediatric focused metrics Staffing challenges related to the care of children and young people are assessed and reported for their impact on the quality of care alongside staff wellbeing and operational challenges						
4.4	The board (via reports to the quality committee) is sighted on the key staffing issues being discussed and actively managed via the incident management						

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Ref	Details	Controls	Assurance (positive and negative)	Residual risk score/ risk register reference	Further action needed	Issues currently escalated to local resilience forum/regional cell/national cell	Ongoing monitoring/ review
	structures and is assured that high quality care is at the centre of decision-making						
4.5	The quality committee is assured that the decision-making via the incident management structures (bronze, silver, gold) minimises any potential exposure of patients to harm that may occur when staffing in extremis						
4.6	The quality committee receives regular information on the system-wide solutions in place to mitigate risks to patients due to staffing challenges						
4.7	The trust board is fully sighted on the workforce challenges and any potential impact on patient care via the						

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Ref	Details	Controls	Assurance (positive and negative)	Residual risk score/ risk register reference	Further action needed	Issues currently escalated to local resilience forum/regional cell/national cell	Ongoing monitoring/ review
	reports from the quality committee The board is further assured that active operational risks are recorded and managed via the trust's risk register process						
4.8	The trust has considered and, where necessary, revised its appetite to both workforce and quality risks given the sustained pressures and novel risks caused by the potential increase in activity related to RSV and paediatric respiratory illnesses The risk appetite is embedded and lived by local leaders and the trust board (ie risks outside the desired tolerance are not accepted without clear discussion and rationale						

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Ref	Details	Controls	Assurance (positive and negative)	Residual risk score/ risk register reference	Further action needed	Issues currently escalated to local resilience forum/regional cell/national cell	Ongoing monitoring/ review
	and are challenged if longstanding)						
4.9	The trust considers the impact of any significant and sustained staffing challenges on its ability to deliver on the strategic objectives and these risks are adequately documented on the board assurance framework						
4.10	Any active significant workforce risks on the board assurance framework inform the board agenda and focus						
4.11	The board is assured that where necessary Care Quality Commission (CQC) and the regional NHS England and NHS Improvement team are made aware of any fundamental concerns arising from significant						

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Ref	Details	Controls	Assurance (positive and negative)	Residual risk score/ risk register reference	Further action needed	Issues currently escalated to local resilience forum/regional cell/national cell	Ongoing monitoring/ review
	and sustained staffing challenges						

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

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/21/09/133**			
SUBJECT:	**Audit Committee Chairs Annual Report 2020-21**			
DATE OF MEETING:	29th September 2021			
AUTHOR(S):	John Culshaw, Trust Secretary			
EXECUTIVE DIRECTOR SPONSOR:	Simon Constable, Chief Executive			
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	SO1 We will.. Always put our patients first delivering safe and effective care and an excellent patient experience.	x		
	SO2 We will.. Be the best place to work with a diverse and engaged workforce that is fit for now and the future	x		
	SO3 We will ..Work in partnership with others to achieve social and economic wellbeing in our communities.	x		
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): **(*Please DELETE as appropriate)***	**All**			
EXECUTIVE SUMMARY *(KEY ISSUES):*	This report seeks to deliver assurance to the Board and Council of Governors that the Committee has met its Terms of Reference and has gained assurance throughout the reporting period of the efficacy of the Trust's internal system of controls. The overall Head of Internal Audit opinion for the period 1st April 2020 to 31st March 2021 provides Moderate Assurance. This provides assurance that there is an adequate system of internal control however, in some areas weaknesses in design and/or inconsistent application of controls puts the achievement of some of the organisation's objectives at risk.			
PURPOSE: *(please select as appropriate)*	Information	**Approval** ✓	To note	Decision
RECOMMENDATION:	**The Board reviews the document, ensure it meets its purpose and ratifies the Committee Chair's Annual Report.**			
PREVIOUSLY CONSIDERED BY:	**Committee**	Audit Committee		
	Agenda Ref.	AC/21/08/68		
	Date of meeting	19 August 2021		
	Summary of Outcome	Approved		
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: *(if relevant)*	None			

AUDIT COMMITTEE REPORT 2020-21

The Committee

The Audit Committee is required to report annually to the Board and to the Council of Governors outlining the work it has undertaken during the year and, where necessary, highlighting any areas of concern. I am pleased to present my Audit Committee Annual Report which covers the reporting period 1 April 2020-31 March 2021.

The Audit Committee is responsible on behalf of the Board for independently reviewing the systems of integrated governance, risk management, assurance and internal control. The Committee's activities cover the whole of the Trust's governance agenda, and are in support of the achievement of the Trust's objectives.

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

During the reporting period, the Committee has been composed of at least three Non-Executive Directors with a quorum of two. I have been the Chair of the Committee since 1st December 2014.

The required relevant and recent financial experience and background necessary for the membership of the Audit Committee is met by myself, the Chair of the Committee and the details of my biography can be found on page 20 (*of the Annual Report and Accounts*).

Member	**Attendance (Actual v Max)**
Ian Jones, Non-Executive Director & Chair	5/5
Margaret Bamforth, Non-Executive Director	5/5
Terry Atherton, Non-Executive Director	5/5
Anita Wainwright, Non-Executive Director	5/5
Cliff Richards, Non-Executive Director	4/5

Regular attendees at the Committee Meetings were Grant Thornton (External Auditors), Mersey Internal Audit Agency ("MIAA") (Internal Audit & Anti-Fraud Services), the Chief Finance Officer and Deputy Chief Executive and the Trust Secretary

Terms of Reference

The Committee's Terms of Reference were reviewed and agreed in March 2020 to ensure they continue to remain fit-for-purpose and are reviewed two years from their approval.

Frequency of Meetings & Summary of Activity

The Committee met five times during the year. A summary of the activity covered at these meetings follows:

Governance & Risk Management

During the Year the Trust continued to develop and enhance its governance and risk management systems and processes. It also fully appraised its key strategic risks and refreshed its Board Assurance Framework which is fully reviewed by the Board at each of its meetings and the Quality Assurance Committee. In year, there was further alignment of the relevant elements of the Board Assurance Framework to the Committees of the Board.

The Audit Committee monitored and tracked all material governance activity during the reporting period to ensure that the system of internal control, risk management and governance is fit for purpose and compliant with regulatory requirements, aligned to best practice where appropriate and provides a solid foundation to support a **Moderate Assurance** rating from the Head of Internal Audit (HOIA).

Internal Audit Activities

MIAA acted as Internal Auditors for the Trust during the year. Internal Audit is an independent and objective appraisal service which has no executive responsibilities within the line management structure. It pays particular attention to any aspects of risk management, control or governance affected by material changes to the Trust's risk environment, subject to Audit Committee approval. A detailed programme of work is agreed with the Committee and set out for each year in advance and then carried out along with any additional activity that may be required during the year.

In approving the internal audit work programme, the Committee uses a three cycle planning and mapping framework to ensure all areas are reviewed at the appropriate frequency.

Detailed reports, including follow-up reviews to ensure remedial actions have been completed, are presented to the Committee by Internal Audit at each meeting throughout the year. All such information and reports are fully recorded in the minutes and papers prepared for each Audit Committee meeting. The assurance level for each audit completed during the year are listed below:

Substantial Assurance	Moderate Assurance	Limited Assurance	Advisory Support and Guidance Provided to
• Financial Systems. • Estates (Statutory Compliance). • Data Quality (A&E Indicators).	• SI Action Plan (including Duty of Candour). • Escalating Deteriorating Patients. • Surgical Standards for Invasive Procedures. • Change Management (Clinical Systems).	• Extra Duties. • Management of Capital Programme - Estates.	• Detailed insight into the overall Governance and Assurance processes gained from liaison throughout the year with Senior Officers including members of the Board and regular review of Board papers • Ongoing discussion with Lead Officers, Managers and Non-Executive Directors throughout the year • Effective utilisation of internal audit including in year communication and changes to the audit plan in respect of Extra duties review • Engagement with MIAA Insights benchmarking, best practice and outcome reporting

			• Opportunities / Involvement through MIAA events. Including the Learning Series, Audit Committee Members Network events, and Quality Improvement Network

An efficient and effective Assurance Framework is a fundamental component of good governance, providing a tool for Boards to identify and ensure that there is sufficient, continuous and reliable assurance, organisational stewardship and the management of the major risks to organisational success.

The Assurance Framework Review concluded that the organisation's Assurance Framework is structured to meet the NHS requirements, all elements rated Green.

Opinion	
Structure	The organisation's AF is structured to meet the NHS requirements.
Engagement	The AF is visibly used by the organisation.
Quality & Alignment	The AF clearly reflects the risks discussed by the Board.

It was also confirmed that the Trust's Assurance Framework is structured to meet the NHS requirements, is visibly used by the Board and clearly reflects the risks discussed by the Board.

The Internal Audit reports include detailed recommendations to improve systems and address weaknesses identified. Based on these recommendations, actions are agreed with Line Management and the Audit Committee tracks the implementation of the agreed actions to ensure implementation within an appropriate timeframe.

An Assurance Framework opinion test against NHS best practice was undertaken and the standards were met.

External Audit

Grant Thornton commenced its initial 3-year term as Auditors to the Trust in January 2017. The company then commenced a two year term in October 2020, following a competitive procurement exercise and recommendation by the Council of Governors. The contract contains the option to extend for one year in the third and fourth years.

During the year the Auditors reported on the 2020-21 Financial Statements. No material or significant issues were raised in respect of these Statements and Accounts. Technical support has been provided on an ongoing basis to the Committee and the Trust and representatives of Grant Thornton attended each Audit Committee.

Grant Thornton have since audited these 2020-21 Financial Statements and their report and opinion is enclosed herein. The auditor assurance work on the Quality Report for 2020-21 has ceased, this is following guidance from NHS England and NHSI.

Anti-Fraud Activity

The Committee and the Trust are supported in carrying out Anti-Fraud activity by MIAA's Anti-Fraud Service (AFS) working to a programme agreed with the Audit Committee. The role of AFS is to assist in creating an anti-fraud culture within the Trust: deterring, preventing and detecting fraud, investigating suspicions that arise, seeking to apply appropriate sanctions and redress in respect of monies obtained through fraud. Where such cases are substantiated, the Trust will take appropriate disciplinary measures.

Pro-active work has also included induction and awareness training along with ensuring Trust policies and procedures incorporate, where applicable, anti-fraud measures including the Anti-Fraud, Bribery and Corruption Policy. The Audit Committee received regular progress reports from the AFS and also received an annual report. No significant cases or issues of Anti-Fraud took place or were identified during the year.

Issues Carried Forward

The Audit Committee will continue its work to ensure the overall system of internal controls and the assurance processes remain robust.

In the reporting period there were no significant and material issues raised by the Committee to the Board of Directors or the Council of Governors.

Whilst the outcomes of the Clinical Audit programme falls under the remit of the Quality Committee and are reported and challenged in that forum, this Committee will review its approach purely from an audit perspective and to obtain assurance of methodology and approach as well as its contribution to improving quality.

With respect to the Internal Audit plan for 2021-22, a certain number of risk areas will be kept under review to see if they should be made a priority above those proposed in the 2020-21 Internal Audit Plan which has already been approved. This will be based on alignment with the strategic risk assessment for the Trust.

During 2021-21, alongside the Audit Committee, three main Board assurance committees were in place: (1) Quality Assurance, (2) Finance & Sustainability and (3) Strategic People. All of these Committees were Chaired by Non-Executive Directors and each Committee included at least two Non-Executive Directors. This structure gave strong visibility and focus at Non-Executive level on the key issues facing the Trust. The NEDs meet several times a year to assess a wide range of Trust issues including the appropriateness and effectiveness across the Committees and to address any potential gaps in assurance.

Summary

In year, the Committee has considered a wide range of issues in relation to financial statements, operations and compliance and has sought to gain assurance on each element by working closely with Internal Audit, the other Board Committees and key individuals across the Trust.

Throughout the reporting period, the Chair of the Committee reported in writing on the nature and outcomes of its work to the Board of Directors highlighting any area that should be brought to its attention through a Chair's Committee Assurance Report.

The Chair of the Committee will provide an overview of the work of the Committee to the Council of Governors in November 2021

The Committee has also assessed its own performance during the year and will report to the Board of Directors in September 2021.

The Audit Committee acknowledges the significant amount of work carried out by the Quality Assurance Committee in continuing to refresh and embed the Trust's governance and risk management systems.

I would also like to thank all members of the Committee, along with Directors, staff, internal and external advisors for their responses, support and contributions during a year which proved to be unusually challenging. The pandemic created significant unexpected pressures, and all concerned adapted to the situation in a highly professional manner to ensure that effective risk management and good governance were maintained throughout.

Ian Jones

Chair of Audit Committee
August 2021

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/21/09/134**			
SUBJECT:	**Amendment to the Constitution – amendment to description of Lead Governor Role & addition of a description of the role of Deputy Lead Governor.**			
DATE OF MEETING:	29 September 2021			
AUTHOR(S):	John Culshaw, Trust Secretary			
EXECUTIVE DIRECTOR SPONSOR:	Simon Constable, Chief Executive			
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	SO1 We will.. Always put our patients first delivering safe and effective care and an excellent patient experience.	✓		
	SO2 We will.. Be the best place to work with a diverse and engaged workforce that is fit for now and the future	✓		
	SO3 We will ..Work in partnership with others to achieve social and economic wellbeing in our communities.	✓		
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): **(*Please DELETE as appropriate)***	**#145** Influence within Cheshire & Merseyside a. Failure to deliver our strategic vision, including two new hospitals and vertical & horizontal collaboration, and influence sufficiently within the Cheshire & Merseyside Healthcare Partnership and beyond, may result in an inability to provide high quality sustainable services may result in an inability to provide the best outcome for our patient population and organisation, potential impact on patient care, reputation and financial position. b. Failure to fund two new hospitals may result in an inability to provide the best outcome for our patient population and organisation, potential impact on patient care, reputation and financial position.			
EXECUTIVE SUMMARY *(KEY ISSUES):*	The Trust's Constitution states: *45. Amendment of the constitution* *45.1. The Trust may make amendments to its constitution if:* *45.1.1 more than half of the members of the Board of Directors of the Trust voting approve the amendments; and* *45.1.2 more than half of the members of the Council of Governors of the Trust voting approve the amendments.* The Paper sets out a proposal to allow, by way of amendment of the Trust's Constitution, an amendment the current description of the role of Lead Governor and the addition of a description of the role of Deputy Lead Governor.			
PURPOSE: *(please select as appropriate)*	Information	**Approval** ✓	To note	Decision
RECOMMENDATION:	The Trust Board is asked to support amendments to the Constitution as outlined above.			
PREVIOUSLY CONSIDERED BY:	**Committee**	Council of Governors		
	Agenda Ref.	COG/21/08/46		
	Date of meeting	12 August 2021		
	Summary of Outcome	Approved		

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

SUBJECT	Amendment to the Constitution – amendment to description of Lead Governor Role & addition of a description of the role of Deputy Lead Governor.	AGENDA REF	COG/21/08/46

1. BACKGROUND/CONTEXT

The Trust's Constitution states:

45. Amendment of the constitution

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

To support the future election of the Lead Governor it is proposed that the current description of the role of Lead Governor is updated, by way of amendment to the Constitution, as described in section 2.

Furthermore, in order to provide ongoing assistance to Lead Governor, and to support continuity amongst the Council of Governors, it is proposed that the role of Deputy Lead Governor is created, and the description entered into the Constitution as described in section 2.

2. KEY ELEMENTS

LEAD GOVERNOR ROLE DESCRIPTION

NHS E/I, in its Code of Governance asks that all Foundation Trusts have a 'lead governor'.

Primary Role

The primary purpose of the Lead Governor is to facilitate direct communication between the Regulator (NHS E/I) and the Council of Governors. The Regulator does not however envisage direct communication with Governors until such time as there may be a real risk of the Foundation Trust significantly breaching its licence or constitution and the Council's concerns cannot be satisfactorily resolved.

Once there is a risk that this may be the case, and the likely issue is one of board leadership, the Regulator will often wish to have direct contact with the Foundation Trust's Governors, but at speed and through one established point of contact – the Foundation Trust's nominated Lead Governor.

Such contact is likely to be a rare event and would be seen, for example, should NHS E/I wish to understand the view of the Governors about the capability of the chair, or be investigating some aspect of an appointment process of decision which may not have complied with the constitution.
It is important to remember that it is the Council of Governors *as a whole* (and no individual governor) that has the responsibilities and powers in statute.

Lead Governor Duties:

- Leading the Council of Governors in exceptional circumstances when it is not appropriate for the chair or another non-executive to do so)
- Collating the input of Governors for the senior independent director or chair regarding annual performance appraisals of the chair and non-executive directors.
- Leading Governors on the Governors nominations and remuneration committee (GNARC) in the process for appointing a chair and non-executive directors.
- To recommend to the Council of Governors on behalf of the Nominations and Remuneration Committee any appointments/reappointments of Chair and/or Non-executive Directors
- Acting as a point of contact and liaison for the chair and senior independent director,
- Acting as a co-ordinator of governor responses to consultations,
- Chairing informal governor-only meetings.
- Attend Pt1 and Pt 2 Board Meeting and report to the Council of Governors on performance of NED's
- Troubleshooting and problem solving by raising issues with the chair and chief executive,
- Leading Governors in holding the non-executive directors to account,
- Contribute to the induction of new Governors.
- Present the Annual Governor's Report to Members at the Annual Members Meeting
- Meet routinely with the Chair, Company Secretary and Deputy Lead Governor to plan and prepare the agenda for Council of Governors meetings
- Work with individual Governors who need advice or support to fulfil their role as a Governor,
- Acting as a point of contact for the CQC and NHS E/I
- Other duties as requested by the Council of Governors or the Chairman

Term

The 'term of office' is two years or until the serving Governor's term ends, whichever is the sooner. The Lead Governor role is subject to two-yearly election or whenever a vacancy arises, whichever is sooner.

Eligibility

To be eligible to stand governors:

1. Must have served at least one year with the WHH Council of Governors
2. Must have achieved reasonable attendance at the CoG (min attendance is 75%)

DEPUTY LEAD GOVERNOR ROLE DESCRIPTION

The role of Deputy Lead Governor is not a statutory role under the NHS Foundation Trust Code of Governance.

Primary Role

The primary purpose of the Deputy Lead Governor is to provide the Foundation Trust with a point of contact for the Council of Governors should the Lead Governor be unavailable for a period or has a conflict of interest.

The Deputy Lead Governor will also:

- Meet routinely with the Chair, Trust Secretary and Lead Governor to plan and prepare the agenda for Council of Governors meetings,
- Attend Trust Board meetings in the absence of the Lead Governor.
- Other duties as requested by the Council of Governors or the Chairman

Term

The Deputy Lead Governor role is subject to two-yearly election or whenever a vacancy arises, whichever is sooner.

Eligibility

To be eligible to stand governors:

1. Must have served at least one year with the WHH Council of Governors
2. Must have achieved reasonable attendance at the CoG (min attendance is 75%)

3. ACTIONS AND RECOMMENDATIONS

The Board is asked to:

- Support amendments to the Constitution as outlined above.

Registered charity number 1051858

CHARITABLE FUNDS COMMITTEE

GOVERNING DOCUMENT

0. THE CHARITY

Warrington and Halton Hospitals Charity is registered in England with the Charities Commission number 1051858. It is the sole Charity of the NHS Foundation Trust known as Warrington and Halton Teaching Hospitals headquartered at Lovely Lane, Warrington WA5 1QG and conducts its activities under the auspices of the Corporate Trustee for the benefit of the patients, staff and volunteers at both Halton and Warrington hospitals.

The Charity is a member of the Institute of Fundraising and NHS Charities Together and abides by the Fundraising Code of Practice.

Its values are:

- **Ethical** - We will never pressure potential donors
- **Transparent** - We will be open and transparent about our charity and keep donors informed of our progress
- **Accountable** - We will ensure that our fundraising costs deliver maximum return
- **Compassionate** - We will ensure that donated funds are distributed for the widest possible benefit of patients and their families
- **Creative** – We will innovate and diversify our fundraising activities to remain an attractive partner to donors

1. PURPOSE

The Board of Directors, acting as Corporate Trustee for the Charitable Funds, hereby resolves to establish a Committee of the Board of Directors to be known as the Charitable Funds Committee. The Committee has no executive powers other than those specifically delegated in these Terms of Reference.

2. AUTHORITY

The Committee is authorised to:

2.1 perform any of the activities within its terms of reference;
2.2 obtain outside professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary; and
2.3 make recommendations to the Board for actions it deems necessary.

The Trust is Corporate Trustee of charitable funds registered together under charity registration 1051858 and the Committee is appointed as the Trust's agent in accordance with s16 of the NHS Trusts (Membership and Procedures) Regulations 1990.

Registered charity number 1051858

The Committee is authorised by the Corporate Trustee to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience if it considers this necessary.

3. REPORTING ARRANGEMENTS

The Committee will have the following reporting responsibilities:

- The Committee will be accountable to the Corporate Trustee (the Trust's Board of Directors). A report of the meeting will be submitted and presented to the Corporate Trustee by the Chair in the Private (part 2) session of the Board meeting (given the commercially sensitive nature of the Charity's activities) and who shall draw to the attention of the Board issues that require disclosure to the full Board, or require executive action, through a Chair's key issues report. The minutes of the Committee meetings will be formally recorded.
- The Committee will report to the Corporate Trustee annually on its work and performance in the preceding year.
- The Trust standing orders and standing financial instructions apply to the operation of the Committee.

4. DUTIES & RESPONSIBILITIES

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

- Ensure that the disbursement of funds are in accordance with the founding principles of the charity ie:

Our purpose as a Charity is to support Warrington and Halton Teaching Hospitals to be OUTSTANDING for our patients, our staff and our communities by fundraising to provide:

1. State of the art equipment, technology or training
2. Funding for WHH-related research and innovation
3. Improving the hospital environment
4. Providing enhancements to support the care and comfort of our patients, carers and visitors while on our premises
5. Support to enable the health and wellbeing of our patients and our staff

….beyond that which the NHS is obliged to provide as part of patient care.

- Ensure that individual fund objectives and spending plans are in keeping with the objectives, spending criteria and priorities set by the donors.
- Obtain plans for all individual funds and approve if/when appropriate.
- Ensure that donations and investment income or losses are attributed to individual funds appropriately.
- Ensure the sources of income and the terms on which donations are received are acceptable to the Trustees.
- Ensure that all funds are correctly allocated as restricted, unrestricted or designated, and accounted for accordingly. This analysis will differentiate between restricted, specific and the General charitable fund.

Registered charity number 1051858

- Recommend an investment advisor – where market conditions are favourable - to the Corporate Trustee following appropriate tendering procedures and regularly monitor and review their performance.
- Ensure that the investment policy for Charitable Funds set by the Corporate Trustee is implemented and that sufficient funds are kept readily available to meet planned requirements.
- Ensure (through the NHS Foundation Trust's Finance Department and accounting systems*)* that there is an appropriate system of control over income and expenditure, and that there are robust governance arrangements in place.
- Ensure that the NHS Foundation Trust's Constitution Standing Financial Instructions and the Scheme of Reservation and Delegation are appropriately interpreted for charitable funds.
- Receive and discuss all audit reports on charitable funds and recommend action to the Corporate Trustee
- Review the Charitable Funds annual accounts and comment/ recommend approval to the Corporate Trustee as appropriate.
- Respond to requests from the Corporate Trustee for review or investigation on relating to charitable funds.
- Receive WHH Charity Strategy and Forecasted income and expenditure and the WHH Charity annual review
- Receive the WHH Charity Annual Operational and Financial Plan
- Receive the Charities Commission Guidance for Trustees checklist bi-annually and submit to the Corporate Trustee
- Receive the WHH Charity Risk Strategy every three years or as circumstances dictate
- Receive the WHH Charity Risk Register annually with any changes or additions to this notified through the Fundraising report
- Conduct an annual committee effectiveness review and submit to the Corporate Trustee with the Chair's Annual Report.

5. MEMBERSHIP

The Committee shall be composed of the Corporate Trustee ie the Trust's voting Board members

The Committee shall comprise the individuals responsible for ensuring that corporate Trustee duties of the Trust are fulfilled. They shall be appointed by the Trust Board and will normally include:

- All the non-executive directors of the Trust (with the exception of the Trust Chairman) one of whom will be appointed as Chair of the Committee by the Trust Board
- Up to (three) voting Executive directors to include the Chief Finance Officer or their nominated deputies and the Chief People Officer.

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

Committee may approve a matter in writing by receiving written approval from all the members of the Committee, such written approval may be by email from the members Trust email account.

6. ATTENDANCE

In addition to the above, the following individuals, or their nominated deputy, shall normally be in attendance at the meetings:

- Director Communications and Engagement
- Head of Fundraising
- Deputy Director of Finance and Commercial Development
- Financial Planning Accountant
- Nominated Governor (Public Constituency)
- Any Senior Trust employees with clinical and operational expertise as nominated by the Trust Board at the invitation of the Committee

7. QUORUM

A quorum shall be:

(2) non-executive directors
(2) executive directors (or their nominated deputies)

8. FREQUENCY OF MEETINGS

The Committee will meet on a quarterly basis.

9. ADMINISTRATIVE ARRANGEMENTS

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

10. REVIEW / EFFECTIVENESS

The Committee will undertake an annual review of its performance against its work plan in order to evaluate the achievement of its duties. This review will inform the Committee's annual report to the Board.

DATE: June 2020

NEXT REVIEW: June 2022

GOVERNING DOCUMENT - REVISION TRACKER

Date: 10 Sept 21, Approved CFC: 10 Sept 21
Review Date: Sept 2023

Registered charity number 1051858

Name of Committee:	**CHARITABLE FUNDS COMMITTEE**
Version:	Issue No 9
Implementation Date:	June 2020
Review Date:	24 Months from the approval date ie June 2022
Approved by:	Charitable Funds Committee
Approval Date:	Charitable Funds Committee 4 June 2020 and Trust Board (insert)

REVISIONS

Date	Section	Reason on Change	Approved
June 2018	**Attendance**	- **Delete** Corporate Affairs from Director of Communications + Engagement title	
March 2019	**Membership**	- The Committee shall comprise the individuals responsible for ensuring that corporate Trustee duties of the Trust are fulfilled. They shall be appointed by the Trust Board and will normally include: - All the non-executive directors of the Trust (with the exception of the Trust Chairman) one of whom will be appointed as Chair of the Committee by the Trust Board - Up to (three) voting Executive directors to include the Director of Finance and Commercial Development or their nominated deputies	CFC 7.03.2019 Trust Board 31.05.2019
March 2019	**Attendance**	- Director Community Engagement and Fundraising - Deputy Director of Finance - Head of Financial Services - Nominated Governor (Public Constituency) - Any Senior Trust employees with clinical and operational expertise as nominated by the Trust Board at the invitation of the Committee	CFC 7.03.2019 Trust Board 31.05.2019
March 2019	**Quorum**	A quorum shall be: (2) non-executive directors (2) executive directors (or their nominated deputies)	CFC 7.03.2019 Trust Board 31.05.2019

Registered charity number 1051858

June 2020	**Attendance**	Replace Head of Financial Services with Financial Planning Accountant Amend title to read - Deputy Director of Finance and Commercial Development Amend title of DoF + Commercial Development to read Chief Finance Officer Add Head of Fundraising Amend title of Director Community Engagement & Fundraising to Director Communications and Engagement	Issue 9 CFC 04.06.2020 Trust Board xx.xx.2020
June 2020	**Charitable Purpose**	To update the charitable purpose following Cttee approval in December 2019	Issue 9 CFC 04.06.2020 Trust Board xx.xx.2020
Sept 2021	**Membership**	To add the Chief People Officer to the membership	Issue 10 CFC Sept 2021 Trust Board 29.9.21

TERMS OF REFERENCE OBSOLETE		
Date	**Reason**	**Approved by:**
04.06.2020	**Issue 8 replaced with Issue 9**	CFC 04.06.2020
10.09.21	**Issue 9 replaced with issue 10**	CFC 10.9.21

CHARITABLE FUNDS COMMITTEE CYCLE OF BUSINESS 2021-23												
	Exec Lead		**June 2021**	**Sept 2021**	**Dec 2021**		**Mar 2022**	**June 2022**	**Sept 2022**	**Dec 2022**		**March 2023**
INTRODUCTION & ADMINISTRATION												
Apologies for Absence	Chair		X	X	X		X	X	X	X		X
Declarations of Interest	Chair		X	X	X		X	X	X	X		X
Minutes of the Last Meeting	Chair		X	X	X		X	X	X	X		X
Matters Arising+ Action Log	Chair		X	X	X		X	X	X	X		X
Rolling attendance	Chair		X	X	X		X	X	X	X		X
FUNDRAISING												
Fundraising Report	Director of Communications + Engagement		X	X	X		X	X	X	X		X
Charitable Funds Strategy	Director of Communications + Engagement			X					X			
FINANCE												
Finance Report	Chief Finance Officer + Deputy CEO		X	X	X		X	X	X	X		X
Bid applications	Director of Communications + Engagement		X	X	X		X	X	X	X		X
Investment Strategy/update	Chief Finance Officer + Deputy CEO						X					X
Annual Review of Reserves Policy	Financial Planning Accountant		X					X				
Investment Guidance Annual update	Financial Planning Accountant		X					X				
GOVERNANCE & COMPLIANCE												
Governing Document (Due Sept 23)	Chair/Director of Community Engagement			X								
Cycle of Business	Chair/Director of Community Engagement			X					X			
Charities Commission Checklist	Director of Communications + Engagement		X		X			X		X		
Charity Risk Register	Director of Communications + Engagement		X	X	X		X	X	X	X		X
Annual Report and Accounts	Chief Finance Officer + Deputy CEO				X					X		
Committee Chair's Annual Report to Board	Chair		X					X				
CLOSING												
Key issues to the Board	Chair		X	X	X		X	X	X	X		X
Any Other Business	Chair		X	X	X		X	X	X	X		X

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/21/09/136**	
SUBJECT:	**Medical Appraisal and GMC Revalidation Annual Report: September 2021**	
DATE OF MEETING:	29th September 2021	
AUTHOR(S):	Janice Fazackerley – Associate Medical Director and Deputy Responsible Officer Andrea Stazicker – Revalidation Lead Paula Harris – Medical Workforce Development Administrator Kate Davidson – Medical Education Operational Manager	
EXECUTIVE DIRECTOR SPONSOR:	Alex Crowe, Executive Medical Director	
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	SO1 We will.. Always put our patients first delivering safe and effective care and an excellent patient experience. SO2 We will.. Be the best place to work with a diverse and engaged workforce that is fit for now and the future SO3 We will ..Work in partnership with others to achieve social and economic wellbeing in our communities.	 X
EXECUTIVE SUMMARY *(KEY ISSUES):*	This report provides assurances to the Board that the system for medical appraisal and the processes for monitoring the completion of annual appraisals to support GMC revalidation for the medical workforce are robust. Doctors who practise medicine in the UK must be registered and hold a licence to practise Both registration and licensing are delivered by the GMC. Every licensed doctor who practises medicine must revalidate. Revalidation is an evaluation of a doctor's fitness to practise. It supports professional development, drives improvements in clinical governance and gives patients confidence that the doctor is up to date. GMC revalidation is based on annual whole practice appraisals; information from systems of clinical governance and a five yearly revalidation recommendation. All doctors have a legal obligation to revalidate and failure to comply with the requirements may result in withdrawal of their licence to practise Most licensed doctors are supported with their appraisal and revalidation through connection to a 'designated body'. Within that organisation, a 'responsible officer' oversees the process of revalidation and makes a recommendation to the GMC about whether a doctor should be revalidated. The designated body is the organisation in which the doctor undertakes most, or all of their practice and their responsible officer is a senior doctor within that organisation. The relationship between a doctor, their designated body and responsible officer is known as their 'connection details'. The Trust maintains the list of doctors for whom it is the designated body. The responsible officer is Dr Alex Crowe.	

	The responsible officer must: 1. Make sure doctors have access to appraisal systems and processes for collecting and holding information 2. Make a recommendation to the GMC every five years, indicating whether the doctor is up to date, fit to practise and should be revalidated. The GMC sets clear guidance on the requirements for annual appraisal and the supporting information that a doctor must present. Doctors at WHHFT collate their supporting information using CRMS - a web based system enabling the secure storage of documentation. Since 2012 WHHFT has had processes and systems in place to enable, track and monitor appraisal completion rates.			
PURPOSE: ***(please select as appropriate)***	Information	Approval √	To note	Decision
RECOMMENDATION:	For the Committee to note and approve the year-on-year results that have been achieved for completion of annual medical appraisals. Annual Board report and Statement of compliance sign off for submission to NHSEI.			
PREVIOUSLY CONSIDERED BY:	**Committee**	Strategic People Committee		
	Agenda Ref.	**SPC/21/09/72**		
	Date of meeting	22/9/21		
	Summary of Outcome	Approved		
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None			

REPORT TO BOARD OF DIRECTORS

SUBJECT	Medical Appraisal and GMC Revalidation Annual Report: Sept 2021	AGENDA REF:	BM/21/09/136

1. BACKGROUND/CONTEXT

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

Most licensed doctors are supported with their appraisal and revalidation through a connection to a 'designated body'. Within that organisation, a 'responsible officer' oversees the process of revalidation and makes recommendations to the GMC about whether a doctor should be revalidated. The designated body is the organisation in which the doctor undertakes most, or all of their practice and their responsible officer is a senior doctor within that organisation. The relationship between a doctor, their designated body and responsible officer is known as their 'connection details.' The Trust maintains the list of doctors for whom it is the designated body. The responsible officer is Dr Alex Crowe.

The responsible officer must:

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

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

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

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

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

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

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

2. KEY ELEMENTS

See appendix 1 - annual board report and statement of compliance

a. Effective Appraisal

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

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

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

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

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

Key Results

The Trust Maintains 70 trained appraisers

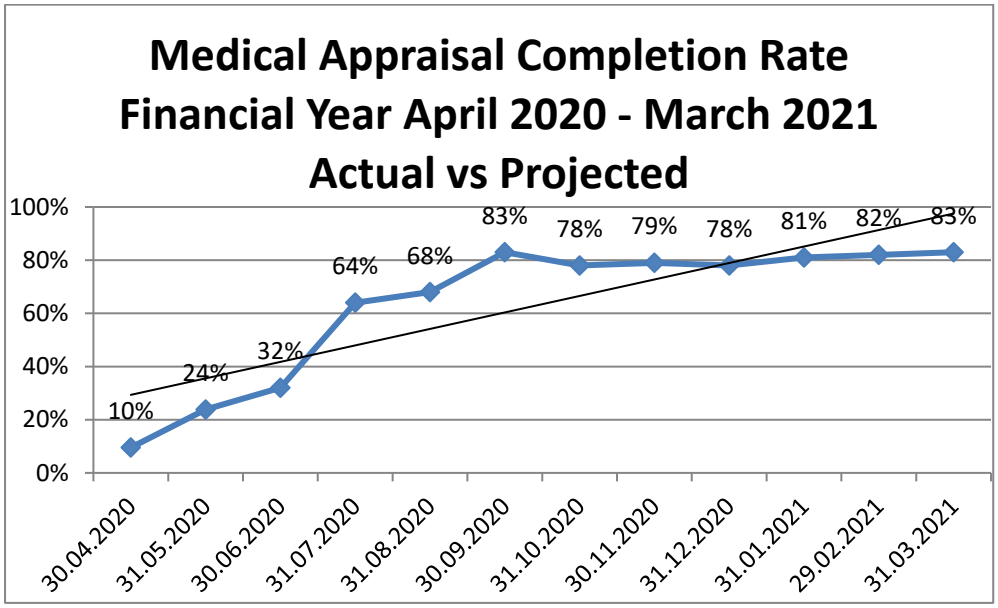
Name of organisation: Warrington & Halton Teaching Hospitals NHS Foundation Trust	
Total number of doctors with a prescribed connection as at 31 March 2021	279
Total number of appraisals undertaken between 1 April 2020 and 31 March 2021	186
Total number of appraisals not undertaken between 1 April 2020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

Total number of agreed exceptions	56

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

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

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



2.2 Recommendations to the GMC

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

2.3 Medical governance

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

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

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

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

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

2.4 Employment Checks

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

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

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

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

3. ACTIONS REQUIRED/RESPONSIBLE OFFICER

See appendix 1 - annual board report and statement of compliance

General review of actions since last Board report :

- Since the 2020 report, we introduced 'Appraisal 2020' with emphasis on reflection and wellbeing, and informed our appraisers by an on-line forum, published guidance, e-mails and personal discussion.

- Trust supplied information for appraisal has been reviewed to remove any which is no longer relevant, thereby reducing the administrative burden of preparing and uploading reports.

- A full review of appraiser allocations has taken place after several years unchanged. The template developed facilitates easy forward planning to change appraiser after three appraisals, in keeping with best practice

- 8 new appraisers were trained and have taken up an allocation of appraisees.

- Quality assurance of appraisal summaries (PROGRESS tool) has commenced.

- Revalidation panels have resumed after a pause by the GMC

- The appointment of a new Medical Education Operations Manager has brought stability after a stressful period for doctors and Appraisal & Revalidation staff

Actions still outstanding & Current Issues :

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

4. MEASUREMENTS/EVALUATIONS

In spite of new challenges from the Covid-19 pandemic affecting both doctors and members of the Appraisal & Revalidation team, we have been able to maintain business as usual, but also to develop using the positive ideas from pandemic working. We have supported doctors to achieve a less onerous but more useful appraisal and those due to revalidate have been recommended on time, except for one short deferral.
Staffing of the team is improved, after a prolonged period without a manager, and we are better placed to work efficiently, share information, and build good relations with the departments of governance and human resources which are fundamental to the smooth running of our work.

5. MONITORING/REPORTING ROUTES

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

6. TIMELINES

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

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

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

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

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

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

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

1. The Revalidation Lead contacts the doctor prior to their revalidation becoming due to inform them that evidence to support a decision is being gathered. The doctor is made aware of any deficiencies by e-mail, asked to provide additional information or documentation required and informed that they cannot be given a positive recommendation for revalidation if they do not meet the criteria and that this would require a deferral being requested.
2. Once a revalidation decision has been made, this is submitted to the GMC via GMC Connect. Each doctor is e-mailed to inform them of the decision.

3. Those who do not receive a positive recommendation are given details of what remains outstanding and what they need to do. If the shortfall in what is required is likely to be achieved before the submission deadline, for example, the 360 MSF report isn't yet available, then the decision would be held back internally and reviewed again by the Responsible Officer nearer to the submission deadline.

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

7. ASSURANCE COMMITTEE

SPC

8. RECOMMENDATIONS

NHS England Template: Statement of Compliance. Annual submission sign off

Appendix 1

Annual Board Report and Stateme

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/21/09/137i**	
SUBJECT:	**Emergency preparedness, resilience and response (EPRR) annual assurance process for 2021-22**	
DATE OF MEETING:	29th September 2021	
AUTHOR(S):	Rachel Clint, Acting EPRR Manager	
EXECUTIVE DIRECTOR SPONSOR:	Daniel Moore, Chief Operating Officer	
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	SO1 We will.. Always put our patients first delivering safe and effective care and an excellent patient experience.	X
	SO2 We will.. Be the best place to work with a diverse and engaged workforce that is fit for now and the future	
	SO3 We will ..Work in partnership with others to achieve social and economic wellbeing in our communities.	
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): **(*Please DELETE as appropriate)***	**#1215** Failure to deliver the capacity required caused by the ongoing COVID-19 pandemic and potential environmental constraints resulting in delayed appointments, treatments and potential harm **#1273** Failure to provide timely patient discharge caused by system-wide Covid-19 pressures, resulting in potential reduced capacity to admit patients safely. **#1272** Failure to provide a sufficient number of beds caused by the requirement to adhere to social distancing guidelines mandated by NHSE/I ensuring that beds are 2 metres apart, resulting in reduced capacity to admit patients and a potential subsequent major incident. **#1275** Failure to prevent Nosocomial Infection caused by asymptomatic patient and staff transmission or failure to adhere to social distancing guidelines resulting in hospital outbreaks **#1289** Failure to deliver planned elective procedures caused by the Trust not having sufficient capacity (Theatres, Outpatients, Diagnostics) resulting in potential delays to treatment and possible subsequent risk of clinical harm. **#115** Failure to provide adequate staffing levels in some specialities and wards. Caused by inability to fill vacancies, sickness. Resulting in pressure on ward staff, potential impact on patient care and impact on Trust access and financial targets. **#134** Financial Sustainability a) Failure to sustain financial viability, caused by internal and external factors, resulted in potential impact to patient safety, staff morale and enforcement/regulatory action being taken. b) Failure to deliver the financial position and a surplus places doubt over the future sustainability of the Trust. There is a risk that current and future loans cannot be repaid and this puts into question if the Trust is a going concern. **#1134** Failure to provide adequate staffing caused by absence relating to COVID-19 resulting in resource challenges and an increase within the temporary staffing domain **#1114** FAILURE TO provide essential and effective Digital Services CAUSED BY increasing demands upon resources (e.g. cyber defences), new technology skillsets (e.g. Cloud), unfit solutions (e.g. Maternity), end-of-life solutions (e.g. Telephony), poor performance (e.g. Lorenzo EPR)RESULTING in a potentially reduced quality of care, data quality, a potential failure to meet statutory obligations (e.g. Civil Contingency measures) and subsequent reputational damage. **#1079** Failure to provide an electronic patient record (EPR) system that can accurately monitor, record, track and archive antenatal (including booking information, intrapartum and postnatal care episodes.	

	Caused by an IT system (Lorenzo) which is not maternity specific, currently does not have a robust internet connectivity, inaccurate input of data, inadequate support to cleanse data and no intra-operability between services, for example by the health visitor services. Resulting in the inability to capture all required data accurately, to have a robust electronic documentation process in cases of litigation or adverse clinical outcome, poor data quality and inadequate communication with allied services, such as health visitors who are then uninformed of women within the system requiring antenatal assessment. This can also result in women being allocated to the wrong pathway and the wrong payment tariff. **#224** Failure to meet the emergency access standard, Caused by system demands and pressures. Resulting in potential risk to the quality of care and patient safety, risk to Trust reputation, financial impact and below expected Patient experience. **#1207** Failure to complete workplace risk assessments for all staff in at-risk groups, within the timeframes set out by NHSI/E. This will be caused by a lack of engagement in the set process by line managers, resulting in a failure to comply with our legal duty to protect the health, safety and welfare of our own staff, for which the completion of a risk assessment for at-risk members of staff is a vital component. **#1372** FAILURE TO deliver the future Electronic Patient Record solution through the Strategic Procurement project in line with the Trust's time, budget and quality requirements CAUSED BY an un-affordable business case due to baseline costs, strong existing benefits & lack of new cash releasing benefits, plus delayed and diluted access to stakeholder support due to operational pressures RESULTING IN continuation of the Trust's challenges with the incumbent EPR, Lorenzo, which were identified in the Strategic Outline Case. **#1233** Failure to review surgical patients in a timely manner and provide a suitable environment for surgical patients to be assessed caused by CAU being bedded and overcrowding in ED resulting in poor patient experience, delays in treating patients and increased admission to the surgical bed base. **#125** Failure to maintain an old estate caused by restriction, reduction or unavailability of resources resulting in staff and patient safety issues, increased estates costs and unsuitable accommodation. **#1108** Failure to maintain staffing levels, caused by high sickness and absence, including those affected by COVID-19, those who are extremely vulnerable, those who are assessed as only able to work on a green pathway, resulting in inability to fill midwifery shifts. This also currently affects the CBU management team. **#145** Influence within Cheshire & Merseyside a. Failure to deliver our strategic vision, including two new hospitals and vertical & horizontal collaboration, and influence sufficiently within the Cheshire & Merseyside Healthcare Partnership and beyond, may result in an inability to provide high quality sustainable services may result in an inability to provide the best outcome for our patient population and organisation, potential impact on patient care, reputation and financial position. b. Failure to fund two new hospitals may result in an inability to provide the best outcome for our patient population and organisation, potential impact on patient care, reputation and financial position.

	#1274 Failure to provide safe staffing levels caused by the mandated Covid-19 staff testing requirement, potentially resulting in Covid-19 related staff sickness/ self-isolation and the requirement to support internal testing; potentially resulting in unsafe staffing levels impacting upon patient safety and a potential subsequent major incident. **#1290** Failure to provide continuity of services caused by the end of the EU Exit Transition date on 31st December 2020; resulting in difficulties in procurement of medicines, medical devices and clinical and non-clinical consumables. The associated risk of increase in cost and a delay in the flow of these supplies.			
EXECUTIVE SUMMARY ***(KEY ISSUES):***	This report will:- • Provide an overview of the Emergency preparedness, resilience and response (EPRR) annual assurance process for 2021-22 • Provide an overview of Warrington and Halton teaching Hospital's compliance with the EPRR Core Standards • Provide an overview of the deep dive into oxygen supply and capacity • Outline a workplan to ensure the Trust continues to move towards full compliance whereby 100% of the NHS EPRR Core standards are met with full compliance			
PURPOSE: ***(please select as appropriate)***	Information	Approval	**To note**	Decision
RECOMMENDATION:	The Trust Board are asked to approve the EPRR Annual Assurance self-assessment rating at 'Substantial compliance'.			
PREVIOUSLY CONSIDERED BY:	**Committee**	Finance + Sustainability Committee		
	Agenda Ref.	FSC/21/09/155		
	Date of meeting	22nd September 2021		
	Summary of Outcome	Approved		
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None			

REPORT TO BOARD OF DIRECTORS

SUBJECT	**Emergency preparedness, resilience and response (EPRR) annual assurance process for 2021-22**	**AGENDA REF:**	**BM/21/09/137**

1. BACKGROUND/CONTEXT

Due to the demands on the NHS, the 2020 EPRR Annual Assurance process was much reduced and focused on learning from the first COVID-19 wave and the preparation for future waves and winter.

The 2021 EPRR NHS England core assurance aims to return some of the previous mechanisms to the process, but also acknowledges the previous 18 months and the changing landscape of the NHS.

The EPRR assurance process usually uses the NHS England and NHS Improvement Core Standards for EPRR. However, as a result of the events of 2020, these standards did not receive their tri-annual review and, as a consequence, not all standards reflect current best practice. Therefore, a small number of standards have been removed to accommodate this year's assurance process.

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

The compliance level for each standard is defined as:

Compliance level	Definition
Fully compliant	Fully compliant with core standard.
Partially compliant	Not compliant with core standard. The organisation's EPRR work programme demonstrates evidence of progress and an action plan to achieve full compliance within the next 12 months.
Non-compliant	Not compliant with the standard. In line with the organisation's EPRR work programme, compliance will not be reached within the next 12 months.

Deep dive

Through the response to the COVID-19 pandemic, a number of factors were that inhibit the ability to increase inpatient capacity. One of these factors is internal piped oxygen system capacity, which have a number of interdependent components to increasing volume and flow rates. In order that NHSE better understand the resilience of internal piped oxygen systems, the 2021-2022 EPRR annual deep dive includes focus on this area.

Organisational assurance rating

The number of core standards applicable to each organisation type is different. The overall EPRR assurance rating is based on the percentage of core standards the organisations assess itself as being 'fully compliant' with. This is explained in more detail below:

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

Action to take/next steps

- All NHS organisations should undertake a self-assessment against the 2021 amended core standards (attached) relevant to their organisation. These should then be taken to a public board or governing body meeting for agreement.
- LHRPs to work with their constituent organisations to agree a process to gain confidence with organisational ratings and provide an environment to promote the sharing of good practice. This process should be agreed with the NHS England and NHS Improvement regional Head of EPRR and ICS leaders.
- NHS England and NHS Improvement regional Heads of EPRR to work with LHRP co-chairs to agree a process to obtain organisation level assurance ratings and provide an environment to promote the sharing of good practice across their region.
- NHS England and NHS Improvement regional heads of EPRR to submit the assurance ratings for each of their organisations and description of their regional process to the National Director of EPRR before Friday 31 December 2021.

2. KEY ELEMENTS

For 2020/2021, the standard annual Core Standards for EPRR were reviewed and mainly involved the approach to managing Covid-19 alongside winter pressures.

The Trust was rated as having **SUBSTANTIAL** compliance during the previous phase of EPRR Assurance.

For 2021/2022, the EPRR Core Standards compliance level is self-assessed **SUBSTANTIAL** compliance.

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

Compliance Level	Criteria
Substantial	The organisation is fully compliant against 89-99% of the relevant NHS EPRR Core Standards

Core Standards 2021/2022	Total standards applicable	Fully compliant	Partially compliant	Non-compliant
Governance	5	5	0	0
Duty to risk assess	2	2	0	0
Duty to maintain plans	9	9	0	0
Command and control	1	1	0	0
Response	5	5	0	0

Warning and informing	3	3	0	0
Cooperation	2	2	0	0
Business Continuity	7	6	1	0
CBRN	12	11	1	0
Total	**46**	**44**	**2**	**0**

Deep Dive

Deep Dive 2021/2022	Total standards applicable	Fully compliant	Partially compliant	Non-compliant
Oxygen Supply	7	5	2	0

Overall including Deep Dive 2021/2022	Total standards applicable	Fully compliant	Partially compliant	Non-compliant
Total	**53**	**49**	**4**	**0**

EPRR Core Standards

Overall the Trust is self-assessed as **FULLY COMPLIANT** in 49 out of 53 core standards. There are 2 Core standards with partial compliance and an additional 2 identified from the Oxygen Supply Deep Dive as part of the 2021/22 assurance process.

The 2 **PARTIALLY COMPLIANT** EPRR Core Standards in 2021/2022 are:-

1. **Data Protection and Security Toolkit**

The Trust made its DSPT submission to NHS Digital in June 2021. The Trust identified a number of areas where compliance was not met and submitted an improvement plan to NHSD. The improvement plan was published within the Trust's DSPT submission. Confirmation was received from NHS Digital that the Trust's improvement plan had been approved and its DSPT status changed to Standards Not Fully Met (with Plan Agreed).

The Trust's 2021 DSPT submission has been reviewed by Mersey Internal Audit Agency and given an assurance rating of Substantial Assurance for the quality of the Trust's DSPT self-assessment. An assurance rating of Moderate Assurance was provided for the Trust's overall compliance across the National Data Guardian's 10 data security standards.

Additional Cyber Resilience assurance will be submitted to NHS England and NHS Improvement in September 2021

2. **Decontamination Capability available 24/7**

Staff training in Chemical Biological Radiological Nuclear (CBRN) decontamination is an area the Trust continues to progress as part of the EPRR work plan. Further opportunities for training are scheduled in the EPRR workplan for 2021-2022. The training will be delivered during ED study days and the schedule of training will commence on 10th November as an 8-week block for refresher training for some of the workforce and in addition the training of ED nurses who have not had access to CBRN training.

Deep Dive

The Deep Dive reviewing piped oxygen capacity with a detailed look into Oxygen Supply presented 2 **PARTIALLY COMPLIANT** standards. These are: -

3. **Medical gasses – governance**

The Medical Gasses Committee was established in March 2021. Reports and issues will be shared with the Executives as the bi-monthly meetings continue.

4. **Medical gasses -workforce**

Education, training and workforce resilience plans will be shared though the Medical Gasses Committee.

3. ACTIONS REQUIRED/RESPONSIBLE OFFICER

The EPRR workplan for 2021-2022 shows a timeline for training and reviews in order to support the progress towards full compliance across all EPRR Core standards. The workplan is attached as Appendix 2.

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

4. IMPACT ON QPS?

In line with NHS England Core standards for EPRR, there is an annual assessment of the standards in accordance with the Civil Contingenies Aact 2004 and the NHS Act 2006.
The Trust has plans in place to;

- Prepare for the common consequences of emergencies rather than for every individual emergency scenario
- Have flexible arrangements for responding to emergencies, which can be scalable and adaptable to work in a wide range of specific scenarios
- Ensure that plans are in place to recover from incidents and to provide appropriate support to affected communities
- Respond to Business Continuity Incidents, Critical Incidents and Major Incidents

As a Category 1 responder, the Trust has plans in place to;

- Assess the risk of emergencies occurring and use this to inform contingency planning
- Enact emergency plans
- Put in place business continuity management arrangements
- Put in place arrangements to make information available to the public about civil protection matters and maintain arrangements to warn, inform and advise the public in the event of an emergency
- Share information with other local responders to enhance co-ordination
- Cooperate with other local responders to enhance co-ordination and efficiency

5. MEASUREMENTS/EVALUATIONS

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

6. TRAJECTORIES/OBJECTIVES AGREED

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

7. MONITORING/REPORTING ROUTES

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

8. TIMELINES

The EPRR workplan details the monthly priorities identified by the EPRR Manager along with Local Health and Resilience Partners.

9. ASSURANCE COMMITTEE

Event Planning Group.

10. RECOMMENDATIONS

The Trust Board are asked to note the EPRR Annual Assurance self-assessment rating at **'SUBSTANTIAL COMPLIANCE'**. The submission is due to NW NHS England NHS Improvement 01/10/21.

11. APPENDIX

Appendix 1 – Core Assurance Framework self-assessment

WHH
B0628-2021-Core-Sta

Appendix 2 – EPRR Workplan 2021-2022

EPRR Workplan
21_22.xlsx

Appendix 3 – EPRR Core Assurance Process

B0628_2021-EPRR-annual-assurance-let

Appendix 4 – Statement of Compliance

CM Assurance process Statement o

Ref	Domain	Standard	Detail	Acute Providers	Evidence - examples listed below	Organisational Evidence	Self assessment RAG Red (not compliant) = Not compliant with the core standard. The organisation's EPRR work programme shows compliance will not be reached within the next 12 months. Amber (partially compliant) = Not compliant with core standard. However, the organisation's EPRR work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months. Green (fully compliant) = Fully compliant with core standard.	Action to be taken	Lead	Timescale	Comments
1	**Governance**	**Senior Leadership**	The organisation has appointed an Accountable Emergency Officer (AEO) responsible for Emergency Preparedness Resilience and Response (EPRR). This individual should be a board level director, and have the appropriate authority, resources and budget to direct the EPRR portfolio. A non-executive board member, or suitable alternative, should be identified to support them in this role.	Y	• Name and role of appointed individual	Dan Moore, Chief Operating Officer	Fully compliant	n/a	n/a	n/a	n/a
2	**Governance**	**EPRR Policy Statement**	The organisation has an overarching EPRR policy statement. This should take into account the organisation's: • Business objectives and processes • Key suppliers and contractual arrangements • Risk assessment(s) • Functions and / or organisation, structural and staff changes. The policy should: • Have a review schedule and version control • Use unambiguous terminology • Identify those responsible for ensuring policies and arrangements are updated, distributed and regularly tested • Include references to other sources of information and supporting documentation.	Y	Evidence of an up to date EPRR policy statement that includes: • Resourcing commitment • Access to funds • Commitment to Emergency Planning, Business Continuity, Training, Exercising etc.	Trust EPRR Policy	Fully compliant	n/a	n/a	n/a	n/a
3	**Governance**	**EPRR board reports**	The Chief Executive Officer / Clinical Commissioning Group Accountable Officer ensures that the Accountable Emergency Officer discharges their responsibilities to provide EPRR reports to the Board / Governing Body, no less frequently than annually. These reports should be taken to a public board, and as a minimum, include an overview on: • training and exercises undertaken by the organisation • summary of any business continuity, critical incidents and major incidents experienced by the organisation • lessons identified from incidents and exercises • the organisation's compliance position in relation to the	Y	• Public Board meeting minutes • Evidence of presenting the results of the annual EPRR assurance process to the Public Board	Trust Board Paper	Fully compliant	n/a	n/a	n/a	n/a
5	**Governance**	**EPRR Resource**	The Board / Governing Body is satisfied that the organisation has sufficient and appropriate resource, proportionate to its size, to ensure it can fully discharge its EPRR duties.	Y	• EPRR Policy identifies resources required to fulfil EPRR function; policy has been signed off by the organisation's Board • Assessment of role / resources • Role description of EPRR Staff • Organisation structure chart • Internal Governance process chart including EPRR group	Trust EPRR Policy Terms of Reference for Event Planning Group Coronavirus Management Board Tactical Board Terms of Reference	Fully compliant	n/a	n/a	n/a	n/a
6	**Governance**	**Continuous improvement process**	The organisation has clearly defined processes for capturing learning from incidents and exercises to inform the development of future EPRR arrangements.	Y	• Process explicitly described within the EPRR policy statement	Trust EPRR Policy Examples of debriefs Learning from COVID-19 - internal Trust debrief exercises	Fully compliant	n/a	n/a	n/a	n/a
7	**Duty to risk assess**	**Risk assessment**	The organisation has a process in place to regularly assess the risks to the population it serves. This process should consider community and national risk registers.	Y	• Evidence that EPRR risks are regularly considered and recorded • Evidence that EPRR risks are represented and recorded on the organisations corporate risk register	hazards EU Transition Risk details Multi agency planning for local events e.g. Creamfields, Neighbourhood weekender.	Fully compliant	n/a	n/a	n/a	n/a
8	**Duty to risk assess**	**Risk Management**	The organisation has a robust method of reporting, recording, monitoring and escalating EPRR risks.	Y	• EPRR risks are considered in the organisation's risk management policy • Reference to EPRR risk management in the organisation's EPRR policy document	EPRR Policy describes local risks and hazards BAF risks related to Core EPRR work streams Tactical Board - Command and Control structure commenced in February 2020 and has been sustained to managed each phase of the COVID-19 pandemic	Fully compliant	n/a	n/a	n/a	n/a
11	**Duty to maintain plans**	**Critical incident**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a critical incident (as defined within the EPRR Framework).	Y	Arrangements should be: • current (although may not have been updated in the last 12 months) • in line with current national guidance • in line with risk assessment • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Trust EPRR Policy Trust Major Incident Policy	Fully compliant	n/a	n/a	n/a	n/a
12	**Duty to maintain plans**	**Major incident**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a major incident (as defined within the EPRR Framework).	Y	Arrangements should be: • current (although may not have been updated in the last 12 months) • in line with current national guidance • in line with risk assessment • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Trust Major Incident Plan Trust EPRR Policy Training plans - Medical, ED, Critical Care	Fully compliant	n/a	n/a	n/a	n/a

13	**Duty to maintain plans**	**Heatwave**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to the impacts of heatwave on the population the organisation serves and its staff.	Y	Arrangements should be: • current (although may not have been updated in the last 12 months) • in line with current national guidance • in line with risk assessment • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Trust Heatwave Plan Tactical Board Patient Safety Committee Trustwide Communications Trustwide Risk Register	Fully compliant	n/a	n/a	n/a	n/a
14	**Duty to maintain plans**	**Cold weather**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to the impacts of snow and cold weather (not internal business continuity) on the population the organisation serves.	Y	Arrangements should be: • current (although may not have been updated in the last 12 months) • in line with current national guidance • in line with risk assessment • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Trust Cold Weather Plan Trust Winter Plan Tactical Board Patient Safety Committee Trustwide Communications Trustwide Risk Register	Fully compliant	n/a	n/a	n/a	n/a
18	**Duty to maintain plans**	**Mass Casualty**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to mass casualties. For an acute receiving hospital this should incorporate arrangements to free up 10% of their bed base in 6 hours and 20% in 12 hours, along with the requirement to double Level 3 ITU capacity for 96 hours (for those with level 3 ITU bed).	Y	Arrangements should be: • current (although may not have been updated in the last 12 months) • in line with current national guidance • in line with risk assessment • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Trust Major Incident Plan Critical Care Admission, Discharge and Escalation Policy Desktop Exercises	Fully compliant	n/a	n/a	n/a	n/a
19	**Duty to maintain plans**	**Mass Casualty - patient identification**	The organisation has arrangements to ensure a safe identification system for unidentified patients in an emergency/mass casualty incident. This system should be suitable and appropriate for blood transfusion, using a non-sequential unique patient identification number and capture patient sex.	Y	Arrangements should be: • current (although may not have been updated in the last 12 months) • in line with current national guidance • in line with risk assessment • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	DXC have worked on this as part of updating the ED Major Incident functionality on Lorenzo	Fully compliant	Process in place, additional training required	EPRR Manager	01 December 2021	n/a
20	**Duty to maintain plans**	**Shelter and evacuation**	In line with current guidance and legislation, the organisation has effective arrangements in place to shelter and/or evacuate patients, staff and visitors. This should include arrangements to shelter and/or evacuate, whole buildings or sites, working in conjunction with other site users where necessary.	Y	Arrangements should be: • current (although may not have been updated in the last 12 months) • in line with current national guidance • in line with risk assessment • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Trust Evacuation Policy	Fully compliant	To be tested Autumn / Winter 2021	EPRR Manager	01 December 2021	n/a
21	**Duty to maintain plans**	**Lockdown**	In line with current guidance and legislation, the organisation has effective arrangements in place to safely manage site access and egress for patients, staff and visitors to and from the organisation's facilities. This should include the restriction of access / egress in an emergency which may focus on the progressive protection of critical areas.	Y	Arrangements should be: • current (although may not have been updated in the last 12 months) • in line with current national guidance • in line with risk assessment • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Trust Lockdown Policy Experiences during visitor restrictions during the COVID-19 pandemic	Fully compliant	n/a	n/a	n/a	n/a
22	**Duty to maintain plans**	**Protected individuals**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond and manage 'protected individuals'; Very Important Persons (VIPs), high profile patients and visitors to the site.	Y	Arrangements should be: • current (although may not have been updated in the last 12 months) • in line with current national guidance • in line with risk assessment • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Trust Major Incident Plan	Fully compliant	n/a	n/a	n/a	n/a
24	**Command and control**	**On-call mechanism**	A resilient and dedicated EPRR on-call mechanism is in place 24 / 7 to receive notifications relating to business continuity incidents, critical incidents and major incidents. This should provide the facility to respond to or escalate notifications to an executive level	Y	• Process explicitly described within the EPRR policy statement • On call Standards and expectations are set out • Include 24 hour arrangements for alerting managers and other key staff.	Trust EPRR Policy Trust On-Call Induction Guidance Single point of contact Tactical response structure Incident Control Room embedded since the start of the COVID-19 pandemic	Fully compliant	n/a	n/a	n/a	n/a
30	**Response**	**Incident Co-ordination Centre (ICC)**	The organisation has Incident Co-ordination Centre (ICC) arrangements	Y		Trust EPRR Policy Trust Major Incident Plan and action cards Embedded as part of COVID-19 management Single point of contact in place Tactical and Recovery Management Board	Fully compliant	n/a	n/a	n/a	n/a
32	**Response**	**Management of business continuity incidents**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a business continuity incident (as defined within the EPRR Framework).	Y	• Business Continuity Response plans	Trust Business Continuity Plan	Fully compliant	n/a	n/a	n/a	n/a
34	**Response**	**Situation Reports**	The organisation has processes in place for receiving, completing, authorising and submitting situation reports (SitReps) and briefings during the response to business continuity incidents, critical incidents and major incidents.	Y	• Documented processes for completing, signing off and submitting SitReps	Trust Major Incident Plan COVID-19 sitreps Critical Care Network sitreps Single point of contact to manage the flow of information Executive sign off processes embedded	Fully compliant	n/a	n/a	n/a	n/a
35	**Response**	**Access to 'Clinical Guidelines for Major Incidents and Mass Casualty events'**	Key clinical staff (especially emergency department) have access to the 'Clinical Guidelines for Major Incidents and Mass Casualty events' handbook.	Y	• Guidance is available to appropriate staff either electronically or hard copies	Email to ED Clinicians and noted through Unplanned Care Group Hard copies available in ED and in the Control Room Electronic copies embedded within the Major Incident Plan	Fully compliant	n/a	n/a	n/a	n/a
36	**Response**	**Access to 'CBRN incident: Clinical Management and health protection'**	Clinical staff have access to the PHE 'CBRN incident: Clinical Management and health protection' guidance.	Y	• Guidance is available to appropriate staff either electronically or hard copies	Email to ED Clinicians and noted through Unplanned Care Group Hard copies available in ED and in the Control Room Electronic copies embedded within the Major Incident Plan	Fully compliant	n/a	n/a	n/a	n/a

37	**Warning and informing**	**Communication with partners and stakeholders**	The organisation has arrangements to communicate with partners and stakeholder organisations during and after a major incident, critical incident or business continuity incident.	Y	• Have emergency communications response arrangements in place • Social Media Policy specifying advice to staff on appropriate use of personal social media accounts whilst the organisation is in incident response • Using lessons identified from previous major incidents to inform the development of future incident response communications • Having a systematic process for tracking information flows and logging information requests and being able to deal with multiple requests for information as part of normal business processes • Being able to demonstrate that publication of plans and assessments is part of a joined-up communications strategy and part of your organisation's warning and informing work	Major Incident Plan Communication Action Card Social Media Policy Communications on-call Communications representation through Event Planning Group Collaboration with system partners	Fully compliant	n/a	n/a	n/a	n/a
38	**Warning and informing**	**Warning and informing**	The organisation has processes for warning and informing the public (patients, visitors and wider population) and staff during major incidents, critical incidents or business continuity incidents.	Y	• Have emergency communications response arrangements in place • Be able to demonstrate consideration of target audience when publishing materials (including staff, public and other agencies) • Communicating with the public to encourage and empower the community to help themselves in an emergency in a way which compliments the response of responders • Using lessons identified from previous major incidents to inform the development of future incident response communications • Setting up protocols with the media for warning and informing	Major Incident Plan Communication Action Card Social Media Policy Communications manager on-call Communications representation through Event Planning Group Collaboration with system partners	Fully compliant	n/a	n/a	n/a	n/a
39	**Warning and informing**	**Media strategy**	The organisation has a media strategy to enable rapid and structured communication with the public (patients, visitors and wider population) and staff. This includes identification of and access to a media spokespeople able to represent the organisation to the media at all times.	Y	• Have emergency communications response arrangements in place • Using lessons identified from previous major incidents to inform the development of future incident response communications • Setting up protocols with the media for warning and informing • Having an agreed media strategy	Trust Media Strategy Communications manager on-call	Fully compliant	n/a	n/a	n/a	n/a
42	**Cooperation**	**Mutual aid arrangements**	The organisation has agreed mutual aid arrangements in place outlining the process for requesting, coordinating and maintaining mutual aid resources. These arrangements may include staff, equipment, services and supplies. These arrangements may be formal and should include the process for requesting Military Aid to Civil Authorities (MACA) via NHS England.	Y	• Detailed documentation on the process for requesting, receiving and managing mutual aid requests • Signed mutual aid agreements where appropriate	Trust Escalation Policy - NWAS Divert and Deflection Critical Care Admissions, Discharges and Escalation Policy Midwifery Escalation Plans and Divert Policy Critical Care mutual aid practice embedded as part of learning from COVID-19 Evidence of planning related to Creamfields Event Planning	Fully compliant	n/a	n/a	n/a	n/a
46	**Cooperation**	**Information sharing**	The organisation has an agreed protocol(s) for sharing appropriate information with stakeholders, during major incidents, critical incidents or business continuity incidents.	Y	• Documented and signed information sharing protocol • Evidence relevant guidance has been considered, e.g. Freedom of Information Act 2000, General Data Protection Regulation and the Civil Contingencies Act 2004 'duty to communicate with the public'.	Data Protection Policy Freedom of Information requests for winter planning / COVID-19 Mutual agreements shared as per MAU during COVID-19	Fully compliant	n/a	n/a	n/a	n/a
47	**Business Continuity**	**BC policy statement**	The organisation has in place a policy which includes a statement of intent to undertake business continuity. This includes the commitment to a Business Continuity Management System (BCMS) in alignment to the ISO standard 22301.	Y	Demonstrable a statement of intent outlining that they will undertake BC - Policy Statement	Trust Business Continuity Plan Trust EPRR Policy	Fully compliant	n/a	n/a	n/a	n/a
48	**Business Continuity**	**BCMS scope and objectives**	The organisation has established the scope and objectives of the BCMS in relation to the organisation, specifying the risk management process and how this will be documented.	Y	BCMS should detail: • Scope e.g. key products and services within the scope and exclusions from the scope • Objectives of the system • The requirement to undertake BC e.g. Statutory, Regulatory and contractual duties • Specific roles within the BCMS including responsibilities, competencies and authorities. • The risk management processes for the organisation i.e. how risk will be assessed and documented (e.g. Risk Register), the acceptable level of risk and risk review and monitoring process • Resource requirements • Communications strategy with all staff to ensure they are aware of their roles	Trust Business Continuity Plan Annual EPRR Board Report EU Exit Risk Register entry COVID-19 Risk Register entry	Fully compliant	n/a	n/a	n/a	n/a
50	**Business Continuity**	**Data Protection and Security Toolkit**	Organisation's Information Technology department certify that they are compliant with the Data Protection and Security Toolkit on an annual basis.	Y	Statement of compliance	DSPT submission to NHS Digital in June 2021. The Trust's 2021 DSPT submission has been reviewed by Mersey Internal Audit Agency and given an assurance rating of Substantial Assurance for the quality of the Trust's DSPT self-assessment. An assurance rating of Moderate Assurance was provided for the Trust's overall compliance across the National Data Guardian's 10 data security standards	Partially compliant	number of areas where they had not achieved compliance and submitted an improvement plan to NHSD. The improvement plan was published within the Trust's DSPT submission. Confirmation was received from NHS Digital that the Trust's improvement plan had been approved and its DSPT status changed to Standards Not Fully Met (Plan Agreed).	IT Manager	01 July 2022	n/a
51	**Business Continuity**	**Business Continuity Plans**	The organisation has established business continuity plans for the management of incidents. Detailing how it will respond, recover and manage its services during disruptions to: • people • information and data • premises • suppliers and contractors • IT and infrastructure	Y	• Documented evidence that as a minimum the BCP checklist is covered by the various plans of the organisation	Trust Business Continuity Plan Service level Business Continuity Plans	Fully compliant	n/a	n/a	n/a	n/a
53	**Business Continuity**	**BC audit**	The organisation has a process for internal audit, and outcomes are included in the report to the board.	Y	• EPRR policy document or stand alone Business continuity policy • Board papers • Audit reports	Trust Business Continuity Plan	Fully compliant	n/a	n/a	n/a	n/a
54	**Business Continuity**	**BCMS continuous improvement process**	There is a process in place to assess the effectiveness of the BCMS and take corrective action to ensure continual improvement to the BCMS.	Y	• EPRR policy document or stand alone Business continuity policy • Board papers • Action plans	Business continuity plans are monitored through Event Planning Group Examples of minutes from Event Planning Group	Fully compliant	n/a	n/a	n/a	n/a

55	Business Continuity	Assurance of commissioned providers / suppliers BCPs	The organisation has in place a system to assess the business continuity plans of commissioned providers or suppliers; and are assured that these providers business continuity arrangements work with their own.	Y	• EPRR policy document or stand alone Business continuity policy • Provider/supplier assurance framework • Provider/supplier business continuity arrangements	Supplies Business Continuity Plan Supplies assurance assessment for EU end of transition period planning Actions following alerts through SPOC	Fully compliant	n/a	n/a	n/a	n/a
56	CBRN	Telephony advice for CBRN exposure	Key clinical staff have access to telephone advice for managing patients involved in CBRN incidents.	Y	Staff are aware of the number / process to gain access to advice through appropriate planning arrangements	Trust HAZMAT/CBRNE Plan	Fully compliant	n/a	n/a	n/a	n/a
57	CBRN	HAZMAT / CBRN planning arrangement	There are documented organisation specific HAZMAT/ CBRN response arrangements.	Y	Evidence of: • command and control structures • procedures for activating staff and equipment • pre-determined decontamination locations and access to facilities • management and decontamination processes for contaminated patients and fatalities in line with the latest guidance • interoperability with other relevant agencies • plan to maintain a cordon / access control • arrangements for staff contamination • plans for the management of hazardous waste • stand-down procedures, including debriefing and the process of recovery and returning to (new) normal processes	Trust HAZMAT/CBRNE Plan	Fully compliant	n/a	n/a	n/a	n/a
58	CBRN	HAZMAT / CBRN risk assessments	HAZMAT/ CBRN decontamination risk assessments are in place appropriate to the organisation. This includes: • Documented systems of work • List of required competencies • Arrangements for the management of hazardous waste	Y	• Impact assessment of CBRN decontamination on other key facilities	Trust HAZMAT/CBRNE Plan Trust EPRR Policy	Fully compliant	n/a	n/a	n/a	n/a
59	CBRN	Decontamination capability availability 24 /7	The organisation has adequate and appropriate decontamination capability to manage self presenting patients (minimum four patients per hour), 24 hours a day, 7 days a week.	Y	• Rotas of appropriately trained staff availability 24 /7	Trust HAZMAT/CBRNE Plan Staff training records	Fully compliant	n/a	n/a	n/a	n/a
60	CBRN	Equipment and supplies	The organisation holds appropriate equipment to ensure safe decontamination of patients and protection of staff. There is an accurate inventory of equipment required for decontaminating patients. • Acute providers - see Equipment checklist: https://www.england.nhs.uk/wp-content/uploads/2018/07/eprr-decontamination-equipment-check-list.xlsx • Community, Mental Health and Specialist service providers - see guidance 'Planning for the management of self-presenting patients in healthcare setting': https://webarchive.nationalarchives.gov.uk/20161104231146/ https://www.england.nhs.uk/wp-content/uploads/2015/04/eprr-chemical-incidents.pdf • Initial Operating Response (IOR) DVD and other material: http://www.jesip.org.uk/what-will-jesip-do/training/	Y	• Completed equipment inventories; including completion date	Trust HAZMAT/CBRNE Plan Equipment checklist	Fully compliant	n/a	n/a	n/a	n/a
62	CBRN	Equipment checks	There are routine checks carried out on the decontamination equipment including: • PRPS Suits • Decontamination structures • Disrobe and rerobe structures • Shower tray pump • RAM GENE (radiation monitor) • Other decontamination equipment. There is a named individual responsible for completing these checks	Y	• Record of equipment checks, including date completed and by whom. • Report of any missing equipment	PRPS inventory	Fully compliant	n/a	n/a	n/a	n/a
63	CBRN	Equipment Preventative Programme of Maintenance	There is a preventative programme of maintenance (PPM) in place for the maintenance, repair, calibration and replacement of out of date decontamination equipment for: • PRPS Suits • Decontamination structures • Disrobe and rerobe structures • Shower tray pump • RAM GENE (radiation monitor) • Other equipment	Y	• Completed PPM, including date completed, and by whom	Completed equipment checklists	Fully compliant	n/a	n/a	n/a	n/a
64	CBRN	PPE disposal arrangements	There are effective disposal arrangements in place for PPE no longer required, as indicated by manufacturer / supplier guidance.	Y	• Organisational policy	Trust HAZMAT/CBRNE Plan	Fully compliant	n/a	n/a	n/a	n/a
65	CBRN	HAZMAT / CBRN training lead	The current HAZMAT/ CBRN Decontamination training lead is appropriately trained to deliver HAZMAT/ CBRN training	Y	• Maintenance of CPD records	ED Major Incident and CBRNE presentation	Fully compliant	n/a	n/a	n/a	n/a
67	CBRN	HAZMAT / CBRN trained trainers	The organisation has a sufficient number of trained decontamination trainers to fully support its staff HAZMAT/ CBRN training programme.	Y	• Maintenance of CPD records	Staff training records	Fully compliant	n/a	n/a	n/a	n/a
68	CBRN	Staff training - decontamination	Staff who are most likely to come into contact with a patient requiring decontamination understand the requirement to isolate the patient to stop the spread of the contaminant.	Y	• Evidence training utilises advice within: • Primary Care HAZMAT/ CBRN guidance • Initial Operating Response (IOR) and other material: http://www.jesip.org.uk/what-will-jesip-do/training/ • All service providers - see Guidance for the initial management of self presenters from incidents involving hazardous materials - https://www.england.nhs.uk/publication/eprr-guidance-for-the-initial-management-of-self-presenters-from-incidents-involving-hazardous-materials/ • All service providers - see guidance 'Planning for the management of self-presenting patients in healthcare setting': https://webarchive.nationalarchives.gov.uk/20161104231146/https://www.england.nhs.uk/wp-content/uploads/2015/04/eprr-chemical-incidents.pdf • A range of staff roles are trained in decontamination technique	Trust HAZMAT/CBRNE Plan - action cards Staff training records	Partially compliant	Further training opportunities identified as part of the workplan for 2021-2022 - refresher training to take place as well as training for most ED Nurses	EPRR Manager / Emergency Department Practice Educator	01 July 2022	n/a

69	**CBRN**	**FFP3 access**	Organisations must ensure staff who may come into contact with confirmed infectious respiratory viruses have access to, and are trained to use, FFP3 mask protection (or equivalent) 24/7.	Y		Pandemic Fit Policy SOP for the management of novel coronavirus PPE SOP Infection Prevention and Control Mandatory Training Robust and embedded fit testing policy Fit testing to a range of FFP3 Protocol for accessing PPE including an out-of-hours process	Fully compliant	n/a	n/a	n/a	n/a

EPRR Workplan

	Subject	January	February	March	April	May	June	July	August	September	October	November	December	January	February	March
EPRR Plans and Policies	Fuel Plan (new following national guidance)										Review					
	EPRR Policy (review and update)										Review					
	Major Incident Plan (review and update)					Complete										
	Evacuation Policy (review and update)										Review					
	Business Continuity Plan (review and update)												Review			
	Escalation Plan (review and udpate)											Review				
	Full Capacity Plan (operationalise)											Review				
	CBRN Plan (review and update)															Review
	Pandemic Flu Plan (update following exercise)										Review					
	Heatwave Plan (review and update)						Complete									
	Cold Weather Plan (review and update)										Review					
	Lockdown (review and update)	Complete												Review		
Event Planning	Produce Easter Plan			Complete												Review
	Produce Early May Bank Holiday Plan				Complete											
	Neighbourhood Weekender Event Planning								Complete							
	Produce Spring Bank Holiday Plan					Complete										Review
	Produce Creamfields/August Bank Holiday Plan								Complete							
	Winter Planning									Review	Review	Review	Review			
	Produce Christmas & New Year Plan											Review	Review			
Corporate	Review Terms of Event Planning Group												Review			
	Produce Annual EPRR Report						Complete									
	On-Call Guidance (review and update)											Review	Review			
	Complete Assurance to NHSE re EPRR								Review	Review						
	Provide LHRP feedback		Complete		Complete		Complete		Complete		Review		Review		Review	
EPRR Training	Refresher training for On-Call Execs and Mgrs											Review				
	Refresher training Loggists											Review				
	Medical Staffing Grand Round													Review		
	Acute Care Team Major Incident training													Review		
	Senior Nursing Team inc Ward Mgrs													Review		
	Refresher training Theatres													Review		
	ED MAJAX and Decon training											Review	Review	Review		
	Disaster Victim Identification											Review	Review			
EPRR Exercising	Communications Exercise															Review
	Decontamination EMERGO Exercise														Review	Review
	Paediatric major incident table top exercise														Review	
	Whole System Pandemic Influenza exercise														Review	
	Evacuation Exercise											Review				
	Black Start Exercise													Review		
	Cyber attack													Review		
	CBU Business Continuity															

KEY

	Complete
	In progress
	Outstanding
	Exercise
	Training

NHS England and NHS Improvement
Skipton House
80 London Road
London
SE1 6LH

22 July 2021

To:

- NHS accountable emergency officers
- NHS England and NHS Improvement:
  - Regional directors
  - Regional heads of EPRR
  - Regional directors of performance and improvement
  - Regional directors of performance
  - LHRP co-chairs

CC:

- NHS England and NHS Improvement Business Continuity team
- CCG accountable officers
- CCG clinical leads
- CSU managing directors
- Clare Swinson, Director General for Global and Public Health, Department of Health and Social Care
- Emma Reed, Director of Emergency Preparedness and Health Protection Policy Global and Public Health Group, Department of Health and Social Care

Dear Colleagues,

Emergency preparedness, resilience and response (EPRR) annual assurance process for 2021-22

I would like to reiterate my thanks to you and your teams for your leadership and delivery of patient care during the last 18 months. During this time the NHS has not only responded to the COVID-19 Pandemic, but also a number of concurrent incidents, through which the resilience of the NHS has been exceptional. Our ability to respond so effectively to so many concurrent issues is a direct result of the years of dedicated focus on Emergency Preparedness and the hard work of our EPRR teams.

As our work now moves from response to recovery, we will all be using this time to reflect on the last 18 months, so that we can identify lessons for the future. This work will lead to the development of local, regional and national workplans to ensure that we embed the lessons into practice at an appropriate pace.

NHS England maintains its statutory duty to seek formal assurance of both its own and the NHS in England's EPRR readiness. This is discharged through the EPRR annual assurance process. Due to the demands on the NHS, the 2020 process was much reduced and focused on learning from the first COVID-19 wave and the preparation for future waves and winter.

The 2021 EPRR assurance aims to return some of the previous mechanisms to the process, but also acknowledges the previous 18 months and the changing landscape of the NHS.

This letter notifies you of the start of the EPRR assurance process and the initial actions for organisations to take.

Core standards

The EPRR assurance process usually uses the NHS England Core Standards for EPRR. However, as a result of the events of 2020, these standards did not receive their tri-annual review and, as a consequence, not all standards reflect current best practice. We have, therefore, removed a small number of standards to accommodate this year's assurance process, until we undertake a full review. The adapted standards being used for this year's assurance process are attached to this letter.

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

The compliance level for each standard is defined as:

Compliance level	Definition
Fully compliant	Fully compliant with core standard.
Partially compliant	Not compliant with core standard. The organisation's EPRR work programme demonstrates evidence of progress and an action plan to achieve full compliance within the next 12 months.
Non-compliant	Not compliant with the standard. In line with the organisation's EPRR work programme, compliance will not be reached within the next 12 months.

Deep dive

Through our response to the COVID-19 pandemic we have identified a number of factors that inhibit our ability to increase inpatient capacity. One of these factors is internal piped oxygen system capacity, which have a number of interdependent components to increasing volume and flow rates. In order that we better understand the resilience of our internal piped oxygen systems the 2021-2022 EPRR annual deep dive will focus on this area.

The deep dive will be applicable to all providers of NHS funded care that utilise internal piped oxygen systems, including acute, community and mental health trusts.

Organisational assurance rating

The number of core standards applicable to each organisation type is different. The overall EPRR assurance rating is based on the percentage of core standards the organisations assess itself as being 'fully compliant' with. This is explained in more detail below:

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

Action to take/next steps

- All NHS organisations should undertake a self-assessment against the 2021 amended core standards (attached) relevant to their organisation. These should then be taken to a public board or governing body meeting for agreement.
- LHRPs to work with their constituent organisations to agree a process to gain confidence with organisational ratings and provide an environment to promote

the sharing of good practice. This process should be agreed with the NHS England and NHS Improvement regional Head of EPRR and ICS leaders.

- NHS England and NHS Improvement regional Heads of EPRR to work with LHRP co-chairs to agree a process to obtain organisation level assurance ratings and provide an environment to promote the sharing of good practice across their region.
- NHS England and NHS Improvement regional heads of EPRR to submit the assurance ratings for each of their organisations and description of their regional process to myself before Friday 31 December 2021.

If you have any queries, please contact your regional head of EPRR in the first instance.

Yours sincerely,

Stephen Groves
National Director of EPRR
NHS England and NHS Improvement

Cheshire and Merseyside Local Health Resilience Partnership (LHRP)
Emergency Preparedness, Resilience and Response (EPRR) assurance 2021-2022

STATEMENT OF COMPLIANCE

Warrington and Halton Teaching Hospitals has undertaken a self-assessment against required areas of the EPRR Core standards self-assessment tool v1.0

Where areas require further action, Click here to enter text. will meet with the LHRP to review the attached core standards, associated improvement plan and to agree a process ensuring non-compliant standards are regularly monitored until an agreed level of compliance is reached.

Following self-assessment, the organisation has been assigned as an EPRR assurance rating of Substantial (from the four options in the table below) against the core standards.

Overall EPRR assurance rating	Criteria
Fully	The organisation is 100% compliant with all core standards they are expected to achieve. The organisation's Board has agreed with this position statement.
Substantial	The organisation is 89-99% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
Partial	The organisation is 77-88% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
Non-compliant	The organisation compliant with 76% or less of the core standards the organisation is expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months. The action plans will be monitored on a quarterly basis to demonstrate progress towards compliance.

Number of applicable standards	Standards rated as **Red**	Standards rated as **Amber**	Standards rated as **Green**
xx	0	2	44
Acute providers: **46** Specialist providers: **38** Community providers: **37** Mental health providers:**37** CCGs: **29**			

I confirm that the above level of compliance with the core standards has been agreed by the organisation's board / governing body along with the enclosed action plan and governance deep dive responses.

Signed by the organisation's Accountable Emergency Officer

Date signed

Date of Board/governing body meeting	Date presented at Public Board	Date published in organisations Annual Report

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/21/09/138**	
SUBJECT:	Proposed amendment to the standard tender evaluation criterion for the procurement of digital systems	
DATE OF MEETING:	29th September 2021	
AUTHOR(S):	Jason Bradley, Interim CIO	
EXECUTIVE DIRECTOR SPONSOR:	Alex Crowe, Executive Medical Director	
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	SO1 We will.. Always put our patients first through high quality, safe care and an excellent patient experience. SO2 We will.. Be the best place to work with a diverse, engaged workforce that is fit for the future. SO3 We will ..Work in partnership to design and provide high quality, financially sustainable services.	 ✓
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): **(*Please DELETE as appropriate)***	**#1114** FAILURE TO provide essential and effective Digital Services CAUSED BY increasing demands upon resources (e.g. cyber defences), new technology skillsets (e.g. Cloud), unfit solutions (e.g. Maternity), end-of-life solutions (e.g. Telephony), poor performance (e.g. Lorenzo EPR)RESULTING in a potentially reduced quality of care, data quality, a potential failure to meet statutory obligations (e.g. Civil Contingency measures) and subsequent reputational damage.	
EXECUTIVE SUMMARY ***(KEY ISSUES):***	This paper presents a proposal to use an alternative percentage split for tender evaluation from the current Trust standard evaluation criterion of 60% technical and 40% related to cost, when the procurement relates to digital systems. The proposal is to move to a 70:30 model, aiming to deliver the "*Most Economically Advantageous Tender (MEAT)*" that provides assurance that systems being procured deliver value for money in terms of both quality of product and affordability. Experience from recent procurements, and procurements about to start, suggest bidders with a low cost / low quality product could win under a 60:40 evaluation model, creating a risk of low user satisfaction and low delivery of benefits. A move to 70:30 does not remove the risk entirely, but would reduce the risk alongside the wider evaluation approaches such as mandatory questions, site visits and supplier demonstrations. This approach would match external advice being received from NHSE/I and our consultancy partners supporting business case development and procurement, and is a model adopted by Sheffield Teaching Hospitals in their EPR procurement due to similar concerns.	

PURPOSE: ***(please select as appropriate)***	Information	Approval ✓	To note	Decision
RECOMMENDATION:	To approve an amendment to the Trust's Standing Financial Instructions in relation to evaluations of digital systems procurement in that the standard tender evaluation criterion to be based on 70% technical and service capability and 30% related to cost. This follows from a previously approved amendment to SFIs that require "that any request to deviate from this 60/40 standard is approved by the Trust Board following the relevant project team/stakeholder group formally outlining their rationale for change".			
PREVIOUSLY CONSIDERED BY:	**Committee**	Finance + Sustainability Committee		
	Agenda Ref.	FSC/21/09/160		
	Date of meeting	22/09/2021		
	Summary of Outcome	Proposal supported.		
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None			

REPORT TO BOARD OF DIRECTORS

SUBJECT	Proposed amendment to the standard tender evaluation criterion for the procurement of digital systems	**AGENDA REF:**	**BM/21/09/138**

1. BACKGROUND/CONTEXT

The Trust Standing Financial Instructions (SFIs) detail the financial responsibilities, policies and procedures to be adopted by the Trust. They are designed to ensure that its financial transactions are carried out in accordance with the law and government policy in order to achieve probity, accuracy, economy, efficiency and effectiveness. The SFIs outline the Tendering and Contract Procedures for making all contracts by, or on behalf of, the Trust, detailing the basis upon which contracts will be awarded. The Trust SFI's state that contracts will be awarded based on the '*Most Economically Advantageous Tender (MEAT)*' that considers technical and service capability in addition to cost. The standard tender evaluation criterion in the SFIs is based on 60% technical and service capability and 40% related to cost (60/40).

The EPR Strategic and Tactical Procurement Project is about to start a procurement for a new Electronic Patient Care Management System (EPCMS) and has taken advice from our external procurement advisors (Apira) and from NHSE/I digital procurement advisors on the appropriate evaluation criterion to use, with both suggesting that 80/20 or 70/30 would be most appropriate. The NHSE/I advice, but not yet formal guidance, is: "…for such a strategically importance solution as an EPR procurement we would recommend an 80/20 ratio (although 70/30 is a fair compromise if 80/20 is not possible) . This ensures a strong emphasis on the product and making sure Trusts are able to purchase the best product they can afford, rather than a race to buy the cheapest offering that may not support all the organisational requirements".

A review of recent procurement exercises, internally and externally, has suggested that remaining at 60:40 could present a risk of a low cost / low quality bid winning in digital procurements, providing a risk of low user satisfaction and low delivery of benefits. Sheffield Teaching Hospitals have adopted a 70:30 model for their current EPR procurement project following Trust approval. Sheffield sought recommendations from HSS procurement framework advisors and developed modelling to show how a cheap product could be successful even with a very low quality score.

The SFIs notes that where, for whatever reason, the project team/stakeholder group for any specific procurement objects to the standard 60/40 percentage split, they will be required to formally outline their rational and recommendation for an alternative percentage split for approval by the Trust Board prior to any procurement activity commencing. Noting the above risk of a low quality tender winning a procurement process, the Digital Board presents in this paper the rationale for moving to a 70:30 split for digital system procurements.

2. KEY ELEMENTS

In accordance with the Trust SFI's contracts will be awarded based on the '*Most Economically Advantageous Tender (MEAT)'* that considers technical and service capability in addition to cost. During the tender evaluation, scores will be calculated for quality and cost and at the end of the evaluation process, the two percentages will be brought together in the Full Evaluation Model to result in an overall percentage score for each supplier.

Example 1

Bidder	*Quality Score*	*Price Score*	*Overall Score*	*Ranking*
Supplier 1	48%	40%	88%	1st
Supplier 2	45%	35%	80%	2nd
Supplier 3	40%	34%	74%	3rd
Supplier 4	42%	30%	72%	4th

The above example shows a model of an evaluation process with quality being marked out of 60% and cost out of 40%. The bidder with the lowest cost getting 40%. The two scores are added together to make the overall score which is then ranked. In this model the supplier with the highest quality bid is also the bidder with lowest price and is ranked 1st.

Example 2

Bidder	*Quality Score*	*Price Score*	*Overall Score*	*Ranking*
Supplier 1	48%	30%	78%	3rd
Supplier 2	45%	34%	79%	2nd
Supplier 3	42%	35%	77%	4th
Supplier 4	40%	40%	80%	1st

In example 2 the supplier with the lowest quality score has the lowest price and the two scores combined then rank that supplier in 1st place.

The Digital Board has noted that advice received by the EPR Tactical and Strategic Procurement Project that has suggested that use of the 60:40 evaluation model for digital systems procurements could lead to a low quality system being procured. Examination of recent digital system procurement projects has presented evidence of this risk existing for those procurement projects which was negated because the supplier demonstrating highest quality also had a comparatively low cost.

The Trust external procurement advisors for the EPR procurement (Apira) have modelled options based on a variety of potential outcomes. These models were also tested on the recently completed Maternity EPR and Radiology Information System procurements. All suggest that a lower quality bid would win for the lowest priced tender using the 60:40 approach.

EPR Examples

In these examples a low cost bidder at £10m, compared to a higher cost bidder at £30m, could score less than half of the quality points of a higher cost bidder (Model D) and still win the tender based on the 60/40 approach. A move to 70/30 starts to reduce the risk, pushing the lowest cost bidder to score at least two thirds of the quality points (Model B).

EPR Example 1: Two bidders comparing 60:40 with 70:30 evaluation models

	Supplier 1	Supplier 2	Supplier 1		Supplier 2	
	£10,000,000	£30,000,000	60/40	70/30	60/40	70/30
Model	Quality evaluation		Overall evaluation		Overall evaluation	
A	500	450	78%	74%	47%	49%
B	400	550	70%	65%	55%	58%
C	350	600	66%	61%	58%	63%
D	300	650	63%	56%	62%	67%
E	275	675	61%	54%	64%	69%

The areas shaded green show the overall evaluation score that would lead that supplier to win the tender. A range of quality scores are used in these examples as the tender process, and therefore the evaluation, has not yet started. The price ranges are based on recent market intelligence.

EPR Example 2: Two bidders comparing 60:40 with 80:20 evaluation models

	Supplier 1	Supplier 2	Supplier 1		Supplier 2	
Model	£10,000,000	£30,000,000	60/40	80/20	60/40	80/20
A	500	450	78%	70%	47%	52%
B	400	550	70%	60%	55%	62%
C	350	600	66%	55%	58%	67%
D	300	650	63%	50%	62%	72%
E	275	675	61%	48%	64%	74%

An 80:20 model could reduce the risk of a low quality product further, but may introduce risks to affordability.

Maternity Examples

The recent maternity procurement led to the preferred bidder being the one who tendered at both the lowest cost and highest quality, using the 60/40 evaluation model. The table below shows how the three bidders concerned would fair when the lowest cost is varied between them. The evaluation is adjusted here for confidentiality purposes.

Maternity Example 1

Bidder	*Quality Score*	*Price Score*	*Overall Score*	*Ranking*
Supplier 1	50%	15%	65%	3rd
Supplier 2	42%	30%	72%	2nd
Supplier 3	35%	40%	75%	1st

In the above example the lowest quality supplier would have won the tender if they had submitted the lowest priced bid. The highest quality bid would have ranked third due to cost.

Maternity Example 2

70/30					*80/20*				
Bidder	***Quality Score***	***Price Score***	***Overall Score***	***Ranking***	***Bidder***	***Quality Score***	***Price Score***	***Overall Score***	***Ranking***
Supplier 1	59%	11%	70%	3rd	Supplier 1	67%	8%	75%	1st
Supplier 2	49%	23%	72%	1st	Supplier 2	56%	15%	71%	2nd
Supplier 3	41%	30%	71%	2nd	Supplier 3	47%	20%	67%	3rd

In the table above, the quality and cost scores are applied using the 70:30 and 80:20 models. In example 1 at 60:40 the lowest quality bid would win. In Example 2 at 70:30 the bidder with the second highest quality score would win, and at 80:20 the highest scoring quality bid would win.

Radiology Examples

A partnership of Trusts across Cheshire and Merseyside has recently re-procured services to provide a radiology information system. In a similar vein to the maternity procurement, the bidder with the highest quality score also submitted a competitive price, just above the lowest priced bid, meaning the bid with the highest quality score won the tender. It is noted that the incumbent supplier was able to provide a low cost bid as they presented zero deployment costs. The table below shows how the bidders would fair when the lowest cost is varied between them. The evaluation is adjusted here for confidentiality purposes.

Radiology Example 1

Bidder	***Quality Score***	***Price Score***	***Overall Score***	***Ranking***
Supplier 1	44%	20%	64%	4th
Supplier 2	40%	40%	80%	1st
Supplier 3	40%	35%	75%	3rd
Supplier 4	38%	40%	78%	2nd

In the above example the lowest quality supplier would have ranked 2nd overall had they submitted the lowest priced bid. The quality scores in this tender were much closer than maternity, leading to a second ranked quality bid winning in this example.

In the table below, the quality and cost scores are applied using the 70:30 and 80:20 models. In these models a bidder with a second highest quality score would rank first overall. This suggests that a tighter range of quality and cost scores means that the assessment is less affected by the ratio of quality:cost, but moving to a 70:30 or 80:20 model does provide more emphasis on the quality scores in the overall assessment.

Radiology Example 2

70/30					*80/20*				
Bidder	***Quality Score***	***Price Score***	***Overall Score***	***Ranking***	***Bidder***	***Quality Score***	***Price Score***	***Overall Score***	***Ranking***
Supplier 1	51%	15%	66%	4th	Supplier 1	59%	10%	69%	4th
Supplier 2	47%	30%	77%	1st	Supplier 2	54%	20%	74%	1st
Supplier 3	47%	26%	73%	3rd	Supplier 3	54%	18%	72%	2nd
Supplier 4	44%	30%	74%	2nd	Supplier 3	51%	20%	71%	3rd

Summary

The examples presented for EPR and Maternity show how a lost cost / low quality submission could win a tender process for digital systems under a 60:40 evaluation model. The Radiology example shows that tenders with a closer range of scores are less affected by this risk. The move to a 70:30 or 80:20 approach would reduce the risk of procuring a lower quality product, with 80:20 providing greater emphasis on quality, and 70:30 ensuring that affordability remains a key element of the assessment.

The proposal would be to move to a 70:30 model for assessing tenders for digital systems, alongside the wider evaluation approaches, such as mandatory questions, site visits and supplier demonstrations, that would be used to assess quality.

Digital Systems are defined, in this context as software tools that electronically store information in a digital format that support the Trust in delivering a number of outcomes and individuals in their working role. The definition excludes hardware such a personal computers, servers and laptops. Examples of Digital Systems would include electronic patient records and patient administration systems both Trust wide and for individual departments such as radiology, maternity and theatres and operational service systems such electronic rostering and electronic staff file.

3. RECOMMENDATIONS

To approve an amendment to the Trust's Standing Financial Instructions in relation to evaluations of digital systems procurement in that the standard tender evaluation criterion to be based on 70% technical and service capability and 30% related to cost.

This follows from a previously approved amendment to SFIs that require "that any request to deviate from this 60/40 standard is approved by the Trust Board following the relevant project team/stakeholder group formally outlining their rationale for change".

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS

BM/21/xx/xx	**BM/21/09/139i**	
SUBJECT:	**Infection Prevention and Control Board Assurance Framework Compliance Report**	
DATE OF MEETING:	September 2021	
AUTHOR(S):	Lesley McKay, Associate Chief Nurse, Infection Prevention + Control	
EXECUTIVE DIRECTOR SPONSOR:	Kimberley Salmon-Jamieson, Chief Nurse + Deputy Chief Executive	
LINK TO STRATEGIC OBJECTIVE:	SO1 We will.. Always put our patients first through high quality, safe care and an excellent patient experience.	√
	SO2 We will.. Be the best place to work with a diverse, engaged workforce that is fit for the future.	√
	SO3 We will ..Work in partnership to design and provide high quality, financially sustainable services.	√
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF):	**#1272** Failure to provide a sufficient number of beds caused by the requirement to adhere to social distancing guidelines mandated by NHSE/I ensuring that beds are 2 metres apart, resulting in reduced capacity to admit patients and a potential subsequent major incident. **#1275** Failure to prevent Nosocomial Infection caused by asymptomatic patient and staff transmission or failure to adhere to social distancing guidelines resulting in hospital outbreaks **#1274** Failure to provide safe staffing levels caused by the mandated Covid-19 staff testing requirement, potentially resulting in Covid-19 related staff sickness/ self-isolation and the requirement to support internal testing; potentially resulting in unsafe staffing levels impacting upon patient safety and a potential subsequent major incident.	
EXECUTIVE SUMMARY	To provide the Board of Directors with assurance on actions in place to meet legislative requirements relating to the prevention and control of infection linked directly to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.	
PURPOSE: (please select as appropriate)	Information	
	Approval	
	To note ✓	
	Decision	
RECOMMENDATIONS:	The Board of Directors are asked to receive the report.	
PREVIOUSLY CONSIDERED BY:	**Committee**	Quality Assurance Committee
	Agenda Ref.	QAC/21/09/218
	Date of meeting	07.09.2021
	Summary of Outcome	Noted

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

Infection Control Sub-Committee

SUBJECT	IPC BAF	AGENDA REF:	BM/21/09/139

1. BACKGROUND/CONTEXT

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

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

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

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

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

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

This assessment has been made against version 1.6 of the Infection Prevention and Control Board Assurance Framework published on 30 June 2021.

2. KEY ELEMENTS

Please see Appendix 1 for compliance assessment.

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

3) ACTIONS REQUIRED/RESPONSIBLE OFFICER

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

4) IMPACT ON QPS?

- **Q**: Visiting restrictions due to risk of infection may have a negative impact on patient experience. Several communication mechanisms have been implemented

- **P**: Risk to staff health and wellbeing from anxiety associated with the unknown situation and risk of infection of self and family members. Risk from continuous high pressure/demand on healthcare services. Several staff are absent from work due to Clinically Extremely Vulnerable (CEV) status

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

5) MEASUREMENTS/EVALUATIONS

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

6) TRAJECTORIES/OBJECTIVES AGREED

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

7) MONITORING/REPORTING ROUTES

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

8) TIMELINES

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

9) ASSURANCE COMMITTEE

- Infection Control Sub-Committee

10) RECOMMENDATIONS

The Board of Directors are asked to receive the report.

Appendix 1 IPC BAF Compliance Assessment 08 2021

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

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

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Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
	• POCT testing is confirmed with a repeat test on All patients at the time of high prevalence			
• when an unacceptable risk of transmission remains following the risk assessment, consideration to the extended use of Respiratory Protective Equipment (RPE) for patient care in specific situations should be given;	• SOP for Personal Protective Equipment in place which includes RPE guidance • PPE SOP includes guidance on consideration of wearing an FFP3 mask and eye shield when caring for green pathway patients and community SARS CoV2 prevalence is high • Programme of Fit Testing continues with an ambition to ensure staff are Fit Tested against 2 types of FFP3 respirators. Data on 23/07/21 - Total Number on Database: 3799 - Total Number passed on at least 1 current supported mask: 2133 - Total Number passed on at least 2 current supported masks: 401			
• there are pathways in place which support minimal or avoid patient bed/ward transfers for the duration of admission unless clinically imperative	• SOP for patient placement. Patients are assessed for location of care according to Clinical Frailty	• Change in placement requirements identified – specialist care	• SOP for patient placement in place which is in line with PHE national guidance • Operational Manager/Silver Command oversight of patient placement at Bed	

1. Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks posed by their environment and other service users				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
	Score and WHO Performance Status and clinical specialty need • The Trust is following PHE national guidance with admission screening and repeat swabbing undertaken 3 days and 5 days post admission or sooner if initial test was negative and if patient exhibits symptoms. Further repeat screening if symptoms develop • Weekly screening if all prior results negative • Screening data • Safe transfer systems in place, including a transfer team and security escort with corridor clearance to limit exposure risks		Meetings (4 times per day and frequency increased at times of increased activity/demand) • Patient Flow Oversight Group establish 12/04/2021 to review operational processes • Covid screening undertaken if a patient is moved to another ward • Covid-19 screening audit	
• that on occasions when it is necessary to cohort COVID or non-COVID patients, reliable application of IPC measures are implemented and that any vacated areas are cleaned as per guidance	• Covid-19 PPE audits (for aerosol and non-aerosol generating procedures) are in place for all clinical areas • Cleaning standards monitoring reports • PPE Champion/Matron daily check of compliance with standards • Vacated areas are decontaminated using Hydrogen Peroxide Vapour (HPV). In the event HPV is unavailable areas are			

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Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
	decontaminated using a 1,000ppm chlorine-based solution			
• resources are in place to enable compliance and monitoring of IPC practice including: - Staff adherence to hand hygiene - patients, visitors and staff are able to maintain 2 metre social & physical distancing in all patient care areas, unless staff are providing clinical/personal care and are wearing appropriate PPE; - Staff adherence to wearing fluid resistant surgical facemasks (FRSM) in: - a) clinical - b) non-clinical settings	Effective systems in place to support prevention of HCAI including: - training, policies and audit plan: - • Hand hygiene audits weekly • PPE (readily available) audits of AGP and non-AGP weekly • Environmental audits according to risk category • High impact intervention audits • Supplies monitoring of PPE levels daily • Social distancing check included on the daily Clinical Area Action Card • Spot checks on break rooms • Signage and refresh campaign aligned to national campaign • Infection Prevention and Control Team visibility on wards	• Auditing of non-clinical areas	• Non-clinical area Action Card to be developed • Escalation of concerns from any staff group to the Infection Prevention and Control Team	
• monitoring of staff compliance with wearing appropriate PPE within the clinical setting	• PPE (AGP/non-AGP) audit programme in place • Refresh PPE Champions role in February 2021 • DIPC communications on the importance of IPC compliance • Sharing good practice Trust-wide via Patient Safety huddle			

1. Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks posed by their environment and other service users				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
	• Challenge to staff where non-compliance is observed			
• that the role of PPE guardians/safety champions to embed and encourage best practice has been considered	• PPE Champions implemented with role defined • Refresh PPE Champions role in February 2021			
• that twice weekly lateral flow antigen testing for NHS patient facing staff has been implemented and that organisational systems are in place to monitor results and staff test and trace;	• Staff screening in place for: symptomatic staff and asymptomatic staff in outbreaks • Occupational Health Service monitor staff cases and areas where clusters of cases are identified are reported to the IPC team • Self-testing – lateral flow implemented November 2020 with electronic test result reporting system including guidance on action to take according to results. Compliance monitored at Tactical meetings • LAMP testing weekly implemented • Staff absence monitoring including staff absent following contact by Test and Trace	• Compliance with staff reporting and using LAMP	Communication strategy to improve uptake including CEO led team brief June 2021	
• additional targeted testing of all NHS staff, if your trust has a high nosocomial rate, as recommended by your local and	• Additional staff testing as part of nosocomial outbreak investigation			

1. Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks posed by their environment and other service users				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
regional infection prevention and control/Public Health Team				
• training in IPC standard infection control and transmission-based precautions is provided to all staff	• Local induction and mandatory IPC training includes standard infection control and transmission-based precautions • Practical demonstrations of donning and doffing have been provided to PPE Champions for cascade training		• 4 training sessions per week are being provided in addition to induction and mandatory training • Compliance with IPC training is monitored at Infection Control Sub-Committee and areas with lower compliance set recovery targets	
• IPC measures in relation to COVID-19 should be included in all staff Induction and mandatory training	• Induction and mandatory IPC training updated to include guidance on COVID -19 • Copies of training presentations • Training session have been recorded and information on Covid-19 added to face to face mandatory training session E-learning session is being updated • Department specific training provided to ICU; ED and theatres • Bespoke training sessions available		• 3 training sessions per week are being provided in addition to induction and mandatory training • Compliance with IPC training is monitored at Infection Control Sub-Committee and areas with lower compliance set recovery targets	
• all staff (clinical and non-clinical) are trained in - putting on and removing PPE; - what PPE they should wear for each setting and context as per national guidance	• PPE guidance included in the Covid 19 Policy is line with PHE national Guidance • PPE Trust Board paper • Trust wide risk assessment			

1. Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks posed by their environment and other service users				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
- all staff clinical and non-clinical have access to the PPE that protects them for the appropriate setting and context as per national guidance	• Local risk assessments in place for the use of PPE • Infection Prevention and Control Team support staff education for PPE • PPE training records • Face Masks distributed to all Non-clinical areas on Friday 12th June ahead of the change in guidance for PPE to be worn in non-clinical areas • Risk assessments include details on Covid-19 secure and when face masks are required • PPE training for visitors where compassionate visiting requirements are indicated • PPE champions (58) support staff education/face to face training • PPE audit tool developed for aerosol/non-aerosol generating procedures – weekly audit • PPE Audit records • Covid-19 PPE staff information booklet (x2) • PHE PPE training video website links shared and compliance monitored • Supplies including PPE is a standing agenda item at the			

1. Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks posed by their environment and other service users				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
	Tactical Meetings and estimated usage rates have been added to all Recovery Plans • A protocol is in place for both in and out of hours access to PPE • Further PPE training with PPE champions in July and August 2020 and February 2021			
• there are visual reminders displayed communicating the importance of wearing face masks, compliance with hand hygiene and maintaining physical distance both in and out of the workplace	• PPE booklet (version 2) distributed in Dec 20 • Sharing of learning from incidents including social distancing in break areas and car sharing • PPE posters in all clinical areas • Desk top messages • Daily (weekdays) Covid-19 Safety huddle • PPE posters revised 02/2021 • Use of electronic desk top messages on hands, face, space, clean workplace • Safety briefings • Daily Covid-19 safety huddle • Signage at all entrances	• Updated NHSE/I communications package	• Plan in development with Communications team to revise signage	
• IPC national guidance is regularly checked for updates and any changes are effectively communicated to staff in a timely way	• Subscription and daily review of Gov.UK email updates. Covid-19 Policy is updated as updates are received (currently version 7)			

1. Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks posed by their environment and other service users				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
	shared at Trust Wide Safety Briefing (TWSB) and via Covid daily Bulletin • Control Room with dedicated email address receives national updates which are distributed as and when received for timely action • Compliance framework tracking compliance with national guidance under clearly defined work streams with nominated leads • Coronavirus Assessment Pod decontamination SOP • Coronavirus Policy version 7. Updates shown in different coloured font to support staff more easily identify latest changes/ updates • SOP for patient placement during Covid-19 pandemic • Quantitative Fit Testing SOP • Qualitative Fit Testing SOP • Reusable PPE Decontamination SOP • Covid-19 Screening SOP • Hospital onset Covid 19 and Outbreak Management SOP • Staff screening SOP			

1. Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks posed by their environment and other service users				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
	• Review of compliance against national guidance – Survey report • Policies, guidelines and SOPs and updates are distributed by Trust Wide Safety Brief			
• changes to national guidance are brought to the attention of boards and any risks and mitigating actions are highlighted	• Covid-19 Tactical Group Meetings and Recovery Board Meetings in place with clear escalation route to Trust Board • Tactical meetings (initially daily (weekdays) from 18/03/20 and stepped down to 3 times per week 01/05/20 and then to twice weekly from 06/07/20, timescale revised according to local prevalence • Recovery Board Meetings were twice per week starting on 05/05/20 feed into Strategic Executive Oversight Group (SEOG) meeting and this feeds into Board. The Associate Director of IPC attends Tactical and Recovery meetings as do the DIPC and Deputy DIPC/Consultant Microbiologist Infection Control Doctor. Recovery meetings stepped down for wave 3			

1. Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks posed by their environment and other service users				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
	• COVID Non-Executive Director Assurance Committee (COVNED)			
• risks are reflected in risk registers and the Board Assurance Framework (BAF) where appropriate	• A Covid-19 specific Risk Register has been created with risks escalated to the corporate Risk Register and Trust BAF as appropriate. Updates are discussed at the Quality Assurance Committee • Corporate Risks include impact on activity • Local risk assessments in place for the use of PPE • 2 risks on the BAF linked to: - national shortage of PPE - oxygen supply • PPE is a standing agenda item for monitoring levels at the Tactical Meetings and estimated usage rates have been added to all Recovery Plans • Oxygen daily SitRep continued beyond national reporting requirements to provide local assurance • HSIB interim bulletin on oxygen January 2021 is under review			

1. Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks posed by their environment and other service users				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
• robust IPC risk assessment processes and practices are in place for non COVID-19 infections and pathogens	• Existing IPC policies in place: - Chickenpox - Clostridium difficile - Scabies - Shingles - Meningitis - MRSA - Multi-drug resistant organisms - Influenza - TB/ MDR TB - Viral Gastroenteritis - Viral haemorrhagic fevers - Isolation of immunosuppressed patients • SOPs for rapid testing for CPE/ MRSA and enteric and respiratory pathogens • Isolation for other infections and pathogens is prioritised based on transmission route • Clostridium difficile Guidelines (2018) in place and all patients with a C. difficile toxin positive or PCR positive result are isolated • Ribotyping of all community onset healthcare associated and hospital onset healthcare associated cases			

1. Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks posed by their environment and other service users				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
	• Root Cause Analysis investigation for all hospital apportioned cases • Compliance with Mandatory HCAI reporting requirements • Distribution of HCAI surveillance data weekly • Re-establishing the C. difficile Cohort Ward is included in Recovery Plans • GNBSI reduction Action Plan has been revised and work stream is being reinstated			
• the Trust Chief Executive, the Medical Director or the Chief Nurse approves and personally signs off, all daily data submissions via the daily nosocomial sitrep	• Chief Nurse/DIPC signs off data submissions • Sign off process in place for daily nosocomial SitRep • Daily data validation process for new admissions and inpatient Covid-19 tests prior to forwarding for sign off • Covid-19 data is reviewed at Tactical meetings and Silver IPC Cell meetings • The IPC Board Assurance Framework is reviewed at QAC and Trust Board of Directors meeting bimonthly			

1. Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks posed by their environment and other service users				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
• this Board Assurance Framework is reviewed, and evidence of assessments are made available and discussed at Trust board	• QAC submission papers bimonthly • Board Submission papers • Board meeting minutes			
• The Trust Board has oversight of ongoing outbreaks and action plans	• Information on outbreaks included in daily executive summary and discussed at the daily Senior Executive Oversight Group Meeting • Learning from Outbreaks included in Nosocomial Board Paper 01 2021 • Nosocomial learning action plan in place reviewed at Silver IPC cell meetings. Plan to feedback at CBU level with drill down to individual ward learning			
• there are check and challenge opportunities by the executive/senior leadership teams in both clinical and non-clinical areas	• Matron and IPC Walkarounds • Senior nursing team checks that action cards are being completed • Executive Team walkabouts • Ward Accreditation with IPC reviewer membership • Challenge occurs at the following meetings: - Tactical - Silver IPC Cell - Quality Assurance Committee			

1. Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks posed by their environment and other service users				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
	- Infection Control Sub-Committee - Senior Executive Oversight Group - Covid NED Group - Increased Microbiology support/ briefings delivered to medical cabinet			

2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
• designated nursing/medical teams with appropriate training are assigned to care for and treat patients in COVID-19 isolation or cohort areas	• SOP for patient placement (agreed wards and critical care locations). Patients are assessed for location of care according to Clinical Frailty Score and WHO Performance Status. Respiratory Step-down Unit SOP • Bespoke simulation training for patient transfer • Availability of rapid SARS-CoV2 testing • Ongoing discussion at Nursing and Midwifery Forum, Medical Cabinet and Allied Health Professionals Forum as mitigation		• Increased IPC support to wards/departments caring for patients with Covid-19 • Increased staffing in IPC team to support training requirements, skilling up of senior staff to disseminate training • Increased Microbiology support/ briefings delivered to medical cabinet	

2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
	• Discussed at the Care Group Meetings and action agreed to update guidance • Matrons provide oversight of staffing levels to ensure all areas are appropriately and safely staffed • IPC team regularly review and have visible presence in all areas			
• designated cleaning teams with appropriate training in required techniques and use of PPE, are assigned to COVID-19 isolation or cohort areas	• Task Team and Domestic Assistant training for Covid-19 cohort ward areas has been carried out • Fit Testing for FFP3 masks undertaken for Domestic Assistants in areas where aerosol generating procedures are performed • Task Team support areas where there are Domestic Assistant shortfalls • Four additional HPV decontamination machines purchased and training on use provided			
• decontamination and terminal decontamination of isolation rooms or cohort areas is carried out in line with PHE and other national guidance	• Terminal cleaning and Decontamination polices in place including guidance on environmental disinfectant required to decontaminate the environment. Decontamination included in the Covid-19 policy			

2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
	• All policies are used in conjunction with any updates provided by COVID-19 national guidance • Terminal Cleaning Guidelines 2018 • Decontamination Policy 2019 • Novel Coronavirus Policy (version 7) • 4 additional HPV machines purchased • CEO meeting and Chief Nurse/Deputy CEO and ADIPC meeting with domestic staff • Associate Director of Estates is a member of Silver IPC cell			
• assurance processes are in place for monitoring and sign off terminal cleans as part of outbreak management and actions are in place to mitigate any identified risk;	• Sign off checklist in place for terminal cleans			
• cleaning is carried out with neutral detergent followed by a chlorine-based disinfectant, in the form of a solution at a minimum strength of 1,000ppm available chlorine, as per national guidance. If an alternative disinfectant is used, the local infection prevention and control team (IPCT) should be consulted on this to ensure that this is effective against enveloped viruses	• Combined detergent/chlorine-based solution in use • Alternative disinfectant used in CT scanning room. • Combined detergent/chlorine-based disinfectant diluted to 1,000ppm available chlorine is used for cleaning in patient areas • Hydrogen Peroxide Vapour is used	• Specialist cleaning plan in place in the CT scanning room •	• CT Manufacturer provided alternative decontamination guidance • Consultant Microbiologists and IPCNs included in discussions on alternative products to ensure effective against coronaviruses	

2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
• manufacturers' guidance and recommended product 'contact time' must be followed for all cleaning/ disinfectant solutions/products as per national guidance:	• Information on contact time is included in the decontamination policy •			
• a minimum of twice daily cleaning of: - areas that have higher environmental contamination rates as set out in the PHE and other national guidance - 'frequently touched' surfaces, e.g. door/toilet handles, patient call bells, over-bed tables and bed rails; - electronic equipment, e.g. mobile phones, desk phones, tablets, desktops and keyboards - rooms/areas where PPE is removed must be decontaminated, timed to coincide with periods immediately after PPE removal by groups of staff;	• Twice daily cleaning in place • Ring the bell it's time for Clinnell campaign • Domestic staff record when they have cleaned areas • Enhanced cleaning – all areas, including non-clinical, supplied with desk wipes • Increased cleaning frequency in all public areas including toilets, communal spaces, lifts • Cleaning of workstations is included in the Environmental Action Plan • Domestic staff time cleaning activity when areas are vacant • Increased cleaning included in ICU Bioquell pod SOP			
• reusable non-invasive care equipment is decontaminated: - between each use - after blood and/or body fluid contamination	• Included in Decontamination Policy • Cleaning monitoring audits • Decontamination audits			

2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
- at regular predefined intervals as part of an equipment cleaning protocol before inspection, servicing or repair equipment;				
• linen from possible and confirmed COVID-19 patients is managed in line with PHE and other national guidance and the appropriate precautions are taken	• Process for managing linen is included in the COVID-19 policy. All linen from COVID-19 possible and confirmed positive patients is treated as infectious and placed in alginate bags which are tied and then placed in a white plastic bag • Laundry policy revised May 20 • No DATIX reports on non-compliance with double bagging of used/infected linen • Scrub suits made available to all staff with a central collection point • Scrub suits laundered by the Trust's laundry contractor • Uniform and workwear policy is under review			
• single use items are used where possible and according to single use policy	• Decontamination Policy in place which includes single use/single patient use guidance used in conjunction with any updates provided by national guidance in response to COVID-19			
• reusable equipment is appropriately decontaminated in line with local and PHE and other national guidance and that	• Decontamination Policy in place used in conjunction with any updates provided by National	• Decontamination Meetings suspended in wave 1	• Meetings reconvened from 17/08/20 • A SOP for decontamination of reusable PPE is in place	

2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
actions in place to mitigate any identified risk;	Guidance in response to COVID-19			
• cleaning standards and frequencies are monitored in non-clinical areas with actions in place to resolve issues in maintaining a clean environment	• Cleaning monitoring programme in place • Monitoring result are circulated to managers for corrective action where standards are not met at time of auditing • Housekeepers accompany monitoring officers when on duty and corrective action is taken at time of auditing or as soon as possible			
• where possible ventilation is maximised by opening windows where possible to assist the dilution of air	• Windows within the waiting space are opened to ventilate the area and any space having forced ventilation is adequate to keep the area ventilated so windows can be kept closed • Signage on social distancing, hand hygiene and face coverings are displayed in ED waiting areas • Ventilation Group meetings with terms of Reference	• Old Estate with limited mechanical ventilation/ air conditioning units • Not all areas will be provided with ventilation or can open windows • Ventilation Policy	• These areas are ventilated by keeping doors and windows open where possible/ patient comfort allows • Review of ventilation across the whole Trust estate in progress (June 2021) with recommendations being finalised • Ventilation Policy being drafted 07/2021	

3. Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
• Arrangements around antimicrobial stewardship are maintained	• Consultant Medical Microbiology daily Ward Round in Critical Care			

3. Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
	• Ward based Pharmacist support • Prescribing advice available by telephone (in and out of hours) • Infection Control Doctor presentations to Medical Cabinet • Formulary review as evidence/guidelines are updated • Antibiotic prescribing guidelines for COVID suspected patients have been published • Antimicrobial Management Steering Group Meetings will be reconvened from September 2020 • C difficile outliers ward rounds recommenced in July • Quarterly Point Prevalence audits with concerns discussed at Medical Cabinet and Infection Control Sub-Committee			
• Mandatory reporting requirements are adhered to and boards continue to maintain oversight	• Mandatory reporting of HCAIs has continued • Data on HCAIs is included on the Quality Committee and Infection Control Sub-Committee Dashboards • DIPC reports HCAI data at Trust Board • Information on Data Capture System			

3. Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
	• Distribution of HCAI surveillance data weekly • HCAI review meetings being reconvened from August 2021			

4. Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
• National guidance on visiting patients in a care setting is implemented	• Restricted visiting implemented 17 March 2020; Visiting fully suspended from 26 March 2020; Compassionate visiting arrangements agreed 09 April 2020. Paper on visiting arrangements taken to SEOG • Visiting the dying guideline in place with training provided by the Palliative Care Team • Trust wide Communication via email on visiting restrictions then cessation • Environmental Safety Plan includes site lock down to restrict access • Compassionate visiting arrangements agreed for the following patient groups where		• Guidance regularly updated in-line with national guidance • Visitor risk assessments • Pre-visit symptom screening checklist • Visitor information leaflet • Family Liaison Officer team • Virtual visiting/ ipads	

4. Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
	close family and friends visiting may be admitted: • Patients in critical care • Vulnerable young adults • Patients living with Dementia • Autism • Learning difficulties • Loved ones who are receiving end of life care • Signage at entrances • Information on Trust website • FLOgrams • Trial wards agreed to re-introduce visiting week commencing 7 June 2021 limiting numbers and visiting time period of 1 hour			
• areas where suspected or confirmed COVID-19 patients are being treated have appropriate signage and have restricted access	• Coronavirus posters with details on Red, Amber or Green pathway, displayed outside areas where patients with suspected or confirmed COVID-19 are cared for • Family Liaison service in place to keep relatives (virtually) updated on care of loved ones • Refresh of Infection Control communications campaign using national toolkit			

4. Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
• Information and guidance on COVID-19 is available on all Trust websites with easy read versions	• Information on COVID-19 is available on the Trust Web Site and at entrances			
• Infection status is communicated to the receiving organisation or department when a possible or confirmed COVID-19 patient needs to be moved	• Covid-19 Alert added to Lorenzo for all patients with a positive SARS-CoV-2 swab (to date **>3828** alerts added – 09/06/2021) • Covid-19 status included on SBAR form • Covid-19 has been added to e-discharge summary template • Pre-admission information provided to patients being admitted electively • Policy for patients being discharged to care homes			
• There is clearly displayed and written information available to prompt patients' visitors and staff to comply with hands, face and space advice	• Information on the Trust website (updated 16/10/2020) • Signage at all entrances • Hand gel and face masks provided at hospital entry points • Entrances are manned (part time) to support visitor compliance – visiting restrictions are currently in place	Lack of concordance by visitors as restrictions are lifted		
• Implementation of the Supporting excellence in infection prevention and control behaviours Implementation Toolkit has been considered	• The toolkit has been reviewed and poster production plan in place with the Trust's			

4. Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
	Communications Team – roll out date to be confirmed			

5. Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
• Screening and triaging of all patients as per IPC and NICE Guidance within all health and other care facilities must be undertaken to enable early recognition of COVID-19 cases	• Triage tool in ED includes questions on recent travel • Triage in ED includes questions on Covid-19 symptoms/ pre-admission testing results where available • Information provided prior to attending Outpatient Departments and further symptom screening in place on arrival • Molecular Point of Care Testing in place in ED • Lateral Flow testing in Maternity • Pre-admission screening as per NICE Guideline 179	• Screening of inpatients who develop respiratory symptoms e.g. hospital acquired pneumonia (HAP)	• Requirement to test for Covid-19, any patient who develops respiratory symptoms / HAP added to the Antibiotic Formulary	
• Front door areas have appropriate triaging arrangements in place to cohort patients with possible or confirmed COVID-19 symptoms and to segregate them from non COVID-19 cases to minimise the risk of cross-infection as per national guidance	• Patients conveyed to hospital by Ambulance are pre-assessed to determine where they are taken to in ED • ED reorganised to have Hot and Cold respiratory assessment zones to segregate patients	• Asymptomatic patients subsequently identified as COVID-19 positive • False negative test results • Old estate, limited number of side rooms	• Process in place to isolate and close the bay to admissions when exposure incidents occur • IPCN and Patient Flow joined up working to identify side room facilities • Plan for a new ED plaza	

5. Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
	presenting with suspected Covid-19 • Triage tool in ED and segregated areas for patients suspected to have COVID-19 • Environmental Safety Action Plan with proposal to lockdown of 25% of entrances • Manned mask stations at main entrance Warrington site (part time) and mask available at other entrances with access to hand sanitisers • ED and IPC meetings established • Testing in Maternity services			
• Staff are aware of agreed template for triage questions to ask	• Triage tool in ED includes questions on recent travel – revised tool discussed at Tactical Meeting on 11 June 2021 • Staff trained in triage questions			
• Triage undertaken by clinical staff who are trained and competent in the clinical case definition and patient is allocated appropriate pathway as soon as possible	• Senior ED staff are rostered to carryout Triage • POCT (Abbot ID Now) testing in place in ED			
• face coverings are used by all outpatients and visitors;	• Observational checks carried out in Departments • Safety teams at entrances • Trust-wide communications to advise face coverings still	• Patient lack of concordance or inability to wear a face covering due to an underlying condition	• Social distancing maintained where patients and anyone accompanying them cannot wear a face mask • SOP to support staff decision making in relation to continuing	

5. Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
	required to coincide with the lifting of restrictions on 19th July 21		with procedure with reasonable adjustments to ensure staff safety where patients are exempt	
• individuals who are clinically extremely vulnerable from COVID-19 receive protective IPC measures depending on their medical condition and treatment whilst receiving healthcare e.g. priority for single room isolation;	• Patient records on Lorenzo are flagged to highlight clinically extremely vulnerable from COVID-19 patients	• Limited side room capacity	• Discussion with Patient Flow Team and review to assess: - absolute neutrophil count - vaccination status - social distancing - face masks - hand hygiene - environmental hygiene	
• clear advice on the use of face masks is provided to patients and all inpatients are encouraged and supported to use surgical facemasks (particularly when moving around the ward) providing it is tolerated and is not detrimental to their (physical or mental) care needs	• Site-wide signage • Compliance recorded on care and comfort round forms and documented in Lorenzo EPR			
• monitoring of inpatients compliance with wearing face masks (particularly when moving around the ward) providing it is tolerated and is not detrimental to their (physical or mental) care needs;	• Compliance recorded on care and comfort round forms and documented in Lorenzo EPR	• Feedback on compliance with inpatient facemask use	• IPCN observation whilst on ward walkabouts • Add assurance to Lead Nurse reporting template for Infection Prevention and Control Sub-Committee	
• patients, visitors and staff are able to maintain 2 metre social & physical distancing in all patient care areas; ideally segregation should be with separate spaces, but there is potential to use screens, e.g. to protect reception staff.	• Inpatient bed spacing assessment • Perspex screens in place at reception areas	• Some bed spaces are closer than 2 metres	• Use of clear curtains between bed spaces • Timing of visits to toilet facilities • Use of face masks where tolerated	

5. Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
• isolation, testing and instigation of contact tracing is achieved for patients with new-onset symptoms, until proven negative;	• Liaison takes place with Patient Flow to identify side room facilities • Rapid testing available 7 days per week • From September 21 – testing will be available 24/7 for a period of 6 months			
• patients that test negative but display or go on to develop symptoms of COVID-19 are segregated and promptly re-tested and contacts traced promptly;	• Where a patient tests positive and has been in a bay – contacts are identified and letters regarding the Covid-19 exposure are provided to contacts • Patients testing positive are transferred to Covid-19 care areas			
• there is evidence of compliance with routine patient testing protocols in line with Key actions: infection prevention and control and testing document;	• All patients admitted via emergency route are tested at admission • Daily monitoring of admission, day 3 and day 5 testing • SOP for pre-discharge to care home testing in place • Elective patients are tested 72 hours/3 days prior to admission and are asked to self-isolate	• Patient compliance with self-isolation guidance for 72 hours prior to admission	• Review of pre-admission information to support compliance with self-isolation guidance	
• Patients that attend for routine appointments who display symptoms of COVID-19 are managed appropriately	• Routine appointments have been stepped down. Social distancing measures are in place in Outpatient Departments	Public lack of concordance with social distancing measures	• Social distancing measures are in place in Outpatient Departments	

5. Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
	• Recovery plan for Outpatients (28/05/2020) includes providing information not to attend if unwell with Covid-19 symptoms • Risk rated appointment schedule based on clinical priority • Virtual 'attend anywhere' clinics • Rooms identified for shielding patients		• Signage in place to keep left on corridors, walk in single file and socially distance • Seating arranged in Outpatient waiting areas to support social distancing	

6. Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
• Patient pathways and staff flow to minimise contact between pathways. For example, this could include provision of separate entrances/exits (if available) or use of one-way entrance/exit systems, clear signage, and restricted access to communal areas;	• Environmental Action plan in place • Keep left signage in place for internal walkways • Restricted key codes/controlled entry in place • Green pathway for surgical patients at CSTM building and Ward A5 elective • Wards identified for care of patients with Covid-19 as per Trust escalation plan • Signage at ward entrances denotes red, amber or green pathway area			

6. Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
	• Refresh of the communications IC Strategy			
• All staff (clinical and non- clinical) have appropriate training, in line with latest PHE and other national guidance to ensure their personal safety and working environment is safe	• PPE Champions (58), roving training on donning and doffing of PPE • Links to PHE videos have been distributed. Individual booklets on COVID-19 and PPE produced and distributed • Training records from all CBUs that staff have read the Covid-19 policy, receive the PPE booklet, watched the PHE videos, received face to face training, read the Covid-19 swabbing SOP • PPE training videos included in mandatory training programme • Record of staff training to carrying Fit testing • Fit testing for FFP3 respirators records	• Staff returning to work, including after pregnancy, long term sick leave or due to Extremely vulnerable status may not be fully informed with the latest guidance	• Action plan in place with Unplanned and Planned Care Groups to ensure all staff return to work receive appropriate level of training • Action plans in place with CBUs where there are shortfalls in staff training • IPC Team provide ongoing training to PPE champions on donning and doffing of PPE • Links to PHE videos are available and distributed and included in IPC mandatory training sessions	
• All staff providing patient care and working within the clinical environment are trained in the selection and use of PPE appropriate for the clinical situation and on how to safely put it on and remove it;	• Links to PHE videos have been distributed. Posters are displayed in clinical areas on donning and doffing • Information recirculated to Planned and Unplanned Care Groups • Bespoke training	• Posters not displayed in all areas • Staff returning from absence may not be fully informed/ updated with latest guidance	• Additional posters ordered and site survey to be completed by IPCNs with PPE champions for each area • IPC team provide ongoing training on donning and doffing of PPE • Links to PHE videos are available and distributed	

6. Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
	• Information circulated on Trust Wide Safety Brief • PPE training included in mandatory training programme			
• A record of staff training is maintained;	• Record of training is held and maintained • Induction and Mandatory training records are held in ESR	• Some areas are below 85% compliance with level 2 training	• Action plan in place with Unplanned and Planned Care Groups to ensure all staff return to work receive appropriate level of training • Action plans in place with Care Groups/CBUs where staff training is required or bespoke training	
• adherence to PHE national guidance on the use of PPE is regularly audited with actions in place to mitigate any identified risk	• Observational audits completed and feedback received from PPE Champions • Electronic Audit Tool developed and launched 15/05/20 • Audits are carried out weekly and repeated in a shorter timescale where issues are identified • Datix reporting of compliance issues • Discussion on the importance of compliance takes place where PPE risks are identified			
• Hygiene facilities (IPC measures) and messaging are available for all patients/ individuals, staff and visitors to minimise COVID-19 transmission such as: - hand hygiene facilities including instructional posters	• Hand hygiene audits			

6. Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
- good respiratory hygiene measures - staff maintaining physical and social distancing of 2 metres wherever possible in the workplace unless wearing PPE as part of direct care; - staff are maintaining physical and social distancing of 2 metres when travelling to work (including avoiding car sharing) and remind staff to follow public health guidance outside of the workplace; - frequent decontamination of equipment and environment in both clinical and non-clinical areas - clear visually displayed advice on use of face coverings and facemasks by patients/individuals, visitors and by staff in non-patient facing areas	• Hand washing signage – wash hands more frequently & for 20 seconds • Catch it Bin It Kill Posters displayed throughout the Trust • Social distancing signage in place Trust-wide • Information provided in staff Covid-19 booklet on safe travel arrangements • Ring the bell cleaning initiative implemented • Office risk assessments in place including use of masks if not in a single person office			
• Staff regularly undertake hand hygiene and observe standard infection control precautions	• Programme of hand hygiene audits in place – carried out weekly in areas operational. Overall compliance • April – December 2020 =98% - 99%; • January – May 2021=98% - 99%			
• The use of hand air dryers should be avoided in all clinical areas. Hands should be dried with soft, absorbent, disposable paper towels from a	• Hand air dryers not in place in clinical areas			

6. Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
dispenser which is located close to the sink but beyond the risk of splash contamination as per national guidance	• Removal of hand driers in public toilets (none in clinical areas) has taken place as part of the environmental action plan • Hand towel dispensers have been installed and waste collection schedule put in place			
• Guidance on hand hygiene, including drying, should be clearly displayed in all public toilet areas as well as staff areas	• Signage on hand washing technique is displayed on all soap dispensers. • HM Government signage has been displayed detailing 20 second handwashing			
• Staff understand the requirements for uniform laundering where this is not provided for on site	• Guidance on home laundering is included in the COVID-19 PPE information leaflets • Scrub Suits have been offered as an alternative to uniforms and are laundered centrally • Trust wide emails with guidance on laundering			
• All staff understand the symptoms of COVID-19 and take appropriate action (even if experiencing mild symptoms) in line with PHE national guidance and other if they or a member of their household display any of the symptoms	• Screening for COVID-19 is undertaken in line with national guidance • Monitored by the Occupational Health and Wellbeing Team and overseen by the Workforce and Organisational Development Team			

6. Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
• A rapid and continued response through ongoing surveillance of rates of infection transmission within the local population and for hospital/ organisation onset cases (staff and patients/ individuals)	• Local statistics included in Tactical meetings agendas • Surveillance on hospital onset patient cases included on the Integrated Performance Report • Information on staff cases/outbreaks reported at Senior Executive Oversight Group by DIPC • Briefings by Consultant Microbiologist/Infection Control Doctor to Medical Cabinet/ Nursing and Midwifery Forum • CEO trust-wide briefings			
• Positive cases identified after admission that fit the criteria for investigation should trigger a case investigation. Two or more positive cases linked in time and place trigger an outbreak investigation and are reported	• Root Cause analysis investigation requested for all cases ≥ day 8 of admission • Outbreak reporting protocol in place including to: - Trust board - NW.ICC; PHE; CCG; CQC; NHSE/I via web-based reporting system • Process in place for RCA review with IPCT and Governance Department and terms of reference agreed • Learning themes from RCA findings are shared with CBUs			

6. Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
	• Outbreak Meeting Terms of Reference and Microbiology DIPC or Deputy presence etc • IIMARCH completed and submitted via web-based reporting system			
• Robust policies and procedures are in place for the identification of and management of outbreaks of infection. This includes the documented recording of outbreak meetings.	• Daily surveillance in place of ≥ day 8 cases and location tested to promptly identifying clusters and initiate outbreak investigation accordingly • Occupational Health and Wellbeing Team monitor for clusters of staff cases			

7. Provide or secure adequate isolation facilities				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
• Restricted access between pathways if possible, (depending on size of the facility, prevalence/ incidence rate low/high) by other patients/ individuals, visitors or staff	• Green pathway for Surgical cases at CSTM building and A5 elective ward • ICU expansion into theatre for non-Covid ICU cases in theatre pods and use of recovery for patients with Covid-19 • Restricted access to green pathway areas			
• Areas/wards are clearly signposted, using physical barriers as appropriate to	• Signage in place stating Covid-19 cases on wards			

7. Provide or secure adequate isolation facilities				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
patients/individuals and staff understand the different risk areas	• Signage displayed at ward/department entrances advising Red, Amber or Green Covid Pathway • Keep left signage • Distancing in waiting areas • Signage clearly states areas are Red, Amber or Green and written information to state what this means			
• Patients with suspected or confirmed COVID-19 are isolated in appropriate facilities or designated areas where appropriate	• SOP for patient placement. Patients are assessed for location of care according to Clinical Frailty Score and WHO Performance Status	• Limited number of single rooms for isolation (65)	• Cohorting in place as advised by the Infection Prevention and Control Team • Operational Manager/Silver Command oversight at Bed Meetings (4 times per day and frequency increased at times of increased activity/demand) • Abbot ID now testing in ED provides rapid results to support patient placement	
• Areas used to cohort patients with suspected or confirmed COVID-19 are compliant with the environmental requirements set out in the current PHE national guidance	• Additional hand washing facilities in anterooms on ward A7 • Side rooms in use for non-clinical activity converted back for clinical inpatient use • 2 single rooms on A2 • 1 single room on A7 • 4 additional single rooms: - 2 between A5 and A6; - 2 between A8 and A9	• Old Estate with limited side room capacity	• Daily review of side room utilization at bed meetings • 4 additional Bioquell pods being installed on ward B18	

7. Provide or secure adequate isolation facilities				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
	• 3 single room pods built in AMU • 1 outside ACCU • ED 1 Bioquell Pod • Critical Care - 5 Bioquell Pods			
• Patients with resistant/alert organisms are managed according to local IPC guidance, including ensuring appropriate patient placement	• Isolation Policy and Alert organism policies in place • Datix completed when it has not been possible to isolate patients	• Limited number of side rooms further reduced by ward closures • Potential non-compliance of patients with shielding pre-operatively	• Isolation priority protocol in place related to transmission-based precautions • Daily liaison with Patient Flow Team to support risk prioritisation	

8. Secure adequate access to laboratory support as appropriate				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
There are systems and processes in place to ensure:				
• Testing is undertaken by competent and trained individuals	• Training on swabbing technique provided verbally and by video	• Small number of samples rejected due to insufficient cellular material or incorrectly labelled	• Swabbing SOP and training provided • Competency assessment tool launched	
• Patient and staff COVID-19 testing is undertaken promptly and in line with PHE and other national guidance	• Swabbing SOP in place covering day of admission, day 3, day 5, weekly thereafter if previous results negative, symptomatic, pre-admission elective and discharge screening • Lateral Flow testing in place for staff with plan in place to introduce LAMP testing	• RCAs identified some routine samples are being missed	• Daily senior nurse oversight to ensure compliance • Electronic systems support identification of patients who have not be screened as per routine testing protocol • Additional control measures put in place to ensure compliance including reminders via daily safety brief, emails to senior staff, electronic monitoring system	
• regular monitoring and reporting of the testing turnaround times with focus on	• Testing turn around times are monitored at Silver IPC cell			

8. Secure adequate access to laboratory support as appropriate				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
the time taken from the patient to time result is available				
• Regular monitoring and reporting that identified cases have been tested and reported in line with the testing protocols (correctly recorded data)	• LION BIS used to monitor testing in line with guidance and follow-up of omitted tests on admission/ day 3 /day 5/ weekly from day 5 • Documentation of IPC advice on receipt of positive results • RCA requests for cases ≥ day 8 of admission, with monitoring system in progress • Daily data validation process for Sit Rep signoff and external reporting • IPC Team Spreadsheet with RCA follow up of all cases ≥ day 8 of admission			
• Screening for other potential infections takes place	• Other routine admission screening (CPE, MRSA, VRE) in place			
• that all emergency patients are tested for COVID-19 on admission	• All patients being admitted to the Trust have Covid admission tests taken in ED using POCT (Abbot ID Now) testing and PCR swab			
• that those inpatients who go on to develop symptoms of COVID-19 after admission are retested at the point symptoms arise	• Covid is considered as a differential diagnosis for inpatients developing respiratory symptoms	• A small number of RCA investigation findings identified missed testing opportunities	• Discussion took place at Medical Cabinet to advise timely testing for Covid in patients developing Hospital acquired pneumonia • Guidance added to the Trust Antibiotic Formulary to test for Covid any patients who develop HAP	

8. Secure adequate access to laboratory support as appropriate				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
• that those emergency admissions who test negative on admission are retested on day 3 of admission, and again between 5-7 days post admission	• Daily monitoring system in place to achieve full screening compliance for admission, day 3 and day 5 swabs • Weekly screening implemented	• RCAs are identifying a very small number of routine samples are being missed	• Daily senior nurse oversight to ensure compliance • Electronic systems support identification of patients who have not be screened as per routine testing protocol • Additional control measures put in place to ensure compliance including reminders via daily safety brief, emails to senior staff, electronic monitoring system	
• that sites with high nosocomial rates should consider testing COVID negative patients daily	• Community prevalence increasing 06/06/2021 • Reduced nosocomial case numbers • Increased testing in outbreak areas as advised be the Infection Control Doctor • Daily testing has been implemented on wards during Covid-19 outbreaks			
• that those being discharged to a care home are being tested for COVID-19 48 hours prior to discharge (unless they have tested positive within the previous 90 days) and result is communicated to receiving organisation prior to discharge	• Discharge screening in place with results shared accordingly prior to patient discharge			
• that those being discharged to a care facility within their 14 days isolation period should be discharged to a designated care setting, where they should complete their remaining isolation	• Named community facility for care of patients who require continued isolation for Covid-19			

8. Secure adequate access to laboratory support as appropriate				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
• that all Elective patients are tested 3 days prior to admission and are asked to self-isolate from the day of their test until the day of admission	• Elective admission screening in place with results reviewed prior to admission • Where result is positive procedures are deferred	• Patient compliance with self-isolation guidance for 72 hours prior to admission	• Review of pre-admission information to support compliance with self-isolation guidance	

9. Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure that:				
• Staff are supported in adhering to all IPC policies, including those for other alert organisms	• PPE Champions in place • Clinical advice for management of patients with suspected infections continued • IPC on call service to provide advice 7 days per week • PPE donning and doffing included in Induction and Mandatory training sessions • IPC Team visit areas to discuss concerns raised in relation to national guidance			
• Any changes to the PHE national guidance on PPE are quickly identified and effectively communicated to staff	• Subscription and daily review of Gov.UK email updates. Covid-19 Policy is updated as updates are received (currently version 7). TWSB and Covid daily Bulletin used to communicate updates • Additional SOPs written	Update required to include pathway guidance in line with latest guidance	• Subscription and daily review of Gov. UK email updates • Control Room inbox is monitored 7 days per week and guidance issued over the weekend- out or of hours is escalated for action • Additional posters ordered Links to PHE videos are available on the Trust Hub and distributed • Meeting held with Critical Care to review PPE levels (April 21/ June 21)	

9. Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure that:				
			• Meeting held with Theatre teams (July 21)	
• All clinical waste and linen/laundry related to confirmed or suspected COVID-19 cases is handled, stored and managed in accordance with current national guidance	• Guidance included in Covid-19 Policy. Early guidance adhered to when initial classification of a HCID. Waste was quarantined and disposed of by incineration • Guidance included in the Coronavirus Policy • Used linen is processed as infected via red alginate stitched bag stream			
• PPE stock is appropriately stored and accessible to staff who require it	• Stock control in place • In and out of hours access protocol in place • Specialist PPE equipment office with access available 7 days/week • National distribution to maintain stock levels			

10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Appropriate systems and processes are in place to ensure:				
• Staff in 'at-risk' groups are identified using an appropriate risk assessment tool and managed appropriately including ensuring their physical and wellbeing is supported	• An integrated self-risk assessment tool has been produced for enable all staff to identify if they are 'at-risk'. Following identification (through			

10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Appropriate systems and processes are in place to ensure:				
	the tool or the personal information held on individuals) and a subsequent detailed risk assessment is completed for all staff who are within an 'at-risk' group, compliance is currently (Aug-21) at 96% and is reported daily • Chief People Officer and Chief Executive Officer and Chairman attended the BAME Staff Network Group in June 2020 to receive feedback • Individual letters have been sent to BAME members of staff, outlining support available • Named midwife contact within Maternity Department provides for pregnant staff • All staff who are considered clinically extremely vulnerable are supported by robust workforce support and the Trust are in the process of having one to one discussion to agree support and adjustments • All staff working at home have been provided with a 'working from home pack', including access to mental health support			

10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Appropriate systems and processes are in place to ensure:				
	• Enhanced Occupational Health Service to 7 days per week with additional staffing both administration and clinical • An enhanced wellbeing offer has been developed, linked to learning from Wuhan, Italy and the British Psychological Society • Electronic system in place for Covid-19 Workforce risk assessment • Access to face to face counselling			
• That risk assessment(s) is (are) undertaken and documented for any staff members in an at risk or shielding groups, including Black, Asian and Minority Ethnic and pregnant staff	• Process in place for electronic self-assessment followed by manager assessment if risks are identified – compliance with completion of risk assessments is monitored by the HR Department			
• Staff required to wear FFP reusable respirators undergo training that is compliant with PHE national guidance and a record of this training is maintained and held centrally	• Fit testing programme, including quantitative and qualitative testing, in place • Qualitative Fit testing SOP • Quantitative Fit testing SOP • Records are added to a central database • Powered Hoods are offered as an alternative where it has not been possible to Fit close fitting face masks • Only EN 149:2001 compliant masks are accepted as fit for use			

10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Appropriate systems and processes are in place to ensure:				
	for Aerosol Generating procedures			
• Staff who carry out fit test training are trained and competent to do so	• Programme of Fit Testing in place which is only carried out by trained Fit testers • An accredited Fit2Fit company or the Department of Health virtual training provided staff training			
• All staff required to wear an FFP respirator have been fit tested for the model being used and this should be repeated each time a different model is used	• Programme of Fit Testing in place • Compliance with Fit testing is monitored. Paper submitted to QAC in February 2021 • Programme of Fit Testing continues with an ambition to ensure staff are Fit Tested against 2 types of FFP3 respirators. Data on 23/07/21 - Total Number on Database: 3799 - Total Number passed on at least 1 current supported mask: 2133 • Total Number passed on at least 2 current supported masks: 401			
• A record of the fit test and result is given to and kept by the trainee and centrally within the organisation	• Database with Fit testing details including those staff requiring specialist respiratory equipment which is updated as additional fit testing is completed	• Data not held on ESR	• Action in place to review use of ESR for recording Fit Testing records	

10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Appropriate systems and processes are in place to ensure:				
• For those who fail a fit test, there is a record given to and held by trainee and centrally within the organisation of repeated testing on alternative respirators and hoods	• Spreadsheet with Fit testing details included	• Data not held on ESR	• Action in place to review use of ESR for recording Fit Testing records	
• For members of staff who fail to be adequately fit tested a discussion should be had, regarding re deployment opportunities and options commensurate with the staff members skills and experience and in line with nationally agreed algorithm	• Alternative respiratory protection is offered i.e. powered hood • Staff are redeployed to green pathway areas or amber areas where aerosol generating procedures are not performed • Provision of specialist PPE equipment is recorded including advice on decontamination of re-usable PPE			
• A documented record of this discussion should be available for the staff member and held centrally within the organisation, as part of employment record including Occupational Health	• Provision of specialist PPE equipment is recorded	• Documented evidence of discussion and central holding of this record	• Process under review to capture this data	
• Following consideration of reasonable adjustments e.g. respiratory hoods, personal reusable FFP3, staff who are unable to pass a fit test for an FFP respirator are redeployed using the nationally agreed algorithm and a record kept in staff members personal record and Occupational health service record	• Provision of specialist PPE equipment is recorded	• Documented evidence of discussion and central holding of this record	• Process under review to capture this data	
• Boards have a system in place that demonstrates how, regarding fit testing,	• Spreadsheet with Fit testing details included	• Data not held on ESR	• Action in place to review use of ESR for recording Fit Testing records	

10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Appropriate systems and processes are in place to ensure:				
the organisation maintains staff safety and provides safe care across all care settings. This system should include a centrally held record of results which is regularly reviewed by the board	• Compliance with Fit testing is monitored. Paper submitted to QAC in February 2021 • Email updates provided by the Fit Testing Team Coordinator		• Information on Fit testing figures is reported at Tactical meetings and included at Senior Executive Oversight Group Meetings • Report to QAC 02/2021	
• Consistency in staff allocation is maintained, with reductions in the movement of staff between different areas and the cross-over of care pathways between planned/elective care pathways and urgent/ emergency care pathways, as per national guidance	• Staffing reviews undertaken for all COVID areas • Staff movements managed by the senior nursing team at daily meetings • Senior Nurse presence 7 days per week 8am-8pm to support staffing management • Planned elective areas have designated teams, who are not moved to any other area in the Trust • Where it is necessary to move staff between different areas to support patient safety, this is discussed with the Infection Control Team. This cross over has not occurred between Elective and Emergency Care pathways			
• All staff adhere to national guidance on social distancing (2 metres) wherever possible, particularly if not wearing a facemask and in non-clinical areas	• Signage in place along corridors to socially distance, keep left and walk in single file • Risk assessments of all areas to achieve Covid-19 Secure spaces • IPC Team and/or Health and Safety Team review where concerns have been raised	• Compliance in office spaces	• Non-clinical area daily action card in development • Health and Safety Team reviews	

10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Appropriate systems and processes are in place to ensure:				
• Health and care settings are COVID-19 secure workplaces as far as practical, that is, that any workplace risk(s) are mitigated maximally for everyone	• Risk assessment in place to reduce risk • Agile working policy includes home working			
• Staff are aware of the need to wear facemask when moving through COVID-19 secure areas	• Guidance on PPE distributed by email, PPE booklet, posters			
• Staff absence and well-being are monitored and staff who are self-isolating are supported and able to access testing	• Managers have been supported to record absence in 'real time'. Daily and weekly absence reporting is in place • Data reported to Tactical meetings • Self-Isolation Approach SOP in place from 08/2021 to enable staff to return to work, if they meet the criteria			
• Staff that test positive have adequate information and support to aid their recovery and return to work	• A COVID-19 Occupatinal Health advice line has been created, to provide a range of advice and guidance to the workforce • The OH Service has also developed the co-ordination and advice service for staff testing (for symptomatic staff) • Enhanced Occupational Health Service to 7 days per week with additional staffing both administration and clinical • Occupational Health and Wellbeing advise staff of test results and provide further	• Test and Trace Service hours of operation	• National guidance for 16 hour per day service (cover in place for 11.5 hours per day) • Notifications from Test and Trace are received in the Control Room and forwarded to the Occupational Health and Infection Control Teams for action	

10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Appropriate systems and processes are in place to ensure:				
	wellbeing support as and when required • Retesting is in place as appropriate and is set out in Staff Testing SOP			

APPENDIX 2 Action Plan for IPC BAF 08 2021

Ref No	Action required	Target / review date	Date met	Supporting action	Lead	Supported by	Evidence/ Current position	RAG status
Criterion 1 Systems are in place to manage and monitor the prevention and control of infection								
1	Develop ventilation policy	Sep 21			ECR	IPCT		
2	Revise risk assessment templates to include prevalence of infection/variants of concern	Sep 21						
3	Improve compliance with LAMP testing	Sep 21		Revise introduction plan Communication strategy to improve uptake including CEO led team brief June 2021	CPO	CBU Triumvirate Leads		
4	Audit non-clinical area compliance with mitigation identified in risk assessments. Develop daily action card for non-clinical areas	Sep 21			ADIPC	IPCNs		
5	Improve compliance with LAMP testing currently 433 staff participating	Sep 21						
6	Improve compliance with level 2 IPC training to ≥ 85%	Sep 21		Three additional training sessions per week are being provided	IPCN	ACNs Planned & Unplanned Care	June 2021 = 82% compliance increased from 73% compliant in March 2021	
Criterion 2 Provide and maintain a clean and appropriate environment – Nil actions identified								
Criterion 3 Ensure appropriate antimicrobial use to optimise patient outcomes – Nil actions identified								
Criterion 4 Provide suitable and accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/medical care in a timely fashion								

Ref No	Action required	Target / review date	Date met	Supporting action	Lead	Supported by	Evidence/ Current position	RAG status
7	Update Signage aligned to Every Action Count resources	Sep 21		Agreement for roll out with DIPC and Communications Team	DIPC Interim Communications Lead	ADIPC	Posters designed and roll out plan being devised	
Criterion 5 Ensure prompt identification of people who have or are at risk of developing an infection								
8	Test inpatients that develop Covid-19 symptoms	Sep 21		Update guidance in the Antibiotic Formulary to test for Covid-19, any patient who develops respiratory symptoms e.g. hospital acquired pneumonia	LPAMS	CMMs		
9	Monitoring of compliance with face mask use by inpatients	Sep 21		Add information on compliance with patient face mask use to Lead Nurse HLBP for ICSC Circulate revised template to Lead Nurses	ADIPC		Revised HLBP in use	
10	Compliance with 10 key actions guidance on testing	Sep 21		Review of pre-admission guidance on self-isolation for elective admission	A C N Planned Care	IPCNs	Copy of information	
Criterion 6 Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection								
11	Increase Level 2 training compliance to ≥ 85%	Sep 21		Review training records and target groups with < 85% compliance	A C Ns Unplanned and Planned Care	ADIPC CBU Triumvirates	Jul 21: - Level 2 overall compliance 82%	
Criterion 7 Provide or secure adequate isolation facilities								
12	Install additional Bioquell pods	Aug 21		Plan developed to install 4 Bioquell pods in ward B18	MC CBU Manager	ADE	Building work in progress	

Ref No	Action required	Target / review date	Date met	Supporting action	Lead	Supported by	Evidence/ Current position	RAG status
Criterion 8 Secure adequate access to laboratory support as appropriate								
13	Daily swabbing compliance review to ensure compliance with Day of admission, Day 3 and Day 5 and weekly Covid screening	Sep 21			ADIPC	IPC Admin	Work in progress to align data on outstanding swabs on the BI LION report and E-outcome	
Criterion 9 Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections – Nil Concerns								
Criterion 10 Have a system in place to manage the occupational health needs and obligations of staff in relation to infection								
14	Centralised records of FFP3 Fit Testing	Sep 21		Add records to ESR	DCN Patient Safety	DCPO	Spreadsheet includes all staff records	
15	Documented (centrally held records) process for supporting staff who fail fit testing including redeployment options. Records should be held centrally of discussions with employees	Sep 21			DCPO		Alternative respiratory protection (powered hoods). Redeployment Hub established for vulnerable staff	

RAG Legend	
Action not commenced	
Action in progress	
Action completed	

Key Personnel	
ACNs	**Associate Chief Nurses**
ADIPC	**Associate Director of Infection Prevention and Control**
ADG	**Associate Director of Governance**
AMD	**Associate Medical Director**
CBU	**Clinical Business Managers**
CMM	**Consultant Medical Microbiologists**
DCN	**Deputy Chief Nurse**
DCOO	**Deputy Chief Operating Officer**
DCPO	**Deputy Chief People Officer**
DD HR	**Deputy Director of Human Resources and Organisational Development**
IPC Admin	**Infection Prevention and Control Administrator**

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/21/09/140**
SUBJECT:	**Infection Prevention and Control**
DATE OF MEETING:	**29th September 2021**
AUTHOR(S):	Lesley McKay, Associate Chief Nurse, Infection Prevention + Control
EXECUTIVE DIRECTOR SPONSOR:	Kimberley Salmon-Jamieson, Chief Nurse + Deputy Chief Executive
LINK TO STRATEGIC OBJECTIVE:	SO1 We will.. Always put our patients first through high quality, safe care and an excellent patient experience. SO2 We will.. Be the best place to work with a diverse, engaged workforce that is fit for the future. SO3 We will.. Work in partnership to design and provide high quality, financially sustainable services.
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF):	**#1272** Failure to provide a sufficient number of beds caused by the requirement to adhere to social distancing guidelines mandated by NHSE/I ensuring that beds are 2 metres apart, resulting in reduced capacity to admit patients and a potential subsequent major incident. **#1275** Failure to prevent Nosocomial Infection caused by asymptomatic patient and staff transmission or failure to adhere to social distancing guidelines resulting in hospital outbreaks **#1274** Failure to provide safe staffing levels caused by the mandated Covid-19 staff testing requirement, potentially resulting in Covid-19 related staff sickness/ self-isolation and the requirement to support internal testing; potentially resulting in unsafe staffing levels impacting upon patient safety and a potential subsequent major incident.
EXECUTIVE SUMMARY (KEY ISSUES):	This report provides a summary of infection prevention and control activity for Quarter 1 (Q1) of the 2021/22 financial year and highlights the Trust's progress against infection prevention and control key performance indicators. National healthcare associated infection (HCAI) reduction targets have not been set for 2021/22. In Q1 Trust apportioned HCAIs included: - • 23 E. coli bacteraemia cases • 4 Klebsiella spp. bacteraemia cases • 1 P. aeruginosa bacteraemia case • 14 Clostridium difficile cases • Nil MRSA bacteraemia cases • 10 MSSA bacteraemia cases Covid-19 cases were detected: - • 89 (0-2 days) • 10 (3-7 days) • 0 (8-14 days – probable healthcare associated) • 3 (15+ days – definite healthcare associated) Nil Covid-19 outbreaks

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

1

RECOMMENDATION:	The Board of Directors are asked to note the contents of the report.	
PREVIOUSLY CONSIDERED BY:	**Committee**	Quality Assurance Committee
	Agenda Ref.	QAC/21/08/184
	Date of meeting	3rd August 2021
	Summary of Outcome	Noted
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None	

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS

SUBJECT	Infection Prevention and Control Q1 report 2021/22	Agenda Ref:	BM/21/09/140

1. BACKGROUND/CONTEXT

This report provides an overview of infection prevention and control activity for Quarter 1 (Q1) of the 2021/22 financial year (FY). The report highlights the Trust's progress against Healthcare Associated Infection (HCAI) reduction targets and the response to the Covid-19 Pandemic.

NHSE/I use Clostridium difficile infection rates as one of a number of metrics to assess Trust performance. Both avoidable and unavoidable cases are taken into account for regulatory purposes. The Clostridium difficile objective has not been published during the Covid-19 pandemic.

The zero-tolerance threshold for avoidable cases of Meticillin resistant *Staphylococcus aureus* (MRSA) bacteraemia remains in place.

There is a national ambition to halve Gram-negative bloodstream infections (GNBSIs). The Antimicrobial resistance 5 year plan provided a revised timescale to meet this objective and advises a systematic approach is required to deliver a 25% reduction by 2021-2022 with the full 50% by 2023-2024.

In July 2020, apportionment of bacteraemia cases (Gram positive and Gram negative) changed to include community onset healthcare associated cases (patients discharged within 28 days of positive sample being taken).

NHSE/I Covid-19 case definitions are as follows:

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

A cluster of cases is defined as 2 cases arising within the same ward/department over a 14 day period. Further investigation assesses if the cases are assessed as linked this is considered an outbreak.

2. KEY ELEMENTS

HCAI data

RAG rating of Trust performance for HCAIs by month is shown in Table 1. Breakdown by ward is included at appendix 1.

Table 1: HCAI data by month

Indicator	Target	Position	A	M	J	Total
C. difficile	Local ≤44	Over trajectory	4	6	4	14
MRSA bacteraemia	Zero tolerance	On trajectory	0	0	0	0
MSSA bacteraemia	No target	No target	4	4	2	10
E. coli bacteraemia	Quality priority	Over trajectory	9	6	8	23
Klebsiella spp. bacteraemia	Quality priority	Over trajectory	1	2	1	4
P. aeruginosa bacteraemia	Quality priority	On trajectory	0	1	0	1

Trust Apportioned HCAI data

Bacteraemia Cases

Apportionment of bacteraemia cases now includes community onset/healthcare associated cases (patients with a prior hospital admission and positive sample taken within 28 days). This change in denominator makes comparison against previous performance difficult and increases the challenge for acute Trusts to meet the national reduction target for GNBSI.

Gram negative bacteraemia (GNBSI) – Trust apportioned

E coli bacteraemia

- 23 cases reported
    - 11 hospital onset/healthcare associated
    - 12 Community onset/healthcare associated
- 23 cases reported for the FY to date

Review of the cases for the FY identified the following primary sources: -

- 2 Gastrointestinal collection
- 3 hepatobiliary
- 12 lower urinary tract infections
- 1 skin/soft tissue infection
- 2 unknown sources
- 3 upper urinary tract infection

Klebsiella Spp.

- 4 cases reported
    - 4 hospital onset/healthcare associated
- 4 cases reported for the FY

Review of the cases for the FY identified the following primary sources: -

- 2 lower respiratory tract infections
- 1 unknown source

Pseudomonas aeruginosa

- 1 case reported
    - 1 hospital onset/healthcare associated
- 1 case reported for the FY

Review of the case for the FY identified the following primary source: -

- 1 upper urinary tract infection

The GNBSI Prevention Group meetings have recommenced with phase one ward (A2, A4, A5, A6, A8, B14, B19) and the Quality Academy. Areas of focus include: - hydration, continence management, urinary catheter management, hand hygiene (including patients) urinary tract infection detection/management and reducing use of urinary catheters. Education sessions on: - the scale of the GNBSI problem, the national resource toolkit and focus areas including hydration to prevent urinary tract infection, oral hygiene to reduce the risk of hospital acquired pneumonia, skip the dip and diagnosing UTI in patients over 65 years, catheterisation and ANTT have been provided to phase 1 wards

The IPC Team at WHH led a joint working group with local partners to adapt the national urinary catheter passport and this version is being adapted for use across Cheshire and Merseyside. A launch plan is being developed with the Trust Communications Team and this will also be shared across the Integrated Care System for use by partners.

In July a catheter prevalence survey will be carried out to determine any areas for improvement in catheter care. Planning has commenced for Sepsis week in September to focus on best practice in management of urinary tract infections.

Gram positive bacteraemia

Meticillin resistant Staphylococcus aureus (MRSA) bacteraemia

- Nil cases reported

Meticillin sensitive Staphylococcus aureus MSSA bacteraemia

- 10 cases reported
    - 9 hospital onset/healthcare associated
    - 1 Community onset/healthcare associated
- 10 cases reported for the FY

Review of the cases for the FY identified the following primary sources: -

- 1 Central venous catheter associated
- 2 endocarditis
- 1 peripheral cannula associated
- 1 septic arthritis
- 1 skin and soft tissue infection
- 3 unknown
- 1 urinary tract infection

Supportive training has been provided to wards where cannula associated infections occurred and wider sharing of learning taken to Trust-wide safety brief.

PHE comparative data on mandatory reportable bacteraemia cases for Q1 was not available at the time of writing the report.

Clostridium difficile

- 14 cases reported
- All hospital apportioned cases undergo post infection review
- RCA review meetings will be recommenced in Q2
- Ribotyping of all hospital onset/healthcare associated and community onset/ healthcare associated cases has not identified any links between the toxin positive cases

Comparative data for C. difficile rolling 12 months with other acute Trusts across the Northwest, to the end of May 2021, is included in appendix 2. The Trust has slightly higher case numbers compared to one Local Delivery System (LDS) partner and lower numbers than the other LDS partner.

Outbreaks/Incidents

Scabies

In April a patient on ward A2 Warrington site was diagnosed with Norwegian scabies by a Dermatologist. The patient was admitted to the Trust from a Residential Home. In view of high transmission risk with Norwegian scabies a decision was taken to carry out mass treatment of other inpatients and staff. All discharged patients who may have had contact (admission episode during the same time as the patient with scabies) were contacted with a warn and inform letter and information leaflet.

All patients remaining inpatients and staff were closely monitored for development of rash illness for a six-week period from detection of the index scabies case. Nil additional cases have been reported.

Pseudomonas

From January 2021 an increase in *Pseudomonas aeruginosa* cases were detected in Critical Care and typing identified 2 distinct clusters. In April, 3 additional patient cases were identified and typing identified: -

- 2 patients with isolates from sputum samples had the same typing result as a case earlier in the year
- 1 patient had the same typing result as a water outlet (but distinct from the cases above)

The situation was notified to Public Health England and outbreak meetings held. The contaminated water outlet was cleaned and disinfected and has since tested clear. All other water outlets were tested, and results were clear. The investigations did not identify any common sources for the linked patient cases and the unit remains under close surveillance.

Community Pneumococcal Cluster

In April, the Infection Prevention and Control Team were informed 9 residents from a residential home had been admitted to the Trust with respiratory problems. These inpatients were isolated pending results from clinical investigation. The causative organism was identified as *Streptococcus pneumoniae.* Antibiotics were reviewed and either treatment or prophylaxis was given. The vaccine for *Streptococcus pneumoniae* wanes over time and where required booster vaccinations were given to the inpatients prior to discharge back to the residential home.

Covid-19

Covid-19 cases detected in Q1 were identified as detailed below: -

- 89 cases (0-2 days)
- 10 cases (3-7 days)
- 0 cases (8-14 days – hospital onset probable healthcare associated)
- 3 cases (15+ days – hospital onset definite healthcare associated)

Hospital onset cases from April 2021 are shown in appendix 3.

All cases detected ≥ day 8 of admission where there is no prior positive Covid-19 result in the last 90 days undergo root cause analysis (RCA). All PCR confirmed cases are referred for genotype and sequencing with available results showing Delta variant.

Local prevalence of Covid-19 cases decreased during April - May however started to rise again in June and consequently an increase in patient admissions with Covid-19 related illness was seen. Point of Care testing in the Emergency Department is ensuring appropriate patient placement to Covid/non-Covid admission areas.

All activities continue in response to the Covid-19 pandemic including promotion of hand hygiene, use of personal protective equipment and social distancing. The programme of Fit Testing of FFP3 respirators has continued.

Restoration of visiting remains on hold due to high local prevalence. Compassionate visiting arrangements remain in place and visitors are supported with training on use of personal protective equipment (PPE).

The Environmental Action Plan produced jointly with Infection Prevention and Control, the Associate Director of Estates and Facilities and the Deputy Chief Nurse for Patient Safety is reviewed and updated regularly. This action plan incorporates several other actions including: - reduction of entrances/exits, signage promoting social distancing, Perspex barriers at reception desks, ensuring high standards of cleanliness and risk assessments to create Covid-19 secure areas for staff.

The procurement team have maintained availability of PPE throughout the pandemic and stock levels remains under constant review.

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

Next steps include: -

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

Infection Prevention and Control Training

Overall compliance with Mandatory training was 87% in June 2021.

Table 2 Infection Control Training compliance

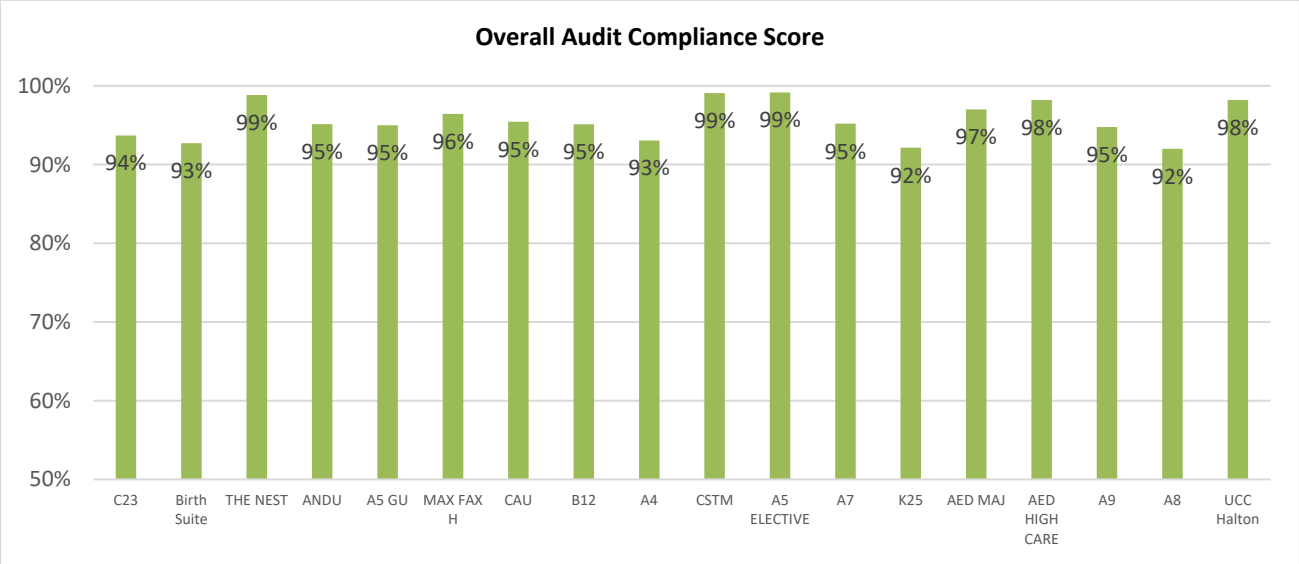
Infection Control Training	A	M	J
Level 1 – Non-Clinical	92%	91%	90%
Level 2 - Clinical	82%	83%	83%
Overall % of staff trained	**87%**	**87%**	**87%**

The Infection Prevention and Control Nurses (IPCNs) have provided additional virtual training sessions via Live MS Teams events to drive up compliance. Clinical Business Unit (CBU) with compliance below 85% have been directed to set improvement trajectories. Additional training sessions have been offered by the IPCNs to support the CBUs.

Infection Prevention and Control Audits

Eighteen audits were completed with overall compliance ranging between 92 – 99%.

Table 3 Infection Control Audits



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

Low PPE scores related to staff not wearing all items of PPE when within 2 metres of a patient, not changing aprons and gloves moving between patients and not washing hands after removal of PPE. Further walkabouts will take place with the IPCNs the CBU matrons to drive forward improvements in environmental standards and PPE compliance.

Environmental Hygiene

Revised National Standards of Healthcare Cleanliness were published in April 2021. There is a requirement to demonstrate how and to what standards hospital premises are cleaned. Meeting aspects of these standards is mandatory, and the document introduces a commitment to cleanliness charter. A Task and Finish Group has been set up to introduce the new standards.

Antimicrobial Point Prevalence Audit

The point prevalence prescribing audit carried out in June highlighted: -

- 89% compliance with the Trust Formulary (just below the internal compliance standard of 90%)
- 10 wards were 100% compliant with the formulary
- 22 patients were prescribed antibiotics considered non-compliant with the Trust's formulary
- 4 patients did not have clear indications for antimicrobials documented

Areas for improvement identified included : -

- CURB score not calculated/documented
- Co-amoxiclav use in elderly patients which is a C. difficile risk
- Duration of antibiotics for simple urinary tract infections (UTI)

Next steps include: -

- Remind prescribers to calculate and document CURB scores
- Promotion of antimicrobial review standards

- Ensure locum staff are aware of the desktop location of the antibiotic formulary
- Target antibiotic ward round activity on areas with high prescribing and/or low formulary compliance
- Escalation of prescribing concerns from ward Pharmacists to the Lead Pharmacist in Antimicrobial Stewardship
- Feedback of audit findings to Medical Cabinet and CBU Governance Meetings in addition to individual prescribers

Awareness raising events

The Infection Prevention and Control Team carried out focussed awareness raising activity on hand hygiene in May for World Hand Hygiene Day by visiting wards, using social media post and desktop messages.

3. ACTIONS REQUIRED/RESPONSIBLE OFFICER

- Develop the Infection Prevention and Control Service recovery plan
- Publish the Infection Prevention and Control Strategy
- Continue to provide expert advice throughout the pandemic
- Review healthcare associated infection prevention plans to replace existing reduction plans

4. IMPACT ON QPS

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

5. MEASUREMENTS/EVALUATIONS

- Mandatory reporting of healthcare associated infection (HCAI) to Public Health England
- Surveillance of nosocomial Covid-19 cases/reporting Covid-29 Outbreaks
- The Infection Prevention and Control Team meet to monitor cases of HCAI. Action is implemented in response to increased incidences of HCAIs and infection control related incidents
- The Infection Control Sub-Committee aims to meet monthly (12 times per annum) and discusses HCAI surveillance data and learning from HCAI incidents
- Meetings will take place weekly to review HCAI incident investigation reports and agree actions to support care improvements
- Healthcare Associated Infection data is included in the Ward Dashboard data

6. TRAJECTORIES/OBJECTIVES AGREED

- The Clostridium difficile threshold for 2021/2022 has been set locally at ≤ 44 cases
- There is a national GNBSI target of 25% reduction by 2021/2022 and the full 50% reduction by 2024. A 25% GNBSI reduction target has been set as a priority within the Quality Strategy for 2021/22
- The Trust's quality priority target is to reduce healthcare associated E. coli bacteraemia by 25% by March 2022

- The zero tolerance to avoidable MRSA bacteraemia cases remains in place

Work streams will continue to:-

- Progress GNBSI reduction
- Launch the revised Urinary Catheter Passport
- Reduce the incidence of Clostridium difficile infection and implement learning from incidents
- Promote Antimicrobial Stewardship and challenge inappropriate prescribing
- Partnership working with Urgent and Emergency Care CBU to support timely blood culture sampling
- Implement Covid-19 screening competency assessments
- Monitor invasive device management/bacteraemia reduction
- Provide ANTT competency assessor training
- Implement an infection control surveillance systems including Catheter Associated UTI
- Support staff training in Infection Prevention and Control where CBU compliance is lower than 85%
- Promote excellent standards in uniform/workwear and the Bare Below the Elbows campaign
- Promote excellence in adherence to Covid-19 PPE guidance
- Support assessment of decontamination standards
- Enhance the surgical site infection surveillance programme
- Implement a recovery plan to review overdue policies
- Launch the revised National Cleaning Standards and Commitment to Cleanliness Charter

7. MONITORING/REPORTING ROUTES

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

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

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

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

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

Exception reports will be submitted to the Quality Assurance Committee when increased incidences of infection are identified.

Daily monitoring by the Senior Executive Oversight Group during the pandemic

8. TIMELINES

- 2021/22 FY

9. ASSURANCE COMMITTEE

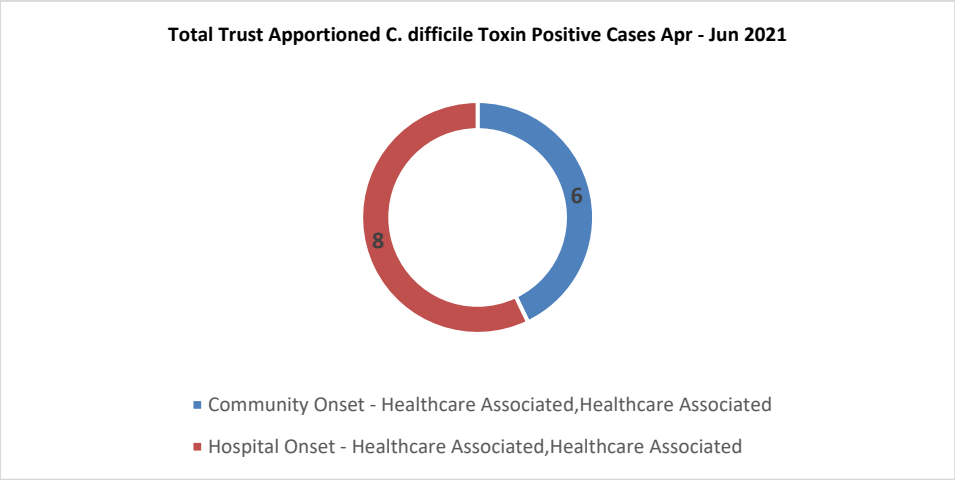
- Infection Control Sub-Committee

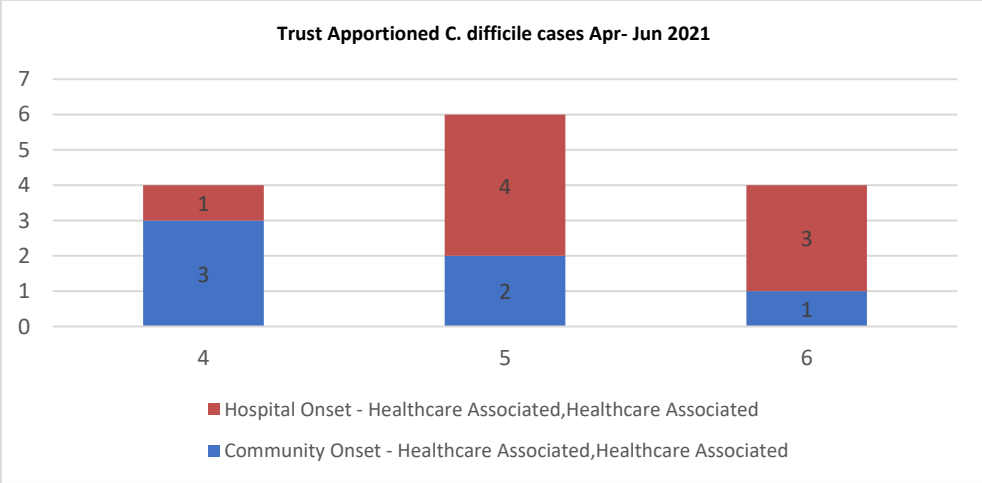
10. RECOMMENDATIONS

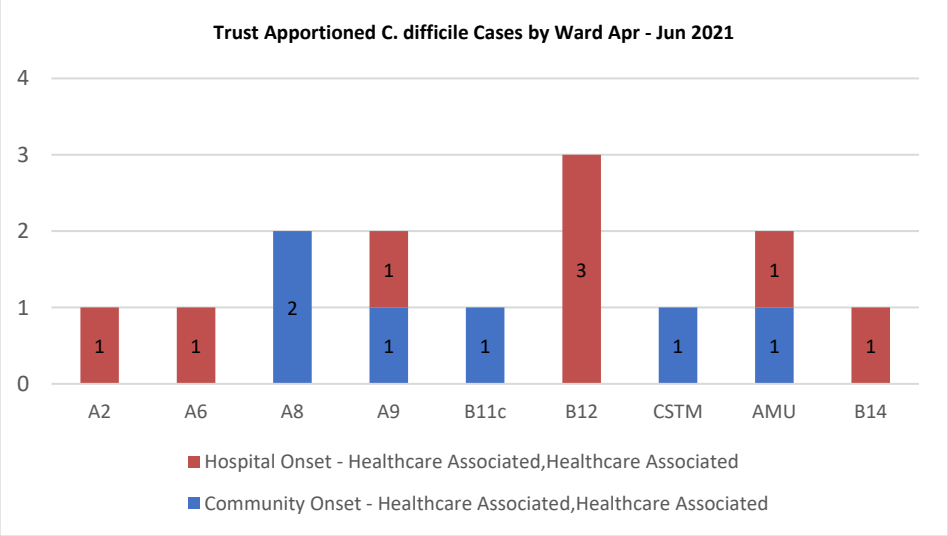
The Board of Directors are asked to receive the report and note the exceptions reported and progress made.

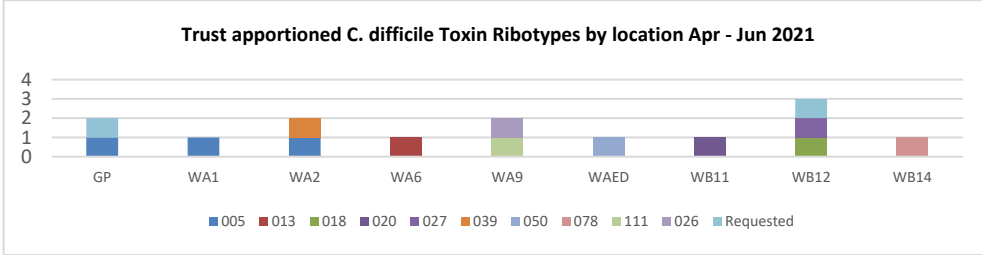
Appendix 1 Healthcare Associated Infection Data Apr – Jun 2021

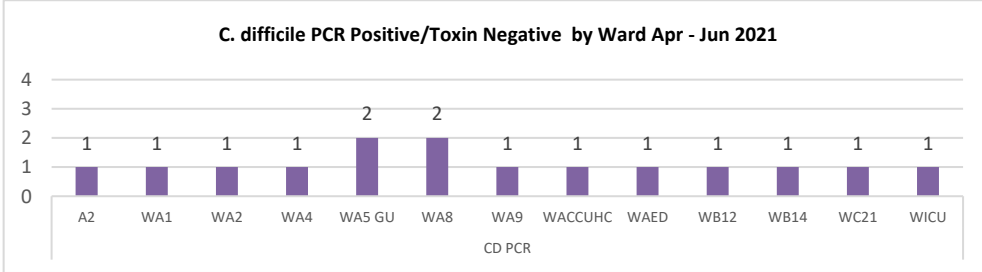
Clostridium difficile Cases



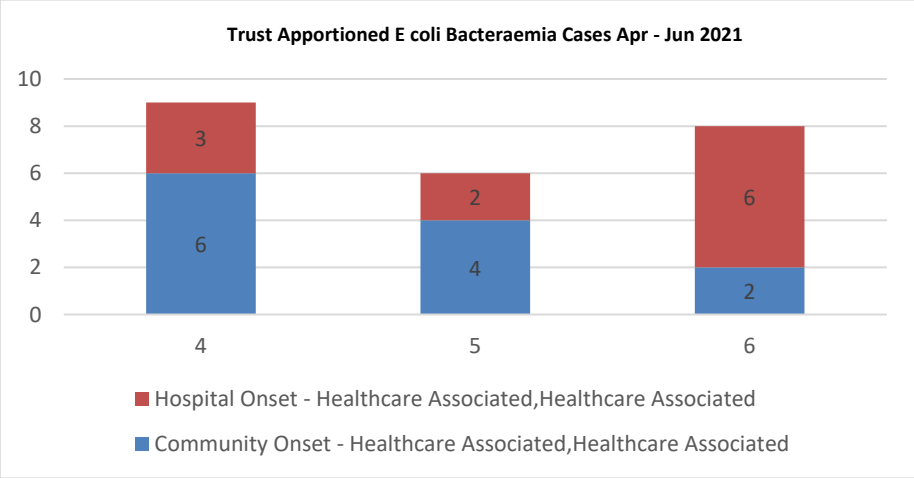


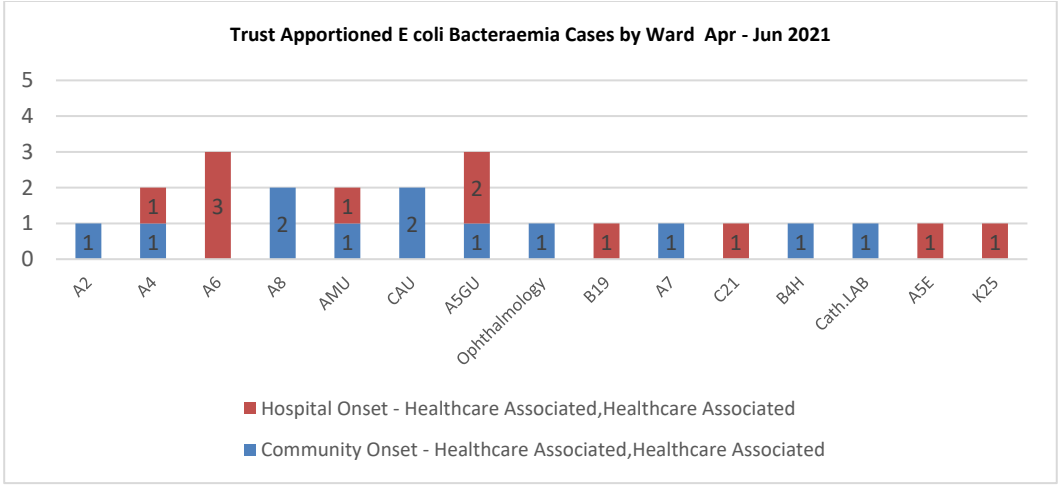


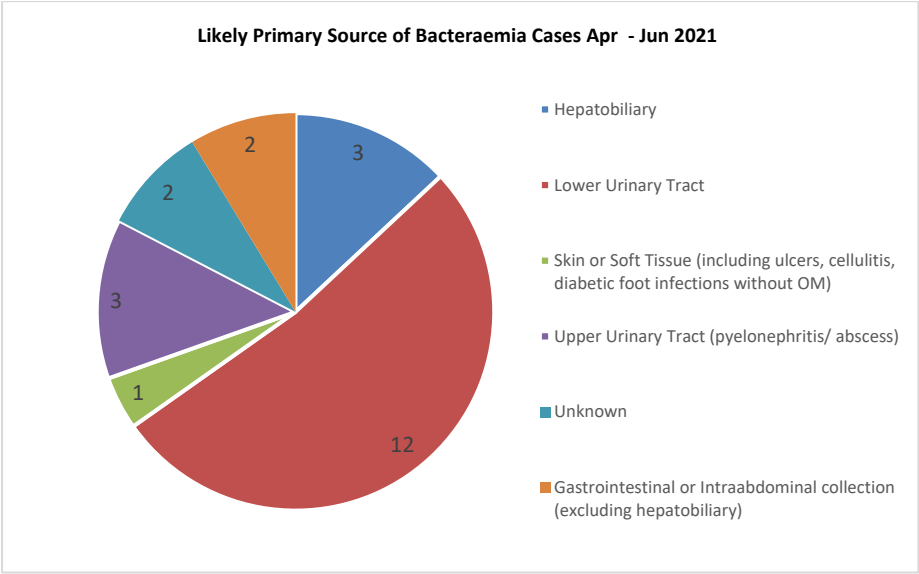


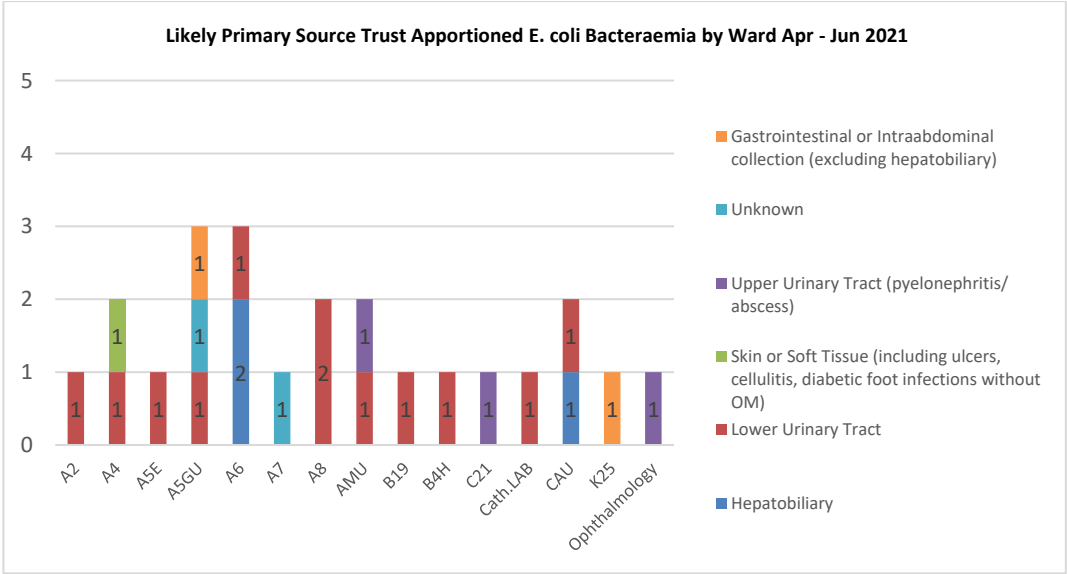


Gram Negative Bacteraemia Cases – E. coli

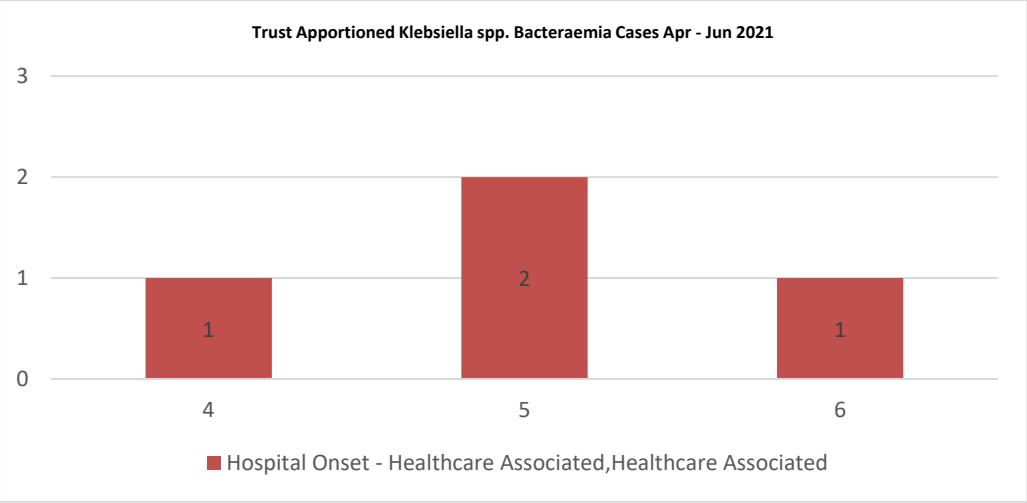


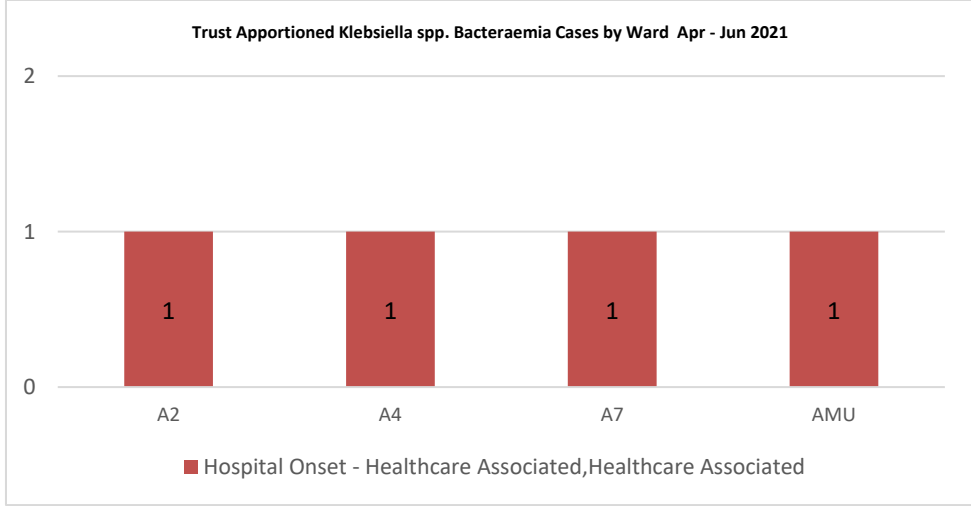


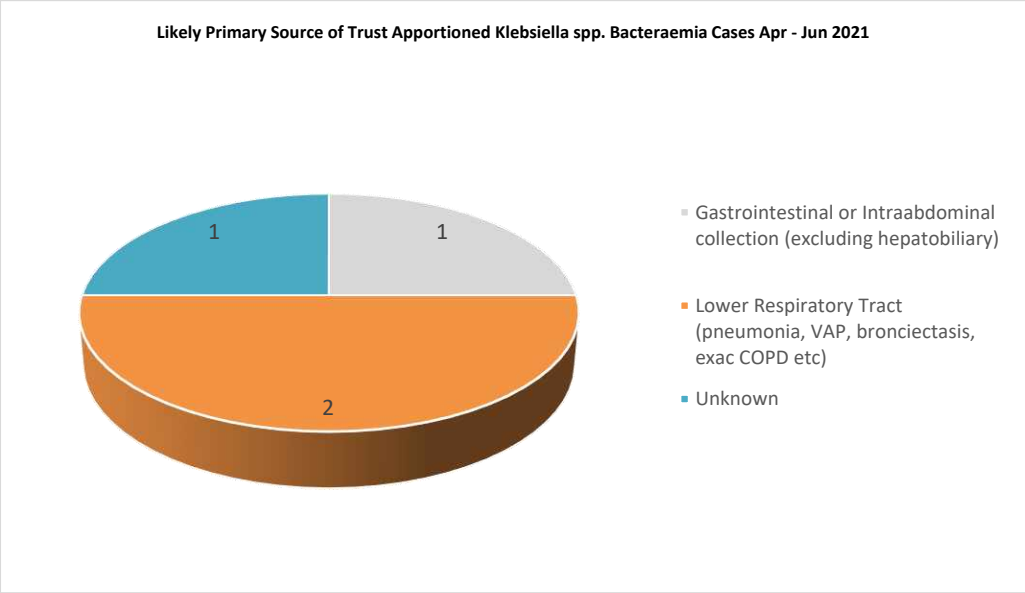


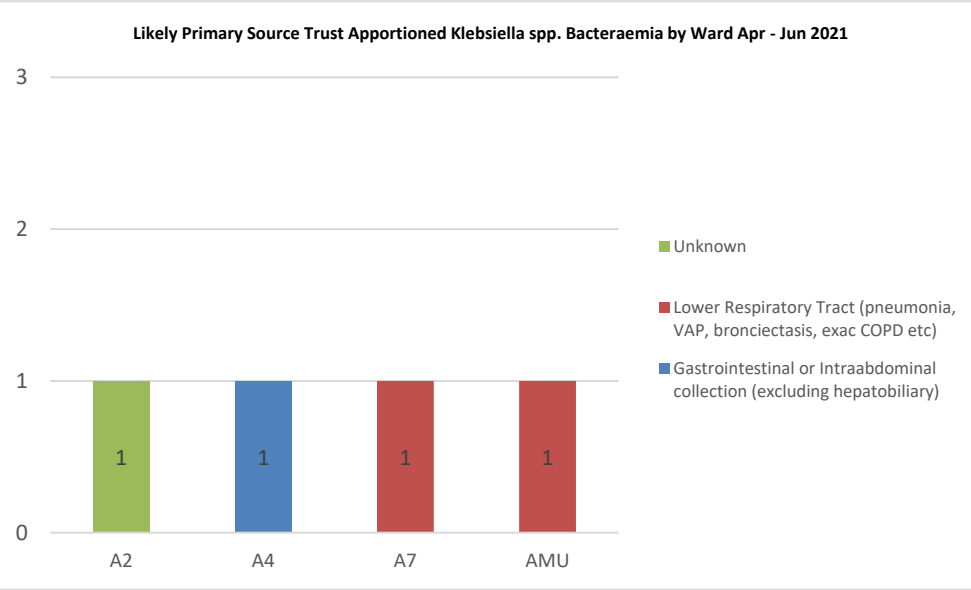


Gram Negative Bacteraemia Cases – Klebsiella spp.

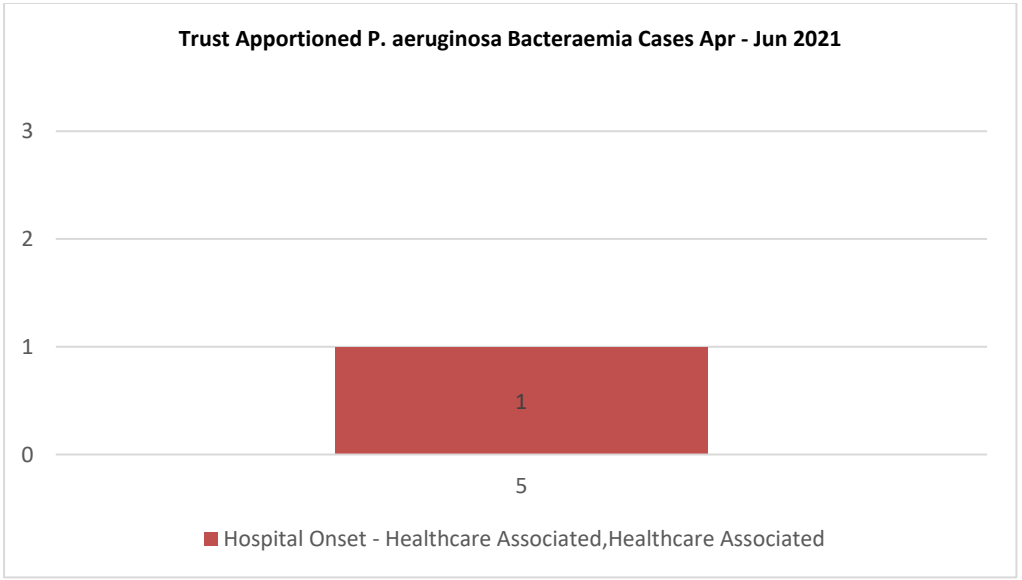


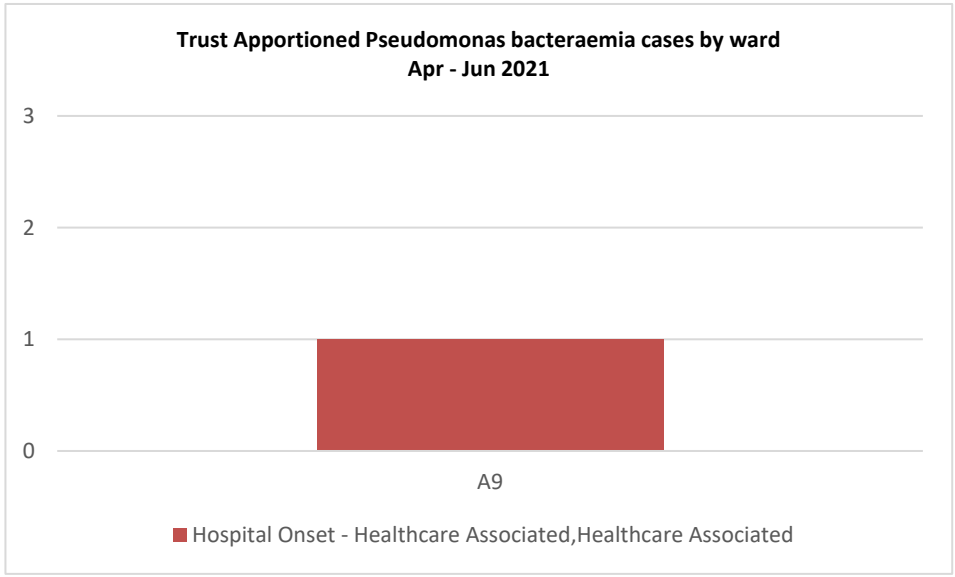


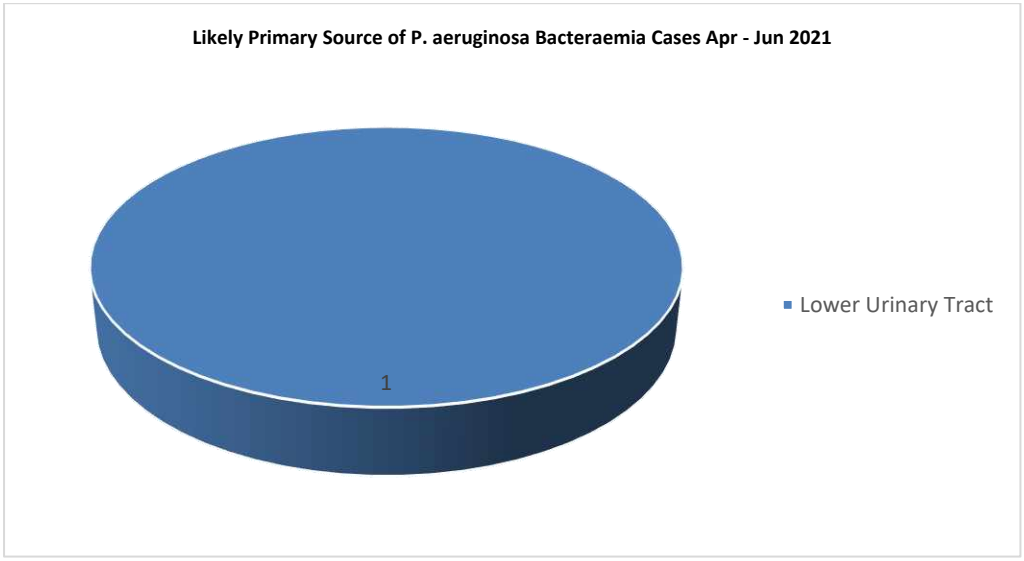


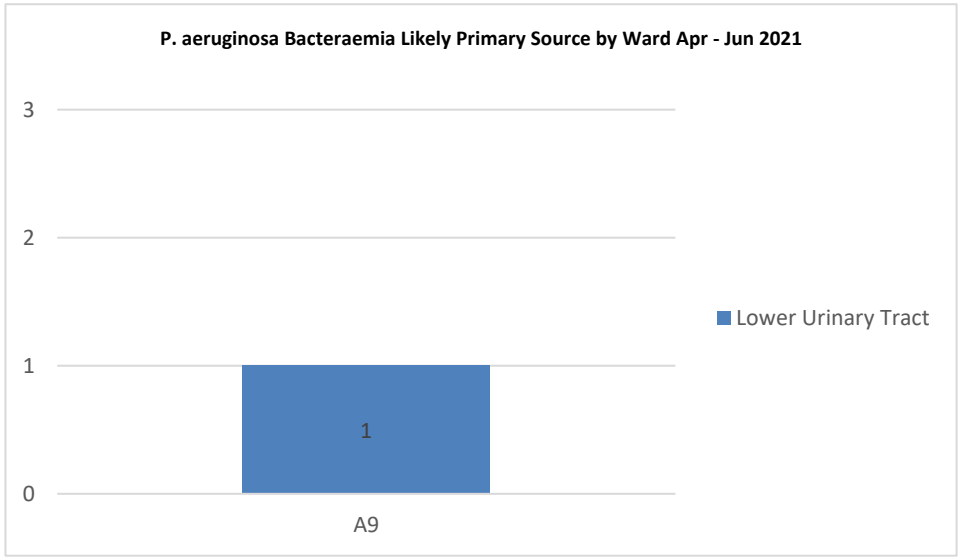


Gram Negative Bacteraemia Cases – Pseudomonas aeruginosa

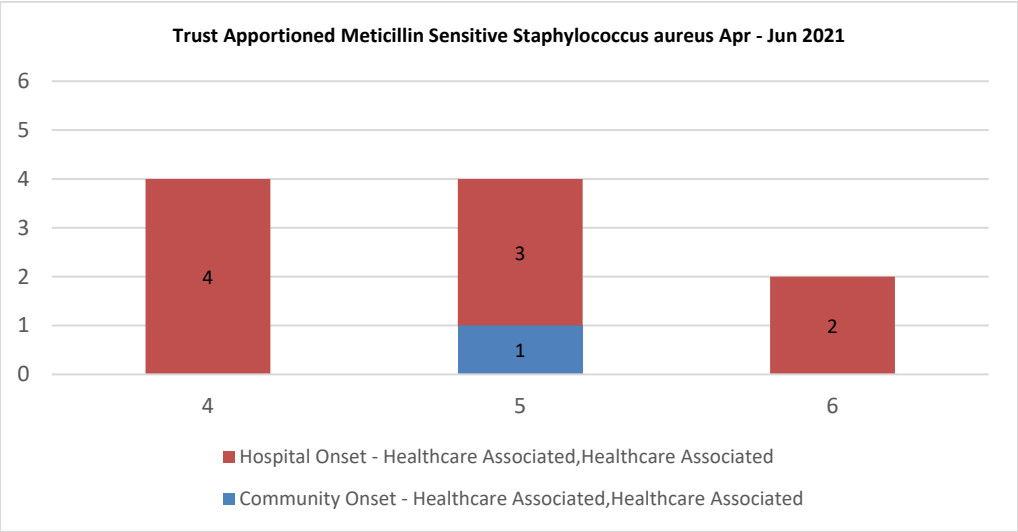


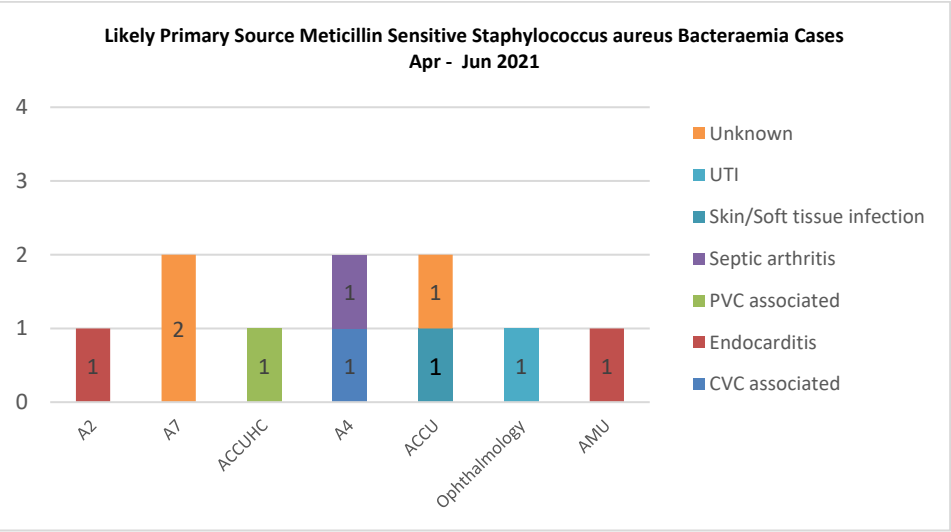


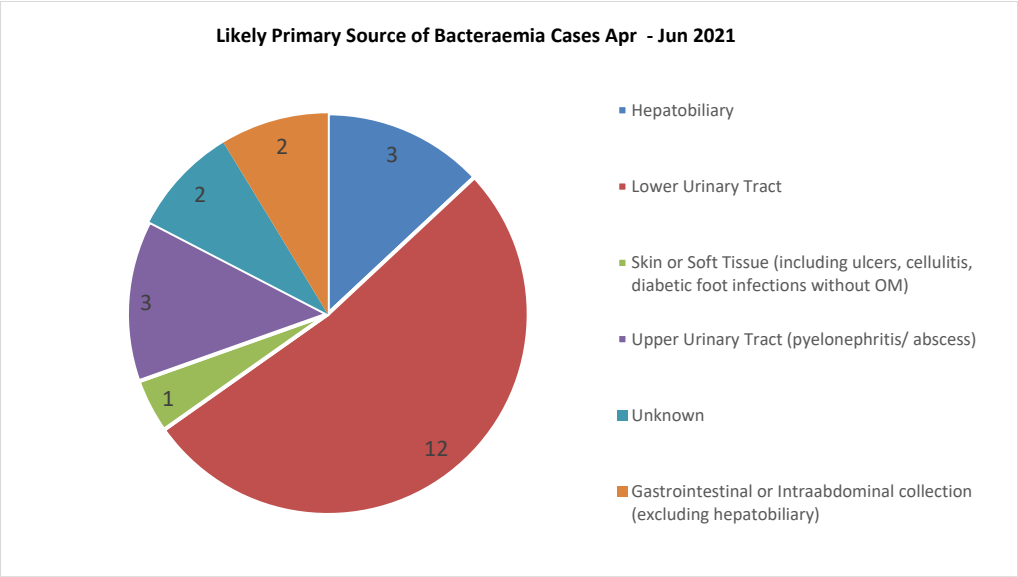


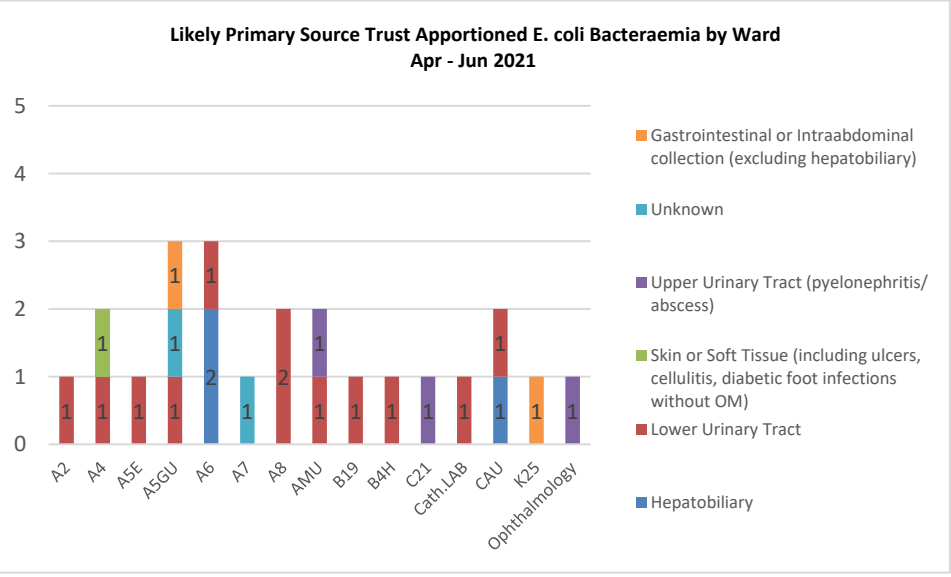


Gram Positive Bacteraemia Cases - Meticillin Sensitive Staphylococcus aureus









Appendix 2 Comparison of Healthcare Associated Infection Data Across the Northwest

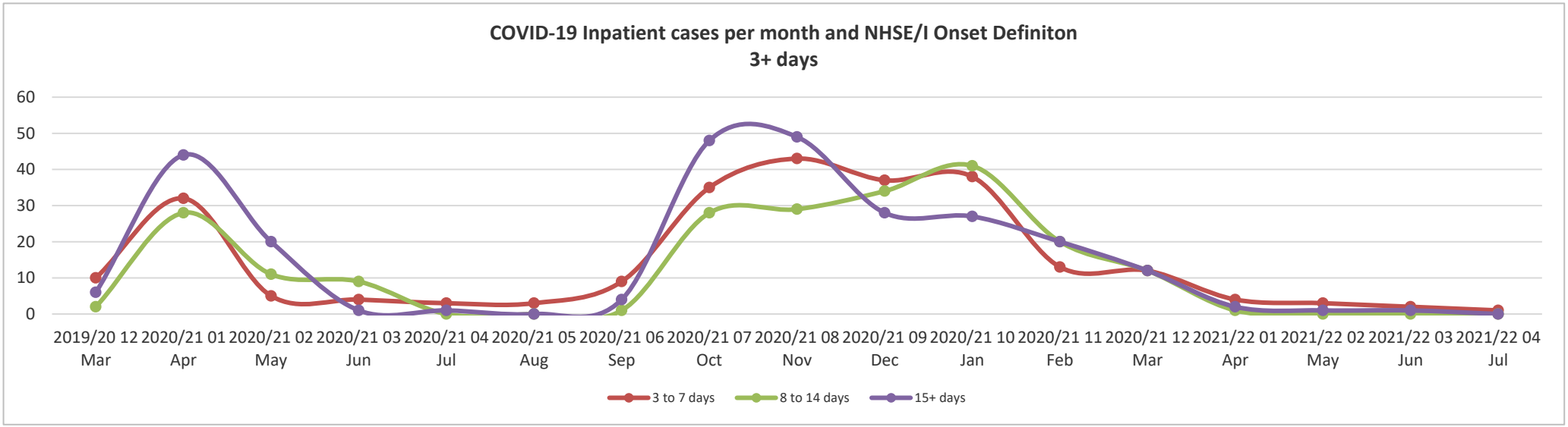
C. difficile – Annual table (June 2020 to May 2021)

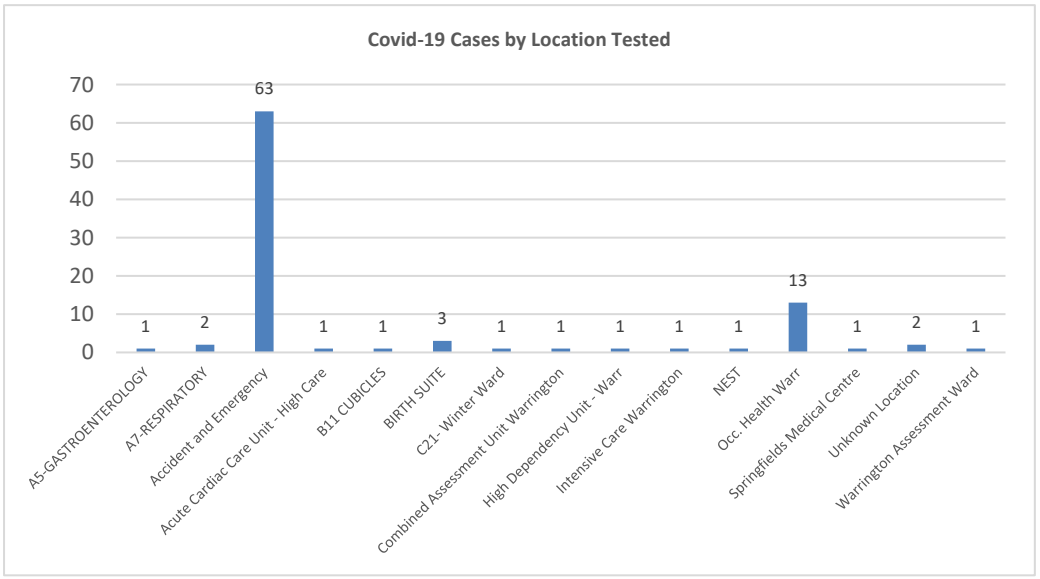
Public Health England

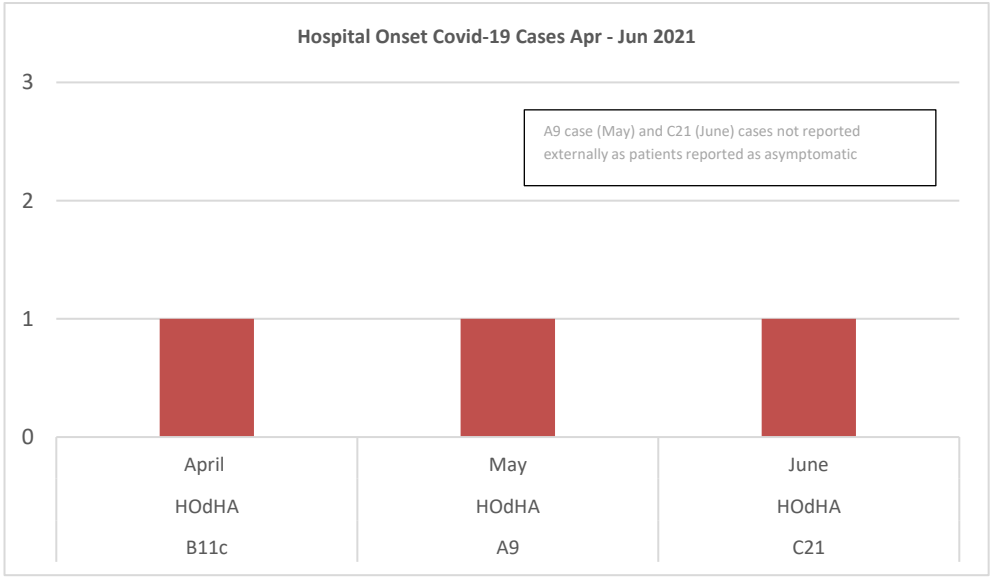
C. difficile annual tables: healthcare associated cases & rates by Trust (hospital onset & community onset)

Organisation Name	June 2020 to May 2021	Rate per 100,000 bed days	Significance
ALDER HEY CHILDREN'S NHS FOUNDATION TRUST	3	6.4	Low (0.001)
BLACKPOOL TEACHING HOSPITALS NHS FOUNDATION TRUST	94	48.0	High (0.001)
BOLTON NHS FOUNDATION TRUST	63	34.5	
COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST	47	31.2	
EAST CHESHIRE NHS TRUST	7	8.2	Low (0.001)
EAST LANCASHIRE HOSPITALS NHS TRUST	67	26.5	
LANCASHIRE TEACHING HOSPITALS NHS FOUNDATION TRUST	110	52.5	High (0.001)
LIVERPOOL HEART AND CHEST HOSPITAL NHS FOUNDATION TRUST	7	23.0	
LIVERPOOL WOMEN'S NHS FOUNDATION TRUST	0	0.0	
LIVERPOOL UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	121	27.9	
MANCHESTER UNIVERSITY NHS FOUNDATION TRUST	167	34.5	
MID CHESHIRE HOSPITALS NHS FOUNDATION TRUST	26	16.5	Low (0.001)
NORTH CUMBRIA INTEGRATED CARE NHS FOUNDATION TRUST	59	37.3	
PENNINE ACUTE HOSPITALS NHS TRUST	87	28.2	
SALFORD ROYAL NHS FOUNDATION TRUST	46	20.6	Low (0.001)
SOUTHPORT AND ORMSKIRK HOSPITAL NHS TRUST	39	34.5	
ST HELENS AND KNOWSLEY TEACHING HOSPITALS NHS TRUST	49	22.4	Low (0.025)
STOCKPORT NHS FOUNDATION TRUST	31	19.1	Low (0.001)
TAMESIDE AND GLOSSOP INTEGRATED CARE NHS FOUNDATION TRUST	28	27.2	
THE CHRISTIE NHS FOUNDATION TRUST	34	79.6	High (0.001)
THE CLATTERBRIDGE CANCER CENTRE NHS FOUNDATION TRUST	9	52.2	
THE WALTON CENTRE NHS FOUNDATION TRUST	6	17.7	
UNIVERSITY HOSPITALS OF MORECAMBE BAY NHS FOUNDATION TRUST	72	37.9	
WARRINGTON AND HALTON TEACHING HOSPITALS NHS FOUNDATION TRUST	46	29.0	
WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FOUNDATION TRUST	63	32.7	
WRIGHTINGTON, WIGAN AND LEIGH NHS FOUNDATION TRUST	46	34.2	
North West	1327	30.8	

Appendix 3 Covid-19 Cases







Appendix 4 Infection Control Audit Scores

Ward	C23	Birth Suite	THE NEST	ANDU	A5 GU	MAX FAX H	CAU	B12	A4	CSTM	A5 ELECTIVE	A7	K25	AED MAJ	AED HIGH CARE	A9	A8	UCC Halton
Environment	79%	78%	95%	78%	78%	100%	70%	90%	87%	98%	94%	90%	89%	94%	92%	94%	87%	95%
Ward Kitchens	81%	85%	96%	N/A	97%	77%	96%	86%	N/A	91%	N/A	94%	N/A	88%	N/A	81%	N/A	N/A
Handling/ Disposal of Linen	100%	94%	100%	N/A	94%	N/A	94%	100%	94%	100%	100%	89%	100%	94%	100%	94%	94%	100%
Departmental Waste	100%	100%	100%	100%	100%	94%	100%	100%	100%	100%	100%	100%	100%	100%	N/A	100%	100%	93%
Safe Handling Disposal of Sharps	95%	95%	100%	95%	100%	100%	100%	96%	100%	100%	100%	96%	91%	100%	100%	100%	95%	100%
Patient Equipment (General)	97%	88%	100%	100%	89%	100%	89%	100%	93%	100%	100%	95%	95%	91%	94%	93%	93%	94%
Patient Equipment (Specialist)	100%	N/A	N/A	100%	N/A	N/A	N/A	100%	N/A	100%	N/A	100%	N/A	N/A	N/A	N/A	N/A	N/A
Personal Protective Equipment	87%	87%	100%	100%	100%	100%	100%	85%	93%	100%	100%	73%	73%	100%	100%	80%	93%	100%
Short Term Catheter Care	100%	100%	100%	N/A	100%	N/A	100%	100%	89%	100%	100%	100%	N/A	100%	100%	100%	89%	100%
Enteral Feeding	n/a	n/a	n/a	N/A	100%	N/A	N/A	N/A	100%	N/A	N/A	100%	N/A	N/A	N/A	N/A	N/A	N/A
Care of Peripheral Intravenous Lines	100%	N/A	N/A	N/A	91%	100%	100%	100%	82%	100%	100%	100%	N/A	100%	n/a	100%	82%	100%
Non-Tunnelled Central Venous Catheters	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	90%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Isolation Precautions	100%	100%	100%	N/A	100%	N/A	100%	100%	100%	100%	100%	100%	N/A	100%	100%	100%	93%	100%
Hand Hygiene	97%	100%	97%	93%	92%	100%	100%	97%	89%	100%	97%	100%	97%	100%	100%	100%	97%	100%
Overall Compliance	**94%**	**93%**	**99%**	**95%**	**95%**	**96%**	**95%**	**95%**	**93%**	**99%**	**99%**	**95%**	**92%**	**97%**	**98%**	**95%**	**92%**	**98%**

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/21/09/141**	
SUBJECT:	**Learning from Experience Report – Q1 2021/22**	
DATE OF MEETING:	29th September 2021	
AUTHOR(S):	Layla Alani, Deputy Director Governance	
EXECUTIVE DIRECTOR SPONSOR:	Kimberley Salmon-Jamieson, Chief Nurse & Deputy Chief Executive	
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	SO1 We will.. Always put our patients first delivering safe and effective care and an excellent patient experience.	x
	SO2 We will.. Be the best place to work with a diverse and engaged workforce that is fit for now and the future	x
	SO3 We will ..Work in partnership with others to achieve social and economic wellbeing in our communities.	
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF):	**#224** Failure to meet the emergency access standard, caused by system demands and pressures. Resulting in potential risks to the quality of care and patient safety, staff health and wellbeing, Trust reputation, financial impact and below expected Patient experience. **#1215** Failure to deliver the capacity required caused by the ongoing COVID-19 pandemic and potential environmental constraints resulting in delayed appointments, treatments and potential harm **#1273** Failure to provide timely patient discharge caused by system-wide Covid-19 pressures, resulting in potential reduced capacity to admit patients safely. **#1275** Failure to prevent Nosocomial Infection caused by asymptomatic patient and staff transmission or failure to adhere to social distancing guidelines resulting in hospital outbreaks **#1289** Failure to deliver planned elective procedures caused by the Trust not having sufficient capacity (Theatres, Outpatients, Diagnostics) resulting in potential delays to treatment and possible subsequent risk of clinical harm. **#115** Failure to provide adequate staffing levels in some specialities and wards. Caused by inability to fill vacancies, sickness. Resulting in pressure on ward staff, potential impact on patient care and impact on Trust access and financial targets. **#1134** Failure to provide adequate staffing caused by absence relating to COVID-19 resulting in resource challenges and an increase within the temporary staffing domain **#1233** Failure to review surgical patients in a timely manner and provide a suitable environment for surgical patients to be assessed caused by CAU being bedded and overcrowding in ED resulting in poor patient experience, delays in treating patients and increased admission to the surgical bed base. **#125** Failure to maintain an old estate caused by restriction, reduction or unavailability of resources resulting in staff and patient safety issues, increased estates costs and unsuitable accommodation. **#1108** Failure to maintain staffing levels, caused by high sickness and absence, including those affected by COVID-19, those who are extremely vulnerable, those who are assessed as only able to work on a green pathway, resulting in inability to fill midwifery shifts. This also currently affects the CBU management team. **#1274** Failure to provide safe staffing levels caused by the mandated Covid-19 staff testing requirement, potentially resulting in Covid-19	

	related staff sickness/ self-isolation and the requirement to support internal testing; potentially resulting in unsafe staffing levels impacting upon patient safety and a potential subsequent major incident.			
EXECUTIVE SUMMARY ***(KEY ISSUES):***	The following report provides an overview of the Learning from Experience Report. The information within the Learning from Experience report is extracted from the Datix system and other Clinical Governance reports for Incidents, Complaints, Claims, Health & Safety, Mortality and Clinical Audit related to Quarter 1, 2021/22.			
PURPOSE: ***(please select as appropriate)***	Information	Approval	To note x	Decision
RECOMMENDATION:	The Board of Directors is asked to receive and note the report.			
PREVIOUSLY CONSIDERED BY:	**Committee**	Quality Assurance Committee		
	Agenda Ref.	QAC/21/09/219		
	Date of meeting	7 September 2021		
	Summary of Outcome	The report was noted by the Quality and Assurance Committee.		
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None			

REPORT TO BOARD OF DIRECTORS

SUBJECT	Learning from Experience Report – Q1 2021/22	AGENDA REF:	BM/21/09/141

1. BACKGROUND/CONTEXT

This report relates to the period April – June 2021 (2021/22 Q1). It contains a quantitative and qualitative analysis (using information obtained from the Datix risk management system) including Incidents, Complaints, Claims, Health & Safety, Mortality and Clinical Audit. The report includes a summary of the key findings identified in Quarter 1 with specific recommendations.

The purpose of the report is to identify themes and trends, make recommendations and provide a formal summary following a review of Incidents, Complaints, Claims, Health & Safety, Mortality and Clinical Audit.

2. KEY ELEMENTS

a. Incident reporting

In Q1 2021/22 2664 incidents were reported. A comparative analysis has been undertaken from Q1 2020/2021 (1890 incidents were reported) to Q1 2021/2022 and notes there is a 41% (774 incidents) increase in incidents reported for the same timeframe, indicating a positive incident reporting culture.

The Governance Department has continued to work to ensure that all rapid reviews are completed and triangulated with other governance systems, including, claims, mortality review group and complaints. The number of incidents graded as moderate to catastrophic harm in Q1 has decreased to 42 (N:57 in Q4). In Q4 2020/21 12 incidents were reported as moderate harm from the Clinical Harm Review process. In Q1 2021/22, no incidents of moderate harm have been reported as a result of the nationally expected delays in appointments that the clinical harm review process reviews.

The incident policy was relaunched last quarter with an update added to the Datix system, which gives examples of definitions of harm to those inputting incidents into the system to ensure the incidents are graded appropriately. Assurance can be provided that all incidents have been reviewed to ensure that incidents are correctly graded by the Governance Managers along with the Associate Director of Governance. There are no incidents awaiting validation.

2.2. Learning and Actions from Incidents

- **Medication Incidents –** Adult patients were not being accurately weighed on admission and their weight was not being recorded promptly on Lorenzo.

  Lessons learnt –
  - A safety alert was taken to the Trust-wide Safety Brief with recommendations for nursing staff, prescribers and housekeepers and a single point lesson 'How to accurately record and update an adults' weight on Lorenzo'.

- **Pressure Ulcers** – Actions from learning include:
  - Following an increase in pressure ulcers related to anti-thromboembolic stockings, and an evaluation of an alternative stocking, wards are now able to order the new stocking and the old stock will be replaced.
  - Accurate documentation on care and comfort charts to be reinforced including prescribed care. Ward Managers and Matrons auditing documentation.
  - Following incidents of pressure ulcers secondary to orthotic devices an orthotic appliance observation chart has been evaluated on ward A6. This is now to be implemented Trust wide.
  - Incident of pressure ulcer secondary to NIV mask. Alternative masks are being sourced to enable switching between masks and reducing prolonged pressure over same areas.

- **Information Governance** – Examples of insecure transmission of person identifiable information from the Trust via unencrypted email to insecure email domains. This type of email transmission represents a data loss risk. Email sent from health and social care organisations must meet the secure email standard (DCB1596) in order to maintain the security of confidential information.

  Lessons learnt –
  - We provided areas where insecure email transmission had been identified as an issue with a list of secure email domains. Such email domains are used across the public sector to ensure secure email transmissions.
  - Staff awareness has been increased as a result and information relating to secure email transmission of person identifiable information is included in data security and protection training products.

2.3. Complaints and PALS

- The Trust had a target to respond to 90% of complaint on time and in Q1 the Trust achieved 100%.
- During Q1 2021/22 81 complaints were received. There was a decrease of 36% in complaints received compared to Q4 (127). Due to the national pause in complaints during Q1 2020/21, the Trust has benchmarked this data against Q1 2019/20 and can confirm the decrease in activity reflects our usual complaints activity.
- Themes identified in complaints mirror those found across PALS and incident reporting; clinical treatment, attitude and behaviour and communication.
- There has been a reduction of the number of complaints received in relation to staff attitude and behaviour.
- 560 PALS concerns were received during Q1 2021/22, which is an increase of 22.4% compared to Q4 (458).
- The Trust received 7 dissatisfied complaints in Q1 2021/22; which was the same at Q4 2020/21.
- In Q1, 7 complaints were closed and deemed to require a concise or SI investigation.
- The Trust currently has 2 open PHSO cases. The PHSO closed one investigation in Q1.
- Actions from complaints are monitored via the speciality governance dashboards and the Clinical Governance Department, reporting to the Complaints Quality Assurance Group. Complaints action reports are also made available Trust-wide on a weekly basis.

2.4. Mortality

- Deaths are being reviewed and discussed at the group which continues to have external representation from our Commissioning bodies.
- SHMI and HSMR, are within the expected range at present.
- There is a key focus on reviewing Covid-19 deaths.
- MRG ‘Case of the Month’ is actively disseminated to ensure learning is filtered across the Trust.
- A lesson learning bulletin has been developed and will be shared across all CBU governance meetings to highlight the learning.
- The Medical Examiners actively feed any themes and learning into MRG.

2.5. Clinical Audit

- There are a number of audits ongoing across the Trust. For Quarter 1 this briefing refers to the National Emergency Laparotomy Audit. The audit findings are favourable indicating significant assurance.

- The Staffing Escalation Process has been audited locally in Quarter 1 to offer assurance that the Trust's legal duty to ensure that all wards and departments are staffed with the appropriate number and skill mix of nurses is working effectively. The audit highlighted all areas have maintained the 100% compliance against all standards providing a high level of assurance.

3. ITEMS TO NOTE

3.1. Clinical Incidents

- Work continues to review the levels of harm reported and to embed the processes introduced with the refreshed Clinical Incidents policy.
- No moderate harm cases have been reported as a result of the Clinical Harm Review process.
- There are no incidents awaiting validation.

3.2. Complaints and PALS

- There has been a continued increase (22.4% in Q1) in the number of PALS concerns received. The Associate Director of Governance has oversight of this and plans in place to address resourcing.
- There has been a decrease in the number of complaints raised in relation to staff's attitude and behaviour.

3.3. Claims

- Payments for clinical claims settled with damages totalled £2,367,064.00 (excluding costs)
- 1 employer Liability Claim was closed with damages (totalling £3,250.00 (excluding costs)
- Learning continues to be shared regarding claims at the claims monthly meeting.

3.4. Clinical Audit

- The key findings of the National Emergency Laparotomy Audit were that there was 100% best practice tariff achieved. Mortality was 9%, which was below the National Average (9.3%).

4. RECOMMENDATIONS

The Board of Directors is asked to receive and note the report.

NHS
Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Learning From Experience Q1 Report

Layla Alani

Deputy Director of Governance

August 2021

Overview

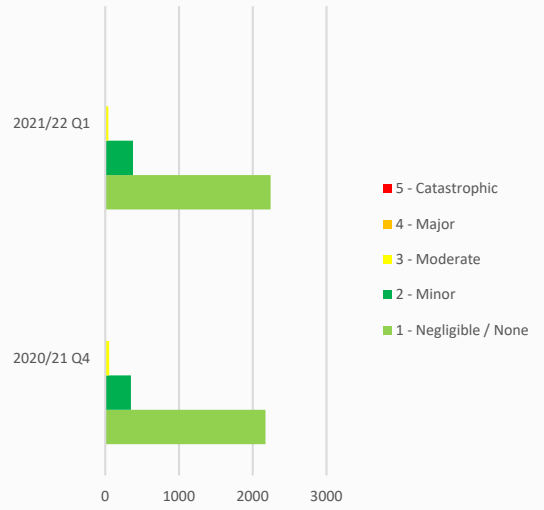
The following slides provide an overview of the information extracted from the Datix system and other clinical governance reports for Incidents, Complaints, Claims, Health & Safety, Mortality and Clinical Audit related to Quarter 1, 2021/22. They should be viewed in conjunction with the High Level Briefing Report.

Incident Headlines Q4 vs Q1

Warrington and Halton Teaching Hospitals NHS Foundation Trust

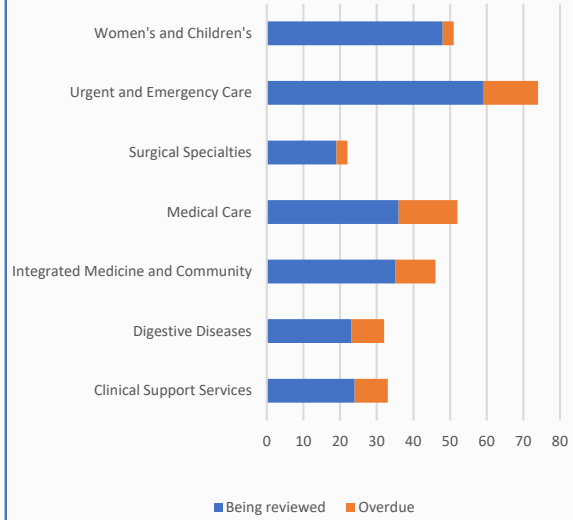
How many staff are raising incidents Q4 vs Q1?

- There was a 3.26% increase in incident reporting within the Trust in 2021/22 Q1 (2580 in 2020/21 Q4 vs 2664 in Q1).
- There was a decrease in incidents causing Moderate to Catastrophic harm in 2021/22 Q1 (59 in 2020/21 Q4 vs 45 in Q1)
- The number of no harm incidents reported increased by 3.22% in Q1 following incident reporting returning to normal levels. The 'Report to Improve' campaign was relaunched following the first-wave of the pandemic to enable this.



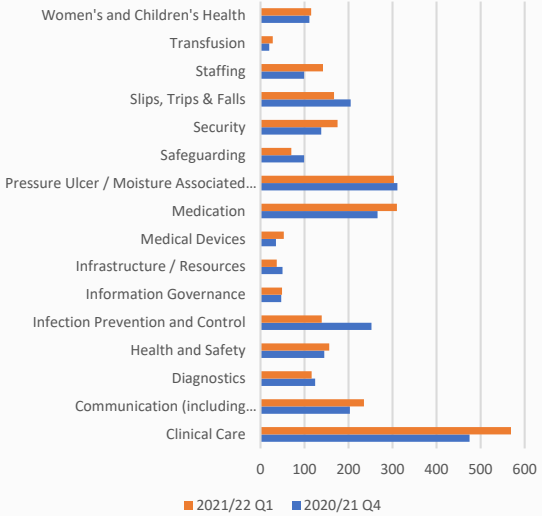
How many incidents are open Q4 vs Q1?

- The Trust reported 253 incidents open in CBUs in the Q4 LFE. To date that has increased to 309. The graph below shows the 7 CBUs with open incidents and the number of which are overdue.
- Providing feedback and closing incidents in a timely manner remains an important focus and work will continue to ensure that performance continues to improve and CBUs are supported during the Covid-19 pandemic.

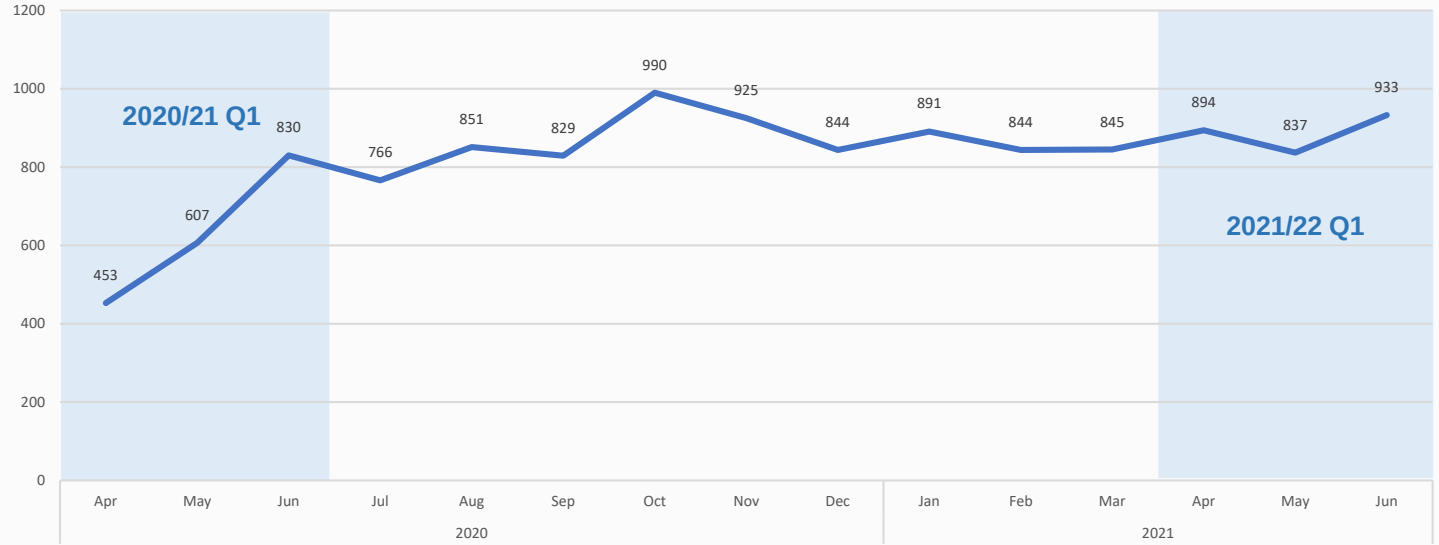


What type of incidents are we reporting Q4 vs Q1?

- There was an increase in the amount of incidents reported. Incidents relating to pressure ulcers, security and health & safety decreased in Q1.
- Incidents relating to clinical care, communication and medication increased in Q1.

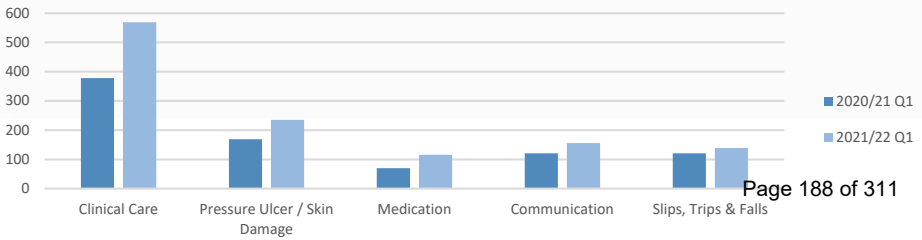


Incident Reporting 2021/22 Q1 vs 2020/21 Q1



In 2021/22 Q1 there was a 41% increase in incident reporting when compared to 2020/21 Q1.

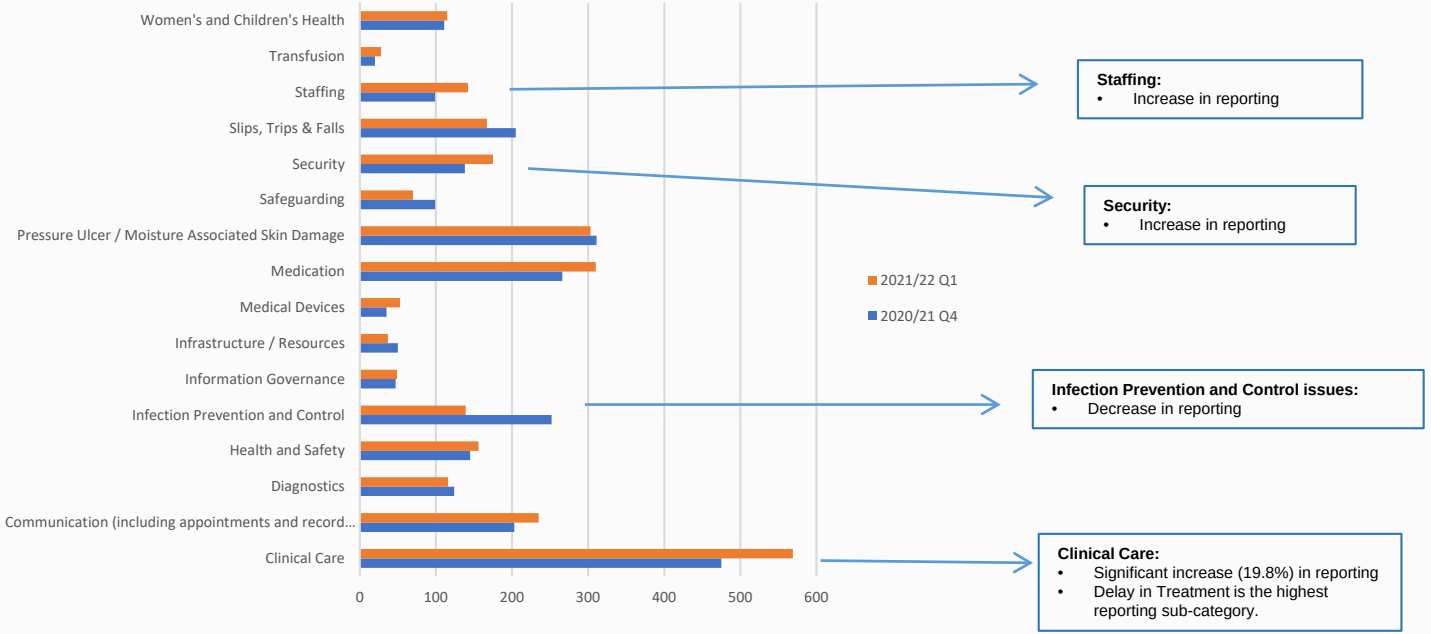
Comparison of Top 5 Incidents Reported



Incident Category Analysis Q4 vs Q1

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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



Staffing:
- Increase in reporting

Security:
- Increase in reporting

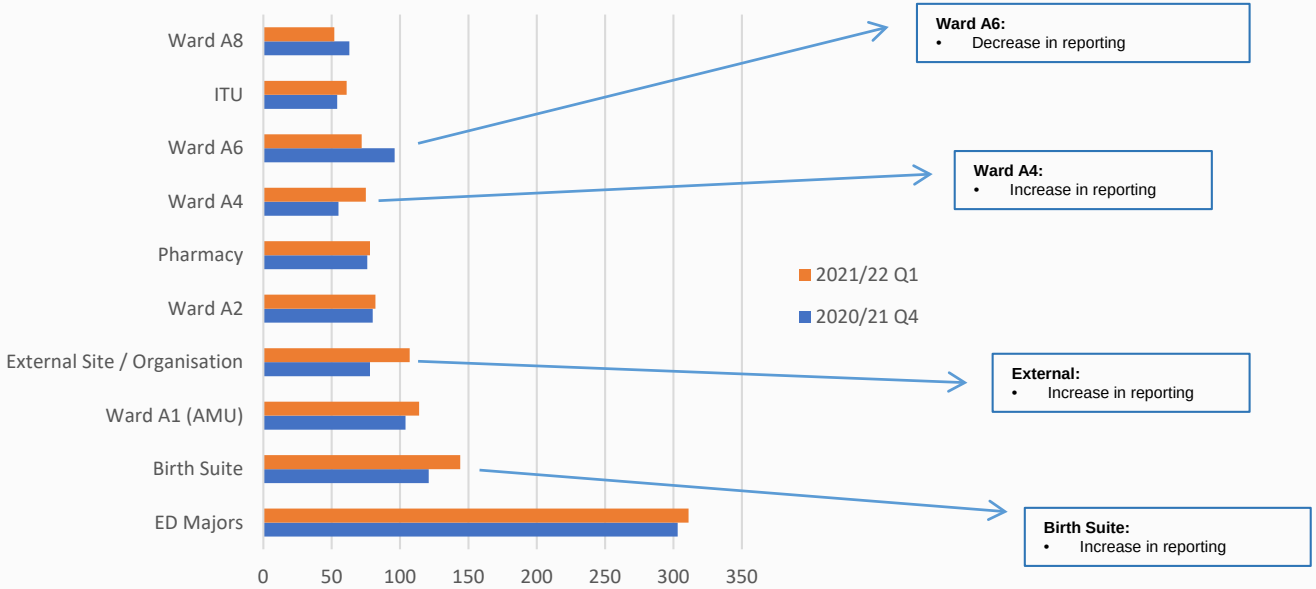
Infection Prevention and Control issues:
- Decrease in reporting

Clinical Care:
- Significant increase (19.8%) in reporting
- Delay in Treatment is the highest reporting sub-category.

Incident Location Analysis Q4 vs Q1

Warrington and Halton Teaching Hospitals NHS Foundation Trust

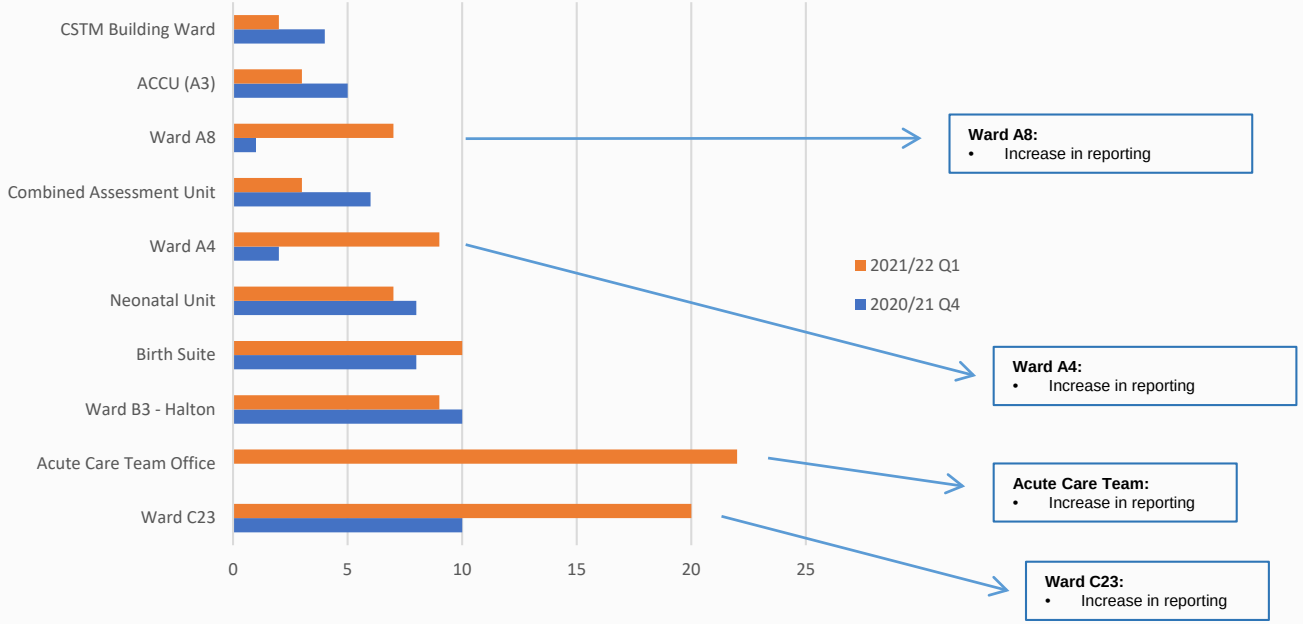
The information shows the top reporting locations and how they differ between the 2 quarters.



Staffing Incidents Location Analysis Q4 vs Q1

Warrington and Halton Teaching Hospitals NHS Foundation Trust

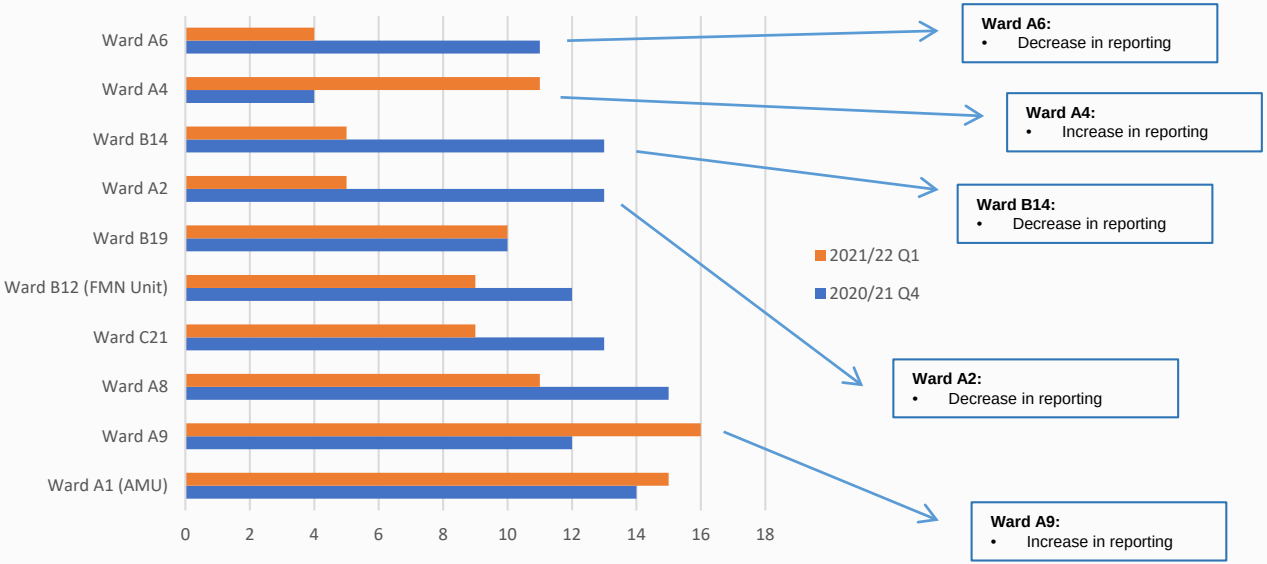
The information shows the top reporting locations in relation to staffing incidents and how they differ between the 2 quarters.



Patient Falls Location Analysis Q4 vs Q1

Warrington and Halton Teaching Hospitals NHS Foundation Trust

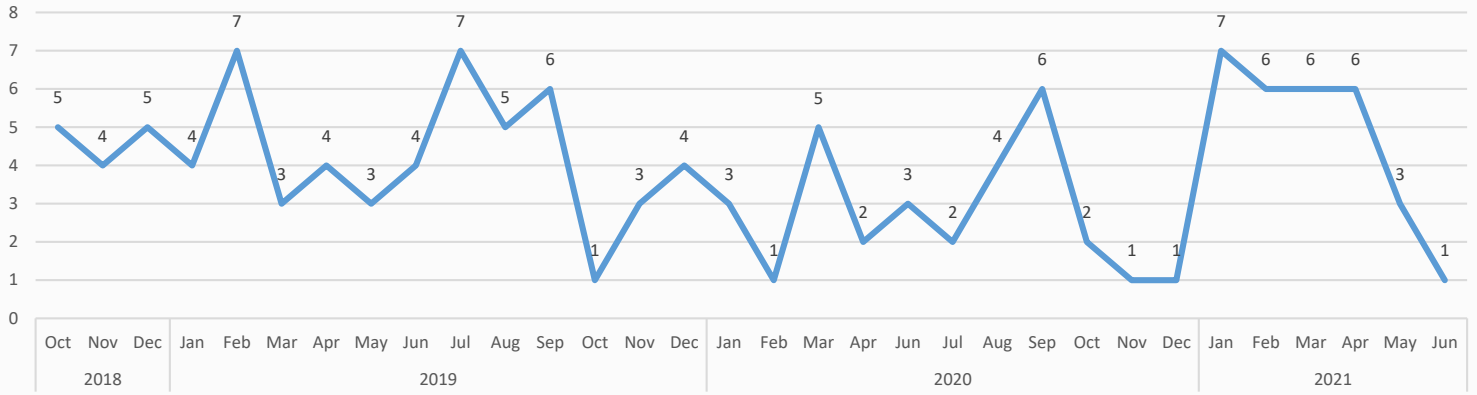
The information shows the top reporting locations in relation to patient falls and how they differ between the 2 quarters.



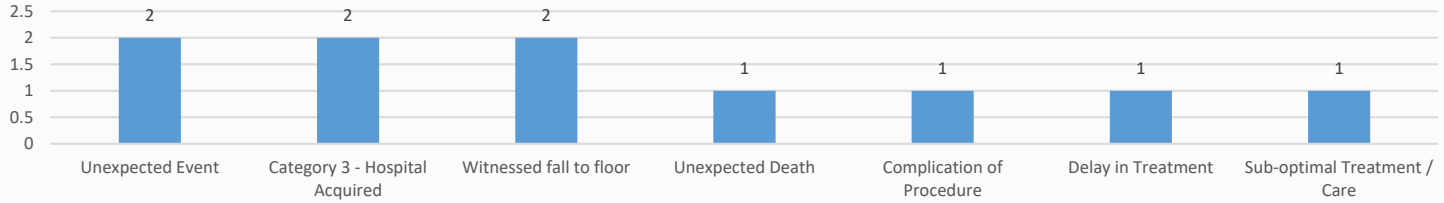
Serious Incident (SI) Reporting

Warrington and Halton Teaching Hospitals NHS Foundation Trust

SIs reported by Month



SI Cause Groups Q1

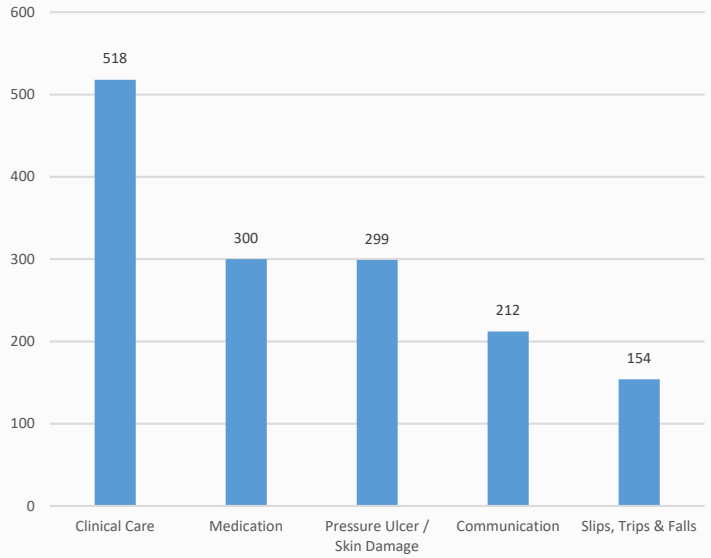


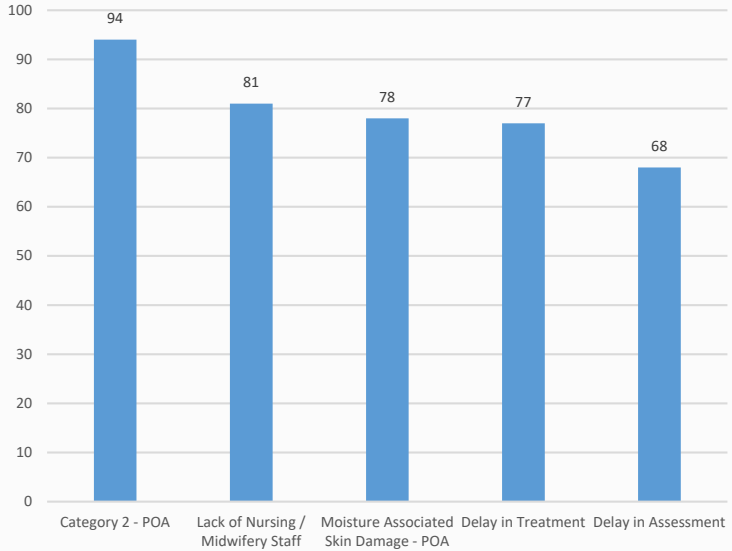
Across the 7 CBUs in Q1

Warrington and Halton Teaching Hospitals NHS Foundation Trust

A total of 2457 incidents were reported across the 7 CBUs in Q1, this has decreased from 2585 from Q4.

The top 5 categories and subcategories in Q1 were reported as follows:





Learning from Incidents – Medical Care

Warrington and Halton Teaching Hospitals NHS Foundation Trust

We found….

On the intensive care unit 15mls Ketamine found at a bed space. The patient received 5mls Ketamine prior to insertion of a chest drain. The remaining amount was found in the bedside nursing trolley. Nurse in charge made aware, 15mls Ketamine wasted and documented in the CD book as wasted medication as per Trust policy.

Lessons learnt: The drugs on ITU are usually signed out and wasted by the nursing team even though they are not actually giving the drug. This is a breach of policy. To be discussed at the Critical Care meeting.

We Acted….

- ✓ Incident discussed on a week of ICU handover / safety brief.
- ✓ The CD book on the ITU requires further review to enable a signature for each action 1) signed out 2) administered 3) wasted. Currently there is only signed out and wasted. A different version to suit the needs is available and in use in the theatre.
- ✓ Medics need to sign out their own drugs unless it is an emergency procedure - to be discussed at the Critical care meeting.
- ✓ Pharmacy to explore the possibility of sourcing smaller volume vials as the maximum ever used is 10ml (100mg) but this is very rare the usual volume used is 5ml (50mg).
- ✓ The two nurses who signed out the medication to complete a reflective practice.
- ✓ The ITU matron to review the LocSSIP for administration and safe disposal

We found….

An elderly patient was admitted with a history of confusion and a recent fall. had a history of unstable diabetes. A chest x-ray demonstrated bilateral rib fractures.
Admitted to the ward, had labile Blood glucose levels with hypoglycaemic episodes. The endocrinologist review recorded happy with high BG as long as no hypos. The Blood sugars remained labile with intermittent hypos, so there were regular reviews by the diabetes team and amendments made to the insulin regime.
The patients' blood sugar was checked at 22.15 and was 22.8, the patient was prescribed PRN insulin which was not utilised and the blood sugar was not re-checked until around 06.30am the next morning when it was >27. The PRN insulin was still not utilised until the day team advised to give. Throughout this episode the patient's ketones were never checked. When the ketone levels were checked fortunately they were below 1 and were not been recorded at over 1 (the level treatment is required) at any time throughout the admission.
Lessons Learnt: The patient had declined the insulin on the night time drugs round but this was not highlighted to the medics and the ketones were not checked.
Further Training was required by the individual clinician regarding Diabetes and Ketones.

We Acted….

- ✓ Insulin was given, a medical review requested and the ketone level tested.
- ✓ Feedback was provided to the individual and their line manager
- ✓ Individual training to be provided

Learning from Incidents – Integrated Medicine and Community

Warrington and Halton Teaching Hospitals NHS Foundation Trust

We found….

A patient assessed as risk of falls being observed every 15 minute continued wandering around the ward. Assisted back to bed a few times but then had a witnessed fall backward hitting their head on the floor. Staff unable to catch the patient as it happened too fast.
Lessons learned: The patient has a long-standing psychiatric history and was taking antipsychotic medication prior to admission. The admission was to enable medication to be "tweaked" by the psychiatric staff. Other than this the patient had been medically fit for discharge almost from the time of admission.

An iBleep was issued for a review but was not answered and this was not escalated to anyone, so no medical review was completed during the night shift.

The ward staff are not mental health nurses, and this is an acute hospital therefore was the patient in the best place to be treated and observed.

We Acted….

- ✓ A safety brief to be circulated to all staff to remind them of the need to escalate, and how to escalate when an IBleep is not answered.
- ✓ A discussion is required amongst senior staff regarding when concerns should be raised regarding the appropriate place for admission for unstable psychiatric patients
- ✓ A reflection to be completed by the nurse on duty overnight regarding the failure to escalate the lack of response to the iBleep

We found….

An unsafe discharge of a patient with learning difficulties. No support was put in place for mobility as the patient had declined this. No referral had been made to the community OT and there was a DNAR form which was not completed to a satisfactory level. The patient was under a DOLS.

We Acted….

- ✓ Feedback given to the community teams
- ✓ Obtain the patients hospital passport on admission.
- ✓ In patients who lack capacity any discussions around DNACPR including the reasons behind the decision should be documented clearly on the form and in the electronic case notes
- ✓ Audit of DNAR forms
- ✓ The DNACPR and best interest forms should be easily accessible in Lorenzo either as a standalone scanned document or as an electronic form
- ✓ All locum consultants who are employed for regular sessions at the trust should complete mandatory training in this trust.

Learning from Incidents – Clinical Support Services

Warrington and Halton Teaching Hospitals NHS Foundation Trust

We found….

A patient received unnecessary radiation exposure.

We Acted….

- ✓ A safety alert to be circulated to all clinicians who refer patients for imaging. Just to raise the awareness that imaging requests may be acted on very quickly by Radiology so ensure it is required before the request is submitted.
- ✓ Finding of the report to be shared with all clinical specialities
- ✓ As soon as the incident was identified the Surgical specialities Governance manager and the Clinical director were informed and it was discussed at the CBU Governance meeting.

We found….

A patient attended the breast unit for a stereotactic wire localisation prior to surgery. The wire was inserted and one view the position of the wire appeared satisfactory, however on the lateral view the wire was too deep. It was decided to insert a further wire. This is a recognised, relatively common complication of the procedure. The second wire again appeared to be in the incorrect position. The first two wires were removed and a third wire was inserted. The patient went on to have their surgery, with no problems and the specimen x-rays showed correct excision of the lesion. QA tests were completed to investigate the procedural complications. It was at this point the it became apparent there were two different lengths of needles (10 and 12.5cms) in the trolley and this was the issue.

We Acted….

- ✓ The LocSIPP has been updated to include a section: 'Confirm size and type of needle'
- ✓ The incident has been shared with the staff in the breast screening team.

Learning from Incidents – Radiology

Warrington and Halton Teaching Hospitals NHS Foundation Trust

We Found….

A patient arrived at reception at CSTM explaining that they had been to see their GP and had been told they needed a chest x-ray.

The receptionist asked the patient her name and date of birth and searched for her on the Radiology Information System (RIS). The search brought up a long list of patients and the receptionist selected the patient with the details which she thought appeared to match those of the patient in front of her.

However there was no chest x-ray request for the patient on the system. The receptionist explained this to the patient and called the surgery to check; they explained they had not seen a patient with those details.

The patient became verbally aggressive and refused to leave without her x-ray. Security and the police were called and she eventually left the building.

Shortly afterwards the patient attended the Ultrasound reception desk on the Halton site and explained that she was supposed to be having a chest x-ray. A second receptionist searched for her on the system and found the correct details and a referral for a chest x-ray.

She then contacted the first receptionist and at this point it they realised that the first receptionist had selected the incorrect patient on the system, a patient at a different GP practice, different details but with the same date of birth as the correct patient.

By the time the error was identified the patient had left the department.

We Acted….

The Radiology Clerical Manager called the patient to apologise.

Arrangements were made to complete her x-ray the following day and Radiology arranged a taxi to the hospital; the taxi driver waited outside so that she could be taken straight in for her x-ray and straight home again.

The patient was very grateful and thanked the team for rectifying the error and giving her the ‘VIP’ treatment.

The incident is being shared for learning with the rest of the Radiology team and an exercise for learning and reflection.

A personal training plan has been agreed for the member of staff involved.

The Radiology SOP for patient identification has been revised. The updated version includes very specific information on the safest way to search for a patient on the Radiology Information System using both the most appropriate features of the system and demographic data.

The SOP also includes information on what action to take if the initial search does not identify the patient the user is attempting to locate.

Learning from Incidents – Urgent & Emergency Care

Warrington and Halton Teaching Hospitals NHS Foundation Trust

What staff told us…….	Learning
Patient fell onto her stairs and was brought to the ED by NWAS. On arrival Patient had a NEWS of 6, this was not repeated as per NEWS policy or escalated to the nurse in charge. This led to a delay in the care of the patient.	• Ensure that observations are completed as per Trust NEWS2 policy and senior escalation takes place as detailed in the policy • Triage requires an appropriately trained senior band 5 nurse to take handover from ambulance. • Review of current Trust mitigation to prevent crowding
Patient discharged to wrong care home. Discharge process not followed had a phone call taken place with the care home it would have detected that the care home logged on the system was no longer he place of residence.	• All patients should have printed discharge paperwork with them at discharge. This should also, be sent electronically to the GP. • Referrals to services in the community should be made prior to discharge to prevent re-attendance if the service is unable to meet the patient's requirements.

Learning from Incidents - Surgical Specialities

Warrington and Halton Teaching Hospitals NHS Foundation Trust

What Happened?	Learning action points
62 year old, Reviewed in clinic on May 2019. Referred via optometrist for a left exotropia. Seen by Consultant placed on the list for squint surgery. Stopped twice on Incorrect weekly wait (WW) validated numerous times and not picked up initially. Listed at SCTM when Pre-Op on advised Warrington. 52 week breach stopped clocks validated after month end can affect the submission accuracy - Patient not being tracked.	• Patient was never lost in the system, despite the patient being incorrectly stopped they were also restarted by WL team when the error was spotted, although it was not the correct start date the patient was put back again in the RTT spotlight. • Patient remained visible on the new BIS WL dashboard as the new report contains all patients regardless of RTT Clock status. • Patient had been validated twice and assigned a P-Code P3 on both occasions, regardless of RTT Clock • Patient was on 52 week wait Harm Review Tracker and had been highlighted on the Cancellation report
Noted that a number of patients recorded as twice daily Latanoprost/Timolol instead of once daily in Medisight Issue identified following a patient complaint Change of software defaulted meaning that patients were prescribed double dose - changed once day to twice	• The software issue has been resolved. • The records are all being reviewed to rectify them • Not identified anyone who has come to harm • The potential harm was increased side effects such as red eye. • Plan is to review all the patients who have received a letter or change in prescription to establish who has had a double dose and contact the patients to amend the dose look at reviewing the small cohort of patients to establish if any harm occurred.

Learning from Incidents – Digestive Diseases

Warrington and Halton Teaching Hospitals NHS Foundation Trust

What happened…	Learning action points
A non mobile complex patient had a central dislocation where the hip migrates into the pelvis. The patient was found in a seated position with his knees bent which is against advice for hip precautions to avoid dislocation The patient was on a ward which does not have specific training for complex Orthopaedic procedures to ensure that all the staff are aware of hip precautions	• The patient was extremely high risk of an injury like this, unable to specify where this dislocation may have occurred. Plan to be actioned to ensure correct training given to staff on A5b and that correct equipment is ordered and put in place for use in hip patients
Patient screaming in the bathroom crying and disorientated stating she could hear voices and that they were talking about her. Refused to leave the bathroom and sat on the floor, initially thought patient was having a psychotic episode. Psych liaison rang while patient was still in the bathroom. When patient left the bathroom, staff checked and found 4 IV ampules of cyclizine, 1 in the toilet and 3 in the bin. There was an empty syringe packet in the bin but no syringe.	• Patient admitted bringing the cyclizine vials and equipment from their own workplace. • Incident discussed with employers - potential for a fitness to practice referral. • Safeguarding / Mental health / drug & alcohol abuse referrals completed • No concerns with capacity reassessed and confirmed. • No known history of substance abuse. • A drug audit was completed – no evidence of WHH drugs missing. No discrepancies with controlled drugs stock and records. • Bed moved to a bay further away from the clinical area and the door number to the clinical room changed • MDT review to decide how best to provide support

Learning from Incidents – Children's Health

Warrington and Halton Teaching Hospitals NHS Foundation Trust

What happened…	Learning action points
A blood transfusion prescription incorrectly completed, 1 unit prescribed - should have been 196mls, Transfusion started but cannula tissued at which time the error was noted. No patient ID band in place.	• Learning and feedback shared with junior doctors regarding blood for paediatric blood transfusions requires the correct specific amount to be given.
A Child with previous HDU admissions was noted to be deteriorating, nursing concerns were relayed to medical staff who were unable to review the patient. Advised to commence oral antibiotics without review. Nursing staff reported they felt that IV antibiotics would be more appropriate in view of the patient's condition. Consultant review was completed and the patient was intubated and transferred to Alder Hey Hospital for further care.	• When assessing a child who is suspected of clinical deterioration, assess the whole child, not just the values obtained from a blood gas result. • Support to be offered to nursing staff affected by the incident • A Safety brief to be produced regarding the escalation process • A Safety brief to be produced regarding the holistic review of a suspected deteriorating patient • Create a plan to improve communication strategies between medical and nursing team • Skills drills to be facilitated to support the team to over come human factors issues when dealing with a deteriorating patient or emergency
There are a high number of Covid swabs being refused on the children's ward	• Staff to continue to reiterate to patients/parents the importance of following government local/national guidelines and the need to test patients on day's 1,3&5 then weekly if they remain as an in-patients for their own safety and the safety of other patients/staff.

Learning from Incidents – Women's Health

Warrington and Halton Teaching Hospitals NHS Foundation Trust

What happened…	Learning action points
A patient booked with Warrington Community Midwives but planned on birthing in LWH. The Community Midwives were unable to access the notes or blood results because a new LWH system just introduced store these documents electronically online.	• Feed back was given to the staff to highlight the possible problem and that the issue is currently under review. • The Continuity Community Manager has explained that we only have read access to LWH new system and we would need to provide a set of our notes for care we provide in Community. Discussions currently under review by senior staff.
A lady with a known low lying placenta and a compromised foetus needed an emergency caesarean section. Within a short period of time 2 obstetric consultants, a consultant anaesthetist and 2 anaesthetic registrar, a full neonatal team including the consultant were present. An ODA was called in from home for cell salvage as a precaution. The lady sustained a 3 litre blood loss, was stabilised and transferred to ITU for further support. Once fully recovered the lady was transferred back to the maternity department where she was fully debriefed	• Outstanding care was evident throughout from the antenatal period which was all appropriate to the community team who correctly referred the patient into the hospital for review. • Once the lady presented on the birth suite the decision to perform the caesarean section was risky but correct. • The two consultants were present having remained late in case they were required. • Everything was thoroughly discussed with the patient , her partner and the multidisciplinary team. • The PPH was managed appropriately with the 'All Wales' proforma completed to a high standard. • A full debrief was provided upon the lady's return to the postnatal ward with a Consultant follow up appointment arranged prior to discharge
A baby born in need of respiratory support was transferred to the NNU. Baby had increased oxygen requirements and work of breathing so a decision was made to intubate. There was no evidence that the placenta was sent for histology although this was indicated.	• A reminder was sent via the safety brief to remind staff that placentas must be sent for histology when there has been neonatal resuscitation.

Learning from Medication Incidents

Warrington and Halton Teaching Hospitals NHS Foundation Trust

We found…..	We acted…..
Adult patients were not being accurately weighed on admission and their weight was not being recorded promptly on Lorenzo. If an adult patient is not weighed on admission or an accurate weight is not recorded on Lorenzo, this can lead to the patient receiving a subtherapeutic dose or overdose of a medicine, which can cause harm to the patient.	• A Safety Alert was taken to the Trust-wide Safety Brief with recommendations for: o Nursing staff – To accurately weigh adult patients on admission and record their weight promptly on Lorenzo o Prescribers - When prescribing medication where the dose is weight dependant, confirm the patient's weight on Lorenzo and the date it was recorded. If a patient has not been weighed this admission/recently weighed, this must be raised with the patient's nurse so an accurate weight can be obtained. o Housekeepers – To ensure weighing equipment is maintained and stored correctly and if weighing equipment is not working, to report it straightaway to facilitate timely repair. • A Single point lesson 'How to accurately record and update an adults weight on Lorenzo' to be taken to the Trust-wide Safety Brief and to be shared with appropriate staff in wards/clinical areas.
A patient was admitted on Lantus Solostar 100 units/ml prefilled pen and was incorrectly prescribed Insulin glargine Lantus 100units/ml cartridge which was the wrong device. A Toujeo Solostar 300units/ml prefilled pen, was taken from ward stock, and used to administer the evening dose of insulin. The patient was therefore administered the wrong brand and strength of insulin.	• A Safety Alert was taken to the Trust-wide Safety Brief stating the importance of following the 6 Rights of insulin to prescribe/administer insulin safely: o Right Person - Check prescription with patient, carer or relative. o Right Insulin - Prescribe by BRAND name, beware of sound-alike insulins, think about the regime – does it make sense? o Right time - Insulin is a time-critical drug. Ensure it is prescribed at correct times e.g. rapid acting insulins with meals. o Right dose - Confirm dose with patient, carer or relative. o Right strength - Some insulins are now available in double & triple strength. o Right device – Include the name of device.

Learning from Incidents – Pressure Ulcers

Warrington and Halton Teaching Hospitals NHS Foundation Trust

- Following an increase in pressure ulcers related to anti-thromboembolic stockings, and an evaluation of an alternative stocking, wards are now able to order the new stocking and the old stock will be replaced.
- Accurate documentation on care and comfort charts to be reinforced including prescribed care. Ward Managers and Matrons auditing documentation.
- Following incidents of pressure ulcers secondary to orthotic devices an orthotic appliance observation chart has been evaluated on ward A6. This is now to be implemented Trust wide.
- Incident of pressure ulcer secondary to NIV mask. Alternative masks are being sourced to enable switching between masks and reducing prolonged pressure over same areas.
- Robust action plans for the high incidence areas have been produced and are reviewed weekly by Lead Nurse/Matron, Deputy Chief Nurse and Tissue Viability Nurse.
- Nurses and HCA's from high incidence wards are shadowing the TVN's to gain knowledge in pressure ulcer prevention.
- ED are represented at the pressure RCA meetings and lessons learnt are fed back to the ED team. A Tissue Viability newsletter has also been produced by the TV link nurse and is circulated to the ED team.
- Due to a delay in risk assessment completion non-patient facing staff are checking risk assessments daily and informing the ward team.

Learning from Incidents – Information Governance

Warrington and Halton Teaching Hospitals NHS Foundation Trust

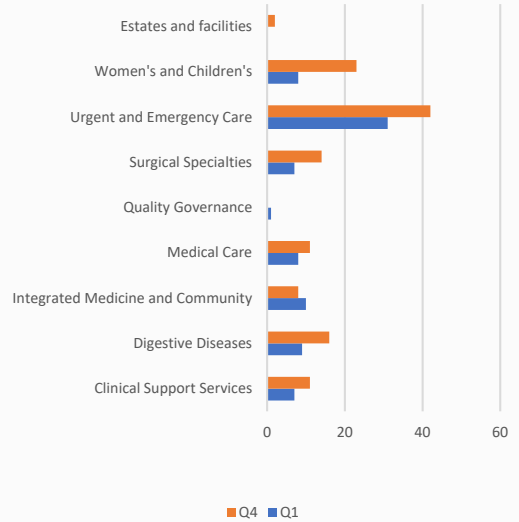
We Found	We Acted….
Examples of insecure transmission of person identifiable information from the Trust via unencrypted email to insecure email domains. This type of email transmission represents a data loss risk. Email sent from health and social care organisations must meet the secure email standard (DCB1596) in order to maintain the security of confidential information.	• We provided areas where insecure email transmission had been identified as an issue with a list of secure email domains. Such email domains are used across the public sector to ensure secure email transmissions. • Staff awareness has been increased as a result and information relating to secure email transmission of person identifiable information is included in data security and protection training products.
A staff member had returned from Maternity leave to discover that their email account had been deleted. This was due to inactivity settings having been affected by NHS Digital work performed to migrate NHS mail to exchange online and a resulting change to the retention policies for inactive email accounts.	• The Digital Services team contacted NHS Digital to ascertain why the account had been deleted. Due to NHS Digital NHS mail migration, and associated retention changes, inactive email accounts had been deleted. • The Digital Services team made local changes so that accounts for staff on extended sick or maternity leave would be placed in a disabled state. This will prevent further deletion of email accounts for such staff members.

Complaints Headlines Q4 vs Q1

Warrington and Halton Teaching Hospitals NHS Foundation Trust

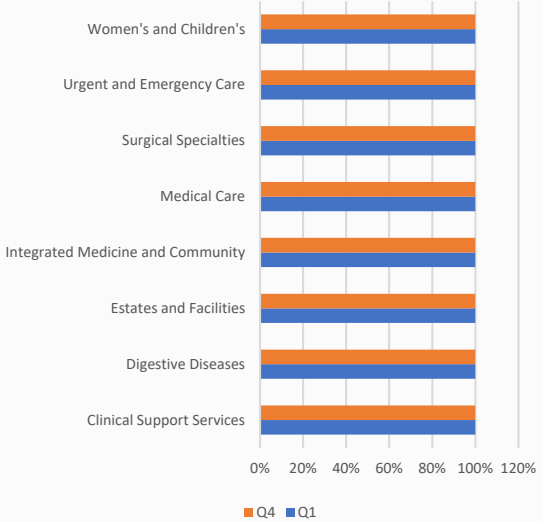
How many people are raising complaints Q4 vs Q1?

- There was a 36% decrease in complaints opened Trustwide in Q4 (127 in Q4 versus 81 in Q4).
- Women's and Children's, Urgent and Emergency Care, Medical Care, Estates and Facilities, Surgical Specialties, Clinical Support Services and Digestive Diseases saw an increase in the complaints received.
- Integrated Medicine and Community saw an increase in their complaints.



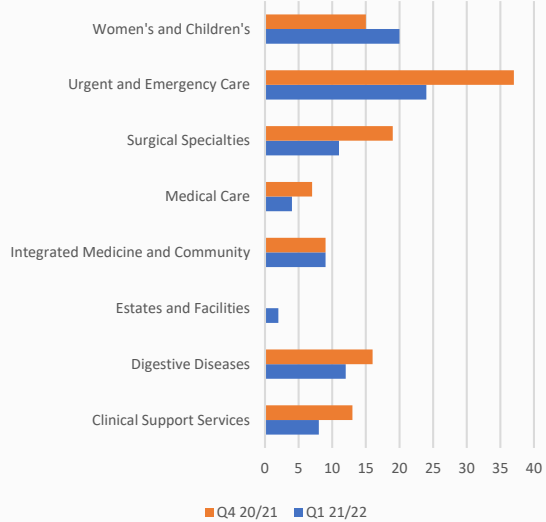
Are we Responsive Q1 vs Q4?

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



How many complaints has the Trust closed Q3 vs Q4?

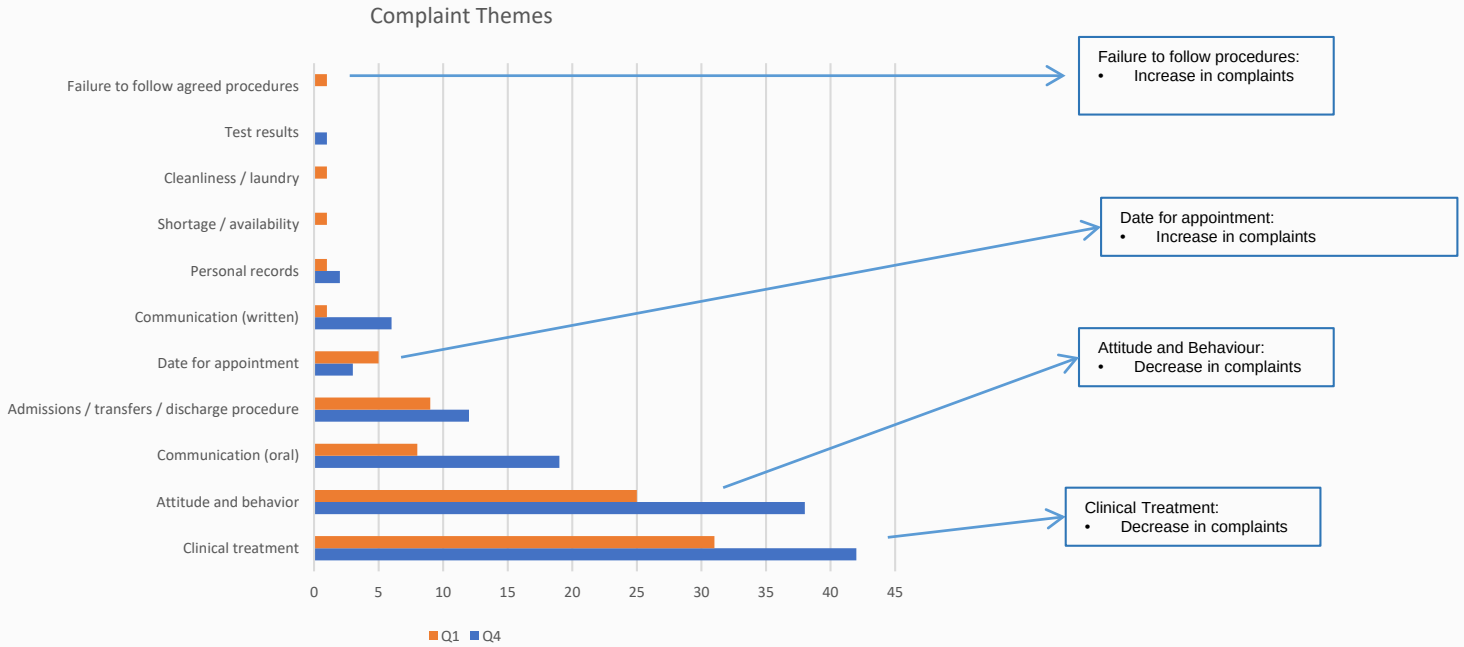
- There was a decrease in the number of complaints closed in the Trust in Q1 (122 in Q4 versus 90 in Q1).
- Women's and Children's and Estates and Facilities have increased the number of complaints closed in Q1.
- All other specialities have decreased the number of complaints closed in Q1.
- Urgent and Emergency Care has seen the highest decrease.



Complaints Analysis Q4 vs Q1

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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



Failure to follow procedures:
- Increase in complaints

Date for appointment:
- Increase in complaints

Attitude and Behaviour:
- Decrease in complaints

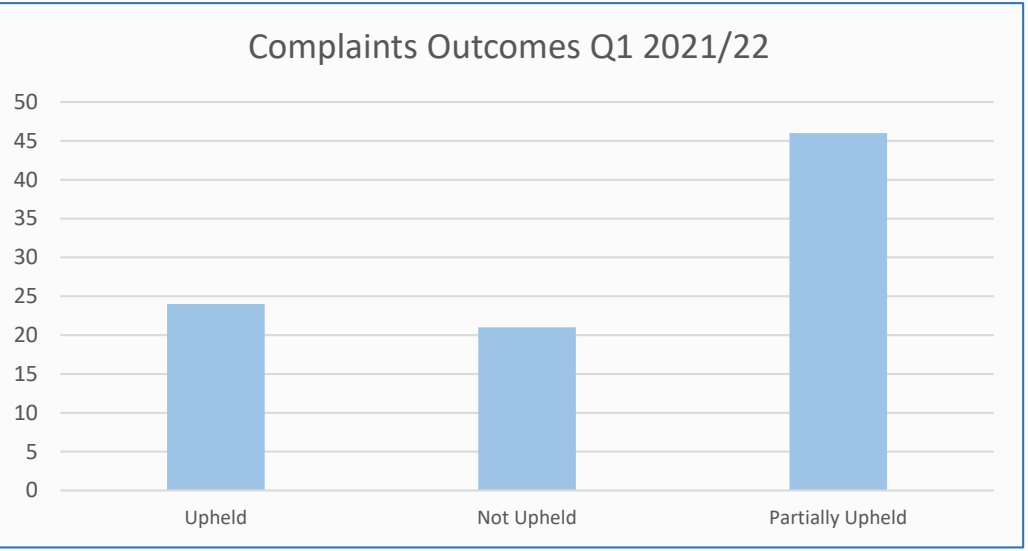
Clinical Treatment:
- Decrease in complaints

Complaints Outcomes Q1

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Once a complaint has concluded (either following a local resolution meeting or once a formal written response has been sent) the outcome will be recorded in line with the findings of the investigation.

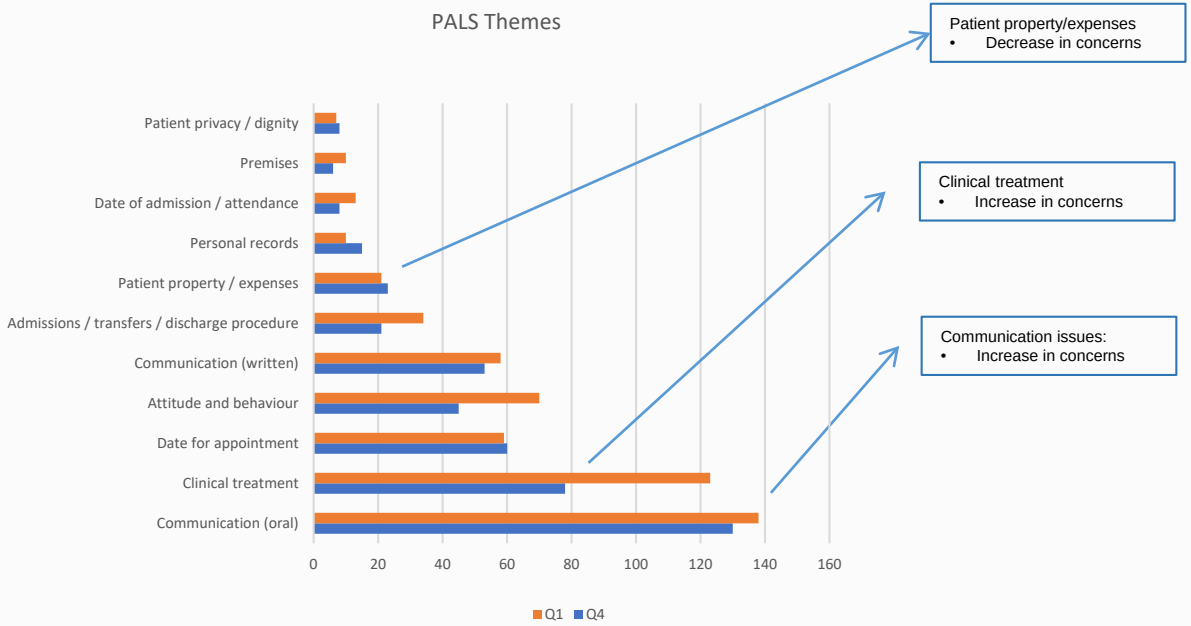
A complaint will be “upheld”, “upheld in part” or “not upheld”.



PALS Analysis Q4 vs Q1

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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



Patient property/expenses
- Decrease in concerns

Clinical treatment
- Increase in concerns

Communication issues:
- Increase in concerns

PALS to Complaints:

Q4	Q1
13	6

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

Q4	Q1
4 days	3 days

Learning from Complaints

Warrington and Halton Teaching Hospitals NHS Foundation Trust

You Said….	We Did….
A patient was concerned that her daughter's condition was not identified when she had her newborn infant physical examination completed.	We reminded all junior doctors of the importance of discussing any abnormalities, no matter how subtle, with senior colleagues.
A parent expressed concerns that her child received an incorrect dose of medication.	We recognised that staff had not correctly followed the procedure. We reminded all staff of the importance of following the Trust's checking process prior to administration of medication.
A family member complained that the ward team did not take into account weekend working arrangements within the hospital when planning the patient's discharge.	We revised the discharge process on the Ward to ensure that where a weekend discharge was planned for a patient, all assessments are completed by 16:30 on a Friday.

Complaints Headlines

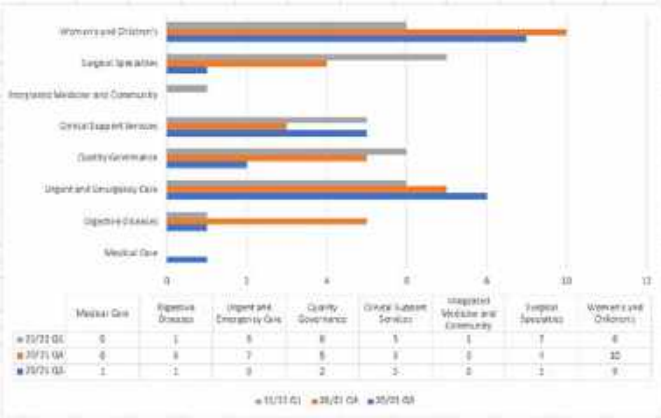
- During Q1 2021/22 81 complaints were received. There was a decrease of 36% in complaints received compared to Q4 (127). Due to the national pause in complaints during Q1 2020/21, the Trust has benchmarked this data against Q1 2019/20 and can confirm the decrease in activity reflects our usual complaints activity.
- In Q1, the number of complaints relating to attitude and behaviour have decreased compared to Q4.
- There has also been a decrease in the number of complaints regarding clinical treatment in Q1 compared to Q4.
- 560 PALS concerns were received during Q1 2021/22, which is an increase of 22.4% compared to Q4.
- There has been an increase in the number of PALS concerns received for communication and there has been a decrease in the number of PALS concerns received regarding patient's property.
- The Trust received 7 dissatisfied complaints in Q1 2021/22; which was the same at Q4 2020/21.
- In Q1, 7 complaints were closed and deemed to require a concise or SI investigation.

Analysis of Claims Received Q1 2021/22

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Clinical Claims Received 2021/22

Q3 20/21: 27 Received
Q4 20/21: 34 Received
Q1 21/22: 32 Received



232 Claims received via:

• Litigant in Person	2
• Letter of Claim	1
• Notice of Funding	1
• Proceedings	1
• Request for extension to limitation	2
• Request for notes	25

There has been 460 request for notes via Medico-Legal Services (398 previous quarter)

Non-Clinical Claims Received Q1 2021/22

There were 3 Non-Clinical Claims received this quarter:
Q2: 5
Q3: 6
Q4: 3
Q1: 3

Integrated Medicine and Community	1
Accident	1
Urgent and Emergency Care	1
Assault	1
Clinical Support Services	1
Failure to supervise	1

Analysis of Claims Closed 2021/22 Q1

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Clinical Claims Closed Q1 2021/22

11 Claims closed with damages (totalling £2,367,064.00) (excluding costs))

Clinical Business Unit	Repudiated	Settled with damages	Withdrawn	Grand Total
Clinical Support Services	0	1	0	1
Digestive Diseases	2	2	3	7
Medical Care	0	2	0	2
Unknown	0	0	1	1
Surgical Specialities	3	2	7	12
Urgent and Emergency Care	0	3	1	4
Women's and Children's	2	1	5	8
Grand Total	**7**	**11**	**17**	**35**

Non-Clinical Claims Closed Q4 2020/21

1 employer Liability Claims closed with damages (totalling £3250.00 (excluding costs))

Specialty	Details
Domestics/Portering	Hit by object

1 Public Liability Claims – successfully repudiated

Specialty	Details
Estates	Fall

Headlines of Learning from Deaths

- Deaths are being reviewed and discussed at the group which continues to have external representation from our Commissioning bodies.
- SHMI and HSMR, are within the expected range at present.
- There is a key focus on reviewing Covid-19 deaths.
- MRG 'Case of the Month' is actively disseminated to ensure learning is filtered across the Trust.
- A lesson learning bulletin has been developed and will be shared across all CBU governance meetings to highlight the learning.
- The Medical Examiners actively feed any themes and learning into MRG.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/21/09/142**	
SUBJECT:	**Mortality Report Q1**	
DATE OF MEETING:	27.09.2021	
AUTHOR(S):	Layla Alani, Deputy Director Governance Eshita Hassan Associate Medical Director, Patient Safety	
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.	x
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): **(*Please DELETE as appropriate)***	**#224** Failure to meet the emergency access standard, caused by system demands and pressures. Resulting in potential risks to the quality of care and patient safety, staff health and wellbeing, Trust reputation, financial impact and below expected Patient experience. **#1215** Failure to deliver the capacity required caused by the ongoing COVID-19 pandemic and potential environmental constraints resulting in delayed appointments, treatments and potential harm **#1273** Failure to provide timely patient discharge caused by system-wide Covid-19 pressures, resulting in potential reduced capacity to admit patients safely. **#1272** Failure to provide a sufficient number of beds caused by the requirement to adhere to social distancing guidelines mandated by NHSE/I ensuring that beds are 2 metres apart, resulting in reduced capacity to admit patients and a potential subsequent major incident. **#1275** Failure to prevent Nosocomial Infection caused by asymptomatic patient and staff transmission or failure to adhere to social distancing guidelines resulting in hospital outbreaks **#1289** Failure to deliver planned elective procedures caused by the Trust not having sufficient capacity (Theatres, Outpatients, Diagnostics) resulting in potential delays to treatment and possible subsequent risk of clinical harm. **#115** Failure to provide adequate staffing levels in some specialities and wards. Caused by inability to fill vacancies, sickness. Resulting in pressure on ward staff, potential impact on patient care and impact on Trust access and financial targets. **#1134** Failure to provide adequate staffing caused by absence relating to COVID-19 resulting in resource challenges and an	

	increase within the temporary staffing domain **#1233** Failure to review surgical patients in a timely manner and provide a suitable environment for surgical patients to be assessed caused by CAU being bedded and overcrowding in ED resulting in poor patient experience, delays in treating patients and increased admission to the surgical bed base. **#1108** Failure to maintain staffing levels, caused by high sickness and absence, including those affected by COVID-19, those who are extremely vulnerable, those who are assessed as only able to work on a green pathway, resulting in inability to fill midwifery shifts. This also currently affects the CBU management team. **#1274** Failure to provide safe staffing levels caused by the mandated Covid-19 staff testing requirement, potentially resulting in Covid-19 related staff sickness/ self-isolation and the requirement to support internal testing; potentially resulting in unsafe staffing levels impacting upon patient safety and a potential subsequent major incident. **#1331** Failure to provide adequate bed capacity to care for level 1, 2 & 3 patients caused by the significant increase in attendances, including COVID-19 positive patients, resulting in potential harm.
EXECUTIVE SUMMARY ***(KEY ISSUES):***	This paper represents the scheduled 'Learning from Deaths' report in compliance with National Guidance requirements. The Q1 report for 2021/2022 provides a report for noting and scrutiny in line with the National Guidance on Learning from Deaths and details learning following reviews. **Key points to note are:** • During Q1 2021/22, 240 deaths occurred within the Trust. • Of these, 44 met the criteria to be subject to a Structured Judgement Review (SJR). • SJRs have been completed on 25 of the 44. • 60 SJRs have been completed in total during Q1. This includes SJRs on deaths from the previous quarter. • 0 were escalated to a Serious Incident investigation following an SJR. • HSMR (Hospital Standardised Mortality Ratio) based on 12 months data up to and including March 2021 is 90.90. This result is not an outlier. • HES SHMI (Summary Hospital-level Mortality Indicator

	based on Hospital Episode Statistics) for the 12-month period up to and including February 2021 is 105.52. This result is not an outlier. • Attached as appendices are the MRG themes of the month for learning. **(Appendix A)**			
PURPOSE: ***(please select as appropriate)***	Information	Approval	To note x	Decision
RECOMMENDATION:	The Board of Directors is asked to receive and note the report.			
PREVIOUSLY CONSIDERED BY:	**Committee**	Quality Assurance Committee		
	Agenda Ref.	QAC/21/08/189		
	Date of meeting	3 August 2021		
	Summary of Outcome	The Quality Assurance Committtee noted the report.		
FREEDOM OF INFORMATION STATUS (FOIA):	Partial FOIA Exempt			
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	Section 41 – confidentiality			

REPORT TO BOARD OF DIRECTORS

SUBJECT	Mortality Report Q1	AGENDA REF:	BM/21/09/142

1. BACKGROUND

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

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

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

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

2. KEY ELEMENTS

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

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

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

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

3. MEASUREMENT AND EVALUATION

3.1 Total number of deaths and investigation levels.

Month	Number of Deaths	Number of deaths which met SI (Serious Incident) criteria
April 2021	75	0
May 2021	86	2
June 2021	79	0

The 2 identified as Serious Incidents in May were not subject to an SJR as a comprehensive investigation is being undertaken and the learning will be identified through this and reported in the next quarter.

3.2 Criteria for SJR identified in the Trust's Learning from Deaths policy:

- 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.
- Death of a patient with mental health needs (this covers Inpatients who are detained under the Mental Health Act).
- 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
- Any concern that a member of staff may have in relation to a patient
- At the request of the Medical Director or Chief Nurse.

If a Concise or Comprehensive Serious Incident investigation is being undertaken on a death that is eligible for SJR, then SJR will not be undertaken as learning will be identified by the SI investigation process.

3.3 SJR reviewed

During Quarter 1 21-22, 60 Structured Judgement Reviews were completed by members of the MRG. This included 35 SJRs from deaths in the previous quarter and 25 SJRs from Q1 21-22.

(Table 1 below denotes the number of SJR completed)

	Overall Assessment Care Rating Following SJR					Total
	1: Very Poor	2: Poor	3: Adequate	4: Good	5: Excellent	
Q1	**0**	**3 (-3)** **2 were presented at May MRG and changed to adequate** **1 was presented at July MRG- changed to adequate**	16 (+3)	40	1	60

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

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

Cases rated as *4:* ***Good*** and *5:* ***Excellent*** are disseminated for learning through the Mortality & Morbidity Meetings.

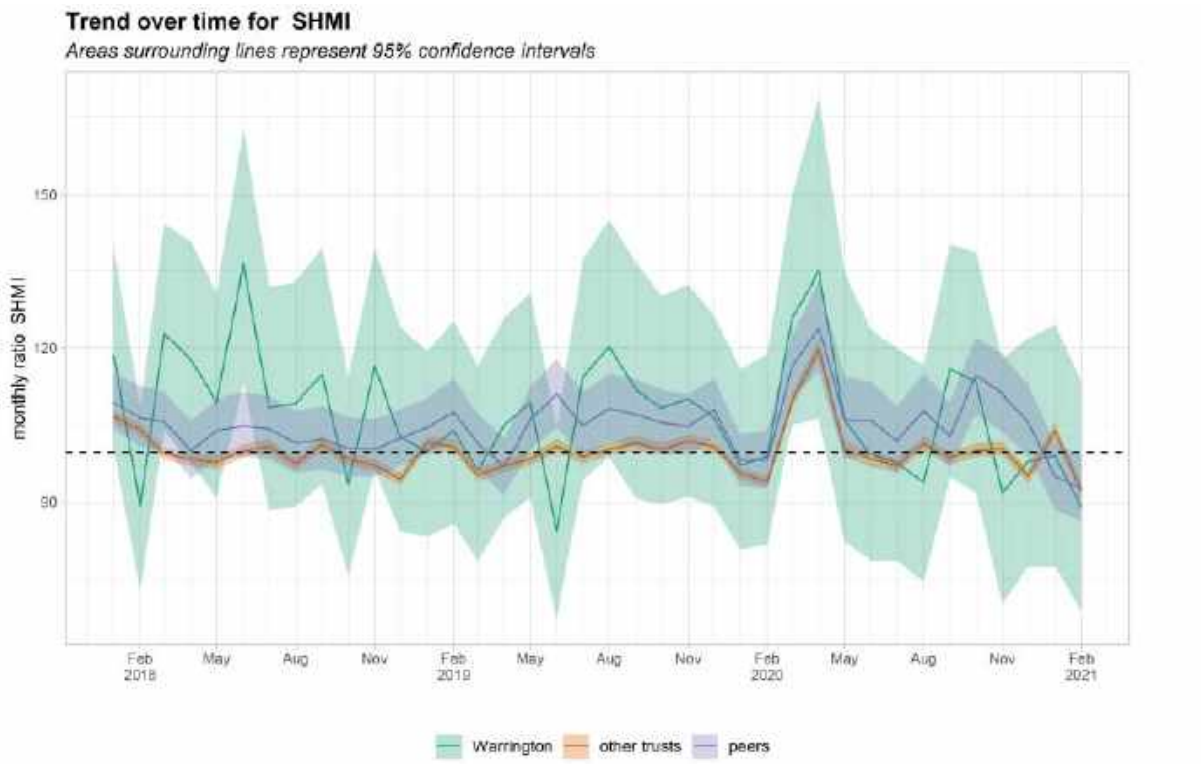
3.4 Snapshot of learning identified in MRG:

- Timely engagement with the palliative care team and improving the quality of End of Life (EOL) care was identified as a learning theme from several of the SJRs reviewed. The Trust Lead consultant for Palliative Care has been provided with the learning from the SJRs to incorporate in the improvement workstream related to improving EOL care. Learning related to this was also disseminated as a MRG Theme of the Month bulletin to the Speciality Governance meetings (see appendix A).
- Learning related to management of a case of nosocomial COVID infection was disseminated as a MRG theme of the month bulletin (Appendix A).
- Incidental learning was identified with regards to weight-based dosing of thromboprophylaxis in a patient whose overall care assessment on SJR was good and whose death was unrelated to suboptimal dosing of thromboprophylaxis in a previous recent admission. Weight-based dosing of thromboprophylaxis is a focus of the HAT (Hospital Acquired Thrombosis) improvement workstream led by the Thrombosis Group and this learning was triangulated to Thrombosis Group to incorporate.

4. TRAJECTORIES/ OBJECTIVES AGREED

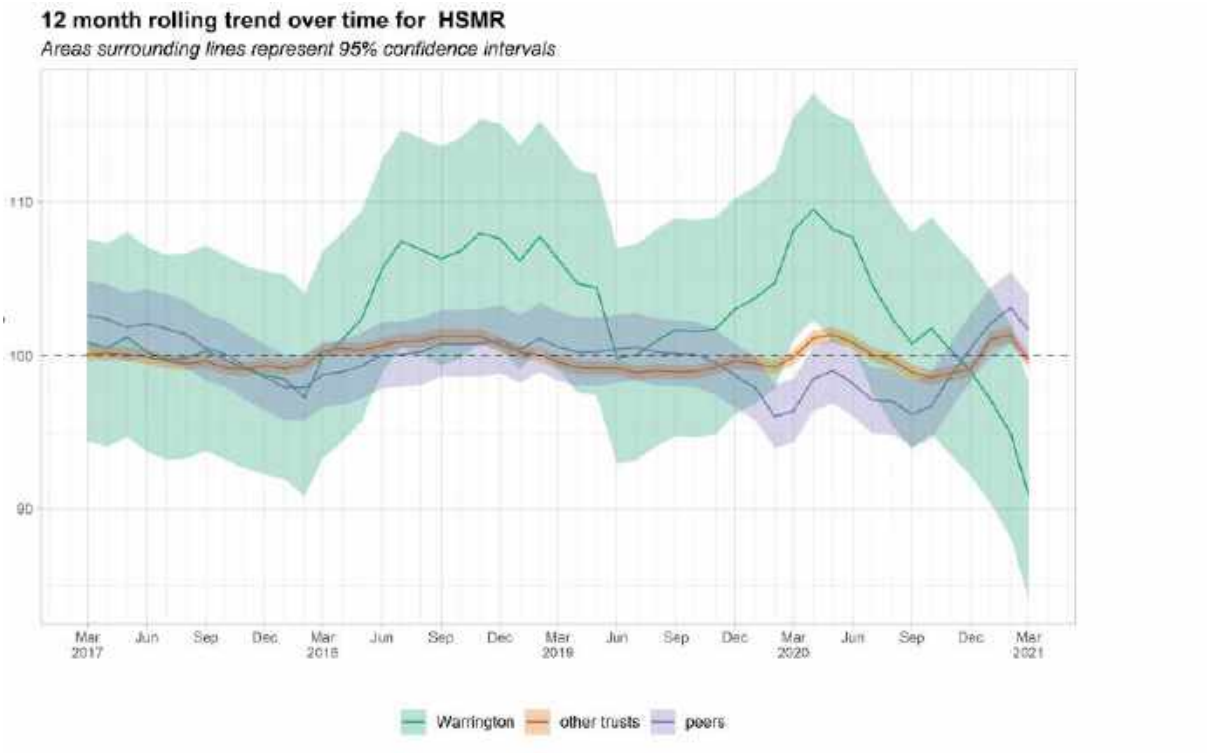
SHMI (Summary Hospital-level Mortality Indicator)
All observed deaths in hospital and within 30 days of discharge. Adjustments are made only for age, admission method, comorbidities. Still births, specialist community, mental health and independent sector hospitals, day cases, regular day and night attenders are excluded.

- SHMI for the 12-month period up to and including February 2021 is 105.52. This result is not an outlier. **(graph 1 below denotes the rolling trend over 12 months compared to peers – NB HED data source is 3 months in lew)**



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

- HSMR based on 12 months data up to and including March 2021 is 90.90. This result is not an outlier. **(graph 2 below denotes the rolling trend over 12 months compared to peers – NB HED data source is 3 months in lew)**



The latest HED report was reviewed at MRG and the key diagnosis groups showing as outliers for HSMR and SHMI were discussed.

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

These alerts will be investigated by undertaking the following:

- Extracting the patient-level data
- Coding review
- Case reviews to assess quality of care

Progress with findings will be reviewed by MRG and presented in the Mortality Report to QAC in the next quarter.

The **CQC Insight Report** has identified UTI in-hospital mortality and fracture neck of femur in-hospital mortality for Oct ’19 – Sep ’20 as worse than national average and declining as compared to Oct ’18 – Sep ’19.
An action plan to improve fracture neck of femur in-hospital mortality has been developed by the Hip Fracture Focus Group and is being monitored by Patient Safety and Clinical Effectiveness Sub-Committee.

Coding review:
The latest HED report provides an overview of coding nationally and at WHH. All trusts have seen higher average recorded levels of comorbidities during the COVID-19 pandemic. WHH consistently has a higher recorded depth of coding than its peers and the average for other trusts.

Levels of recorded signs and symptoms as primary diagnosis for Warrington are on a par with the average for the peer group and other trusts. However, they have been lower at Warrington than elsewhere since July 2020. This reflects results of a quality improvement project that was undertaken to address this.

Average recorded comorbidity levels (looking at the 2nd to the 20th diagnoses for each episode) have historically been lower for Warrington than elsewhere on average. However, since the pandemic averages have risen to a greater extent than seen on average for the peer group and other trusts.

Recorded palliative care levels for Warrington were slightly lower than for other trusts, but since the pandemic they have risen and are now higher than seen elsewhere on average.

Recorded supportive care levels are consistently lower for Warrington than elsewhere, and the pandemic has not changed this.

Key comorbidities seen at Warrington are very similar to that seen at the peer group on average and other trusts. Slight differences are: cancer is key for other trusts but not Warrington; diabetes is key for the peer group but not Warrington; Cerebral Vascular Accident comorbidity is key for Warrington but not the peer group or other trusts on average.

Percentage of episodes with a recorded primary diagnosis of confirmed COVID19 at Warrington are on a par with that seen elsewhere; however, since October this % has been consistently higher.

5. MONITORING/REPORTING ROUTES

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

6. TIMELINES

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

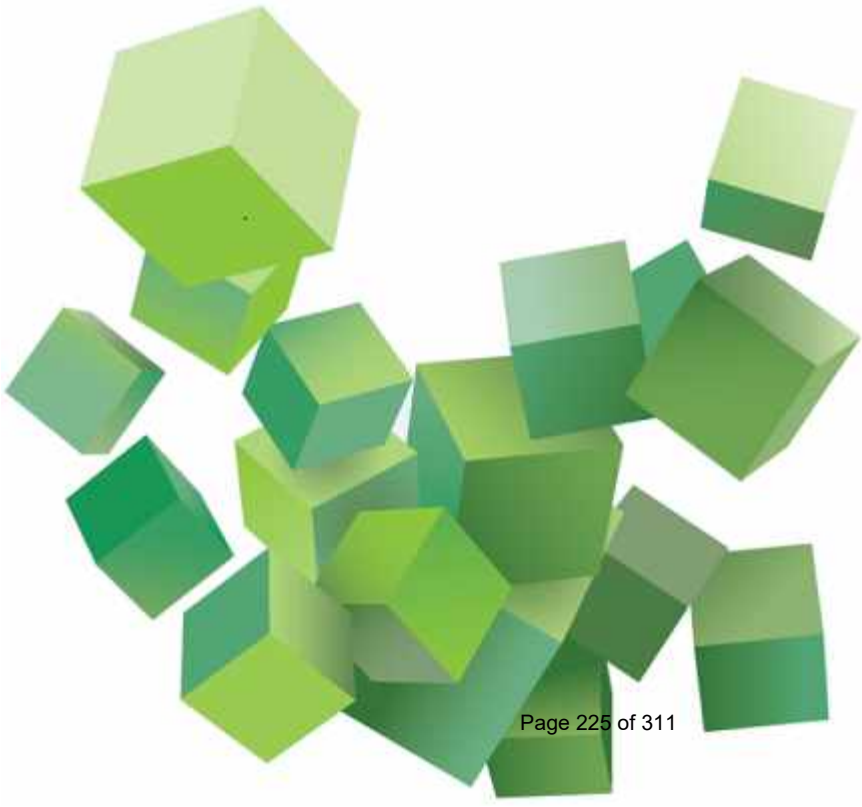
7. RECOMMENDATIONS

The Board of Directors is asked to receive and note the report.

Warrington and Halton Teaching Hospitals NHS Foundation Trust Mortality Report Including data up to 31-Mar-2021

Data Source: Hospital Episode Statistics (HES) and HES-ONS Linked Mortality Dataset © NHS Digital - 2021. Reused with permission of NHS Digital. All rights reserved.

report run 2021-06-29



Contents

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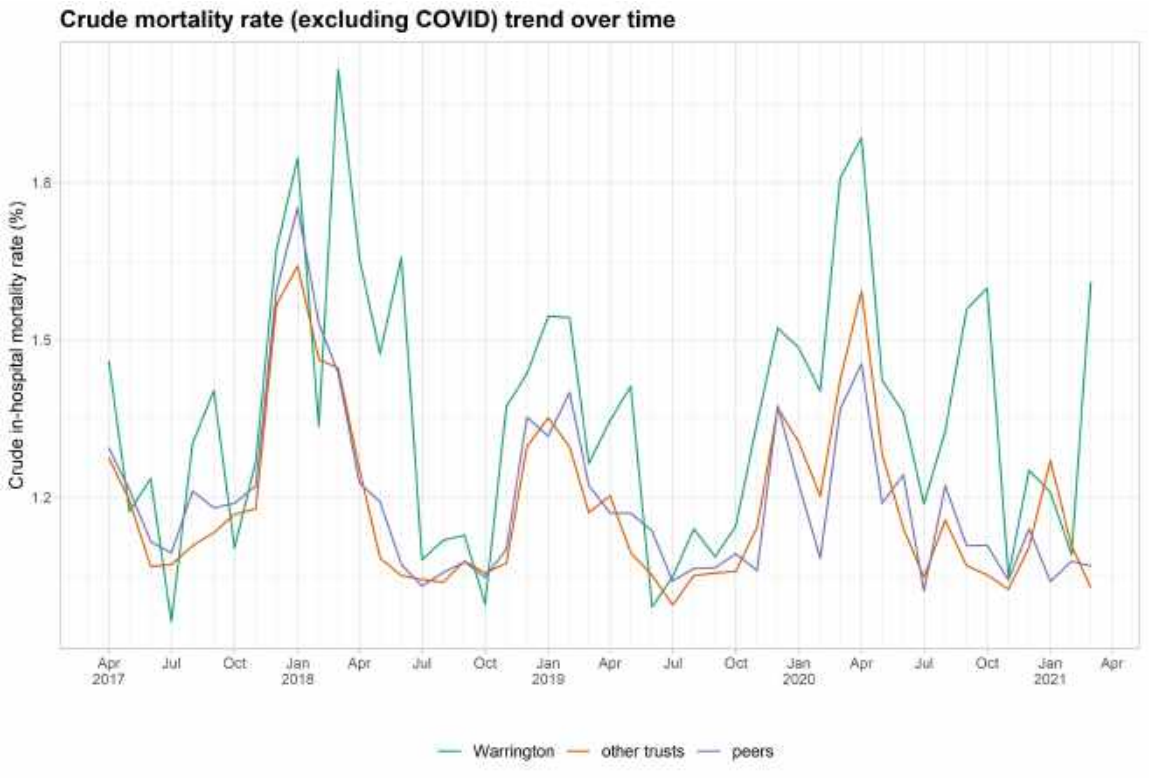
1 High Level Summary

- NHSD latest publicly reported SHMI for Warrington is 104.07 . This relates to 12 months data up to and including January 2021. This result is in band 2 which means this result is as expected.
- HES SHMI (which is based on 12 months data up to and including February 2021) is 105.52 . This result is not an outlier using an over-dispersed funnel plot and is not an outlier based on the stricter Poisson method.
    - In-hospital SHMI for the latest 12 months is 101.14.
    - Out-of-hospital SHMI for the latest 12 months is 113.66.
    - SHMI allowing for palliative care for the latest 12 months is 93.25 (this measure is created using a separate model built by HED which has the same deinition as SHMI except it additionally takes palliative coding into account and risk adjusts for this.)
    - Standard SHMI calculations allow for out-of-hospital and in-hospital deaths but do not take recorded palliative care into account. HSMR takes recorded palliative care into account but only looks at in hospital deaths.
- Standard 56 CCS group HSMR (which is based on 12 months data up to and including March 2021) is 90.90. This result is not an outlier based on the Poisson method.

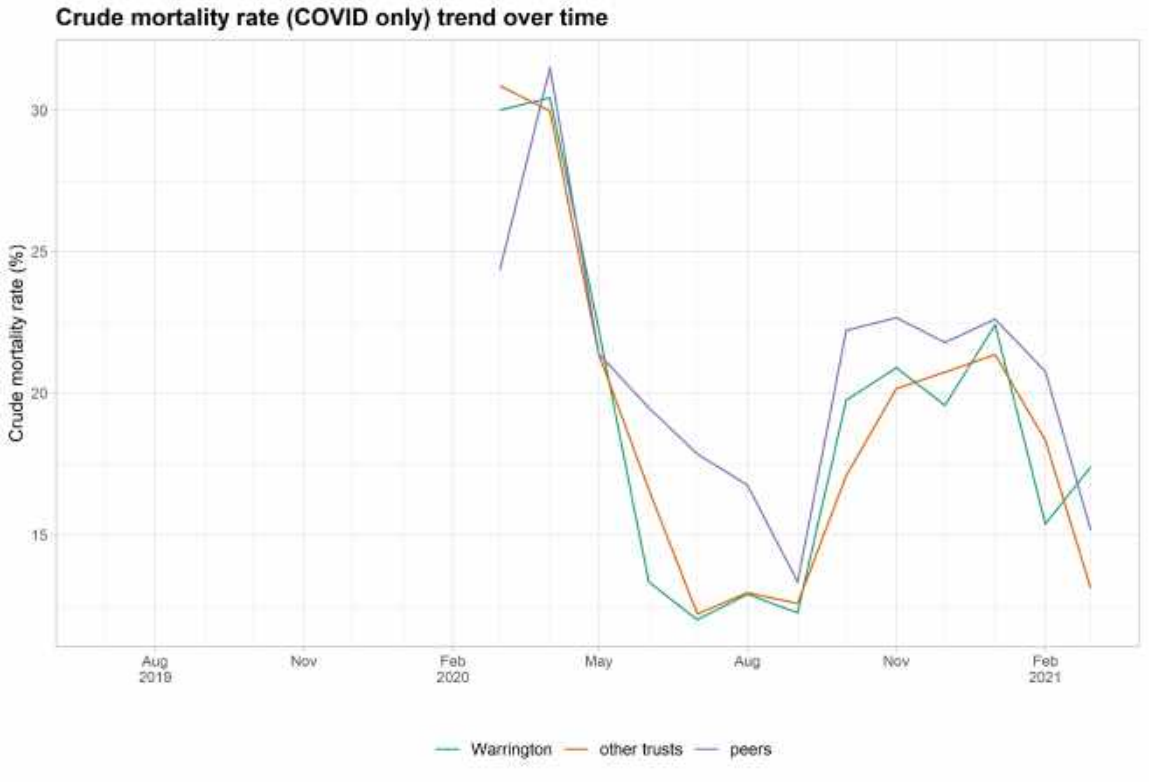
2 Crude in-hospital mortality trends

Crude Mortality rates can be a simple way to track basic trends in mortality. As they do not take case-mix into account, it should be viewed with caution. Please note the following graph excludes recorded COVID-related activity which is separately analysed for greater clarity.



Crude mortality was quite high in March 2021 for Warrington despite this graph excluding patients with a recorded COVID diagnosis. 60/78 deaths in February were assigned to the primary diagnosis 'R69X - Unknown and unspecified causes of morbidity'. These may include some COVID cases when coding is finalised and they will therefore at that point drop from this graph. Last month's high numbers for February have now reached more normal levels due to resolution of the same problem with that month's data.

3 COVID



Crude mortality for cases with a recorded diagnosis of COVID for Warrington is in line with that for other trusts.

4 Key diagnosis groups with higher mortality than predicted

4.1 Key SHMI diagnosis groups

There are 142 SHMI diagnosis groups used within the SHMI definition, some of which are single CCS groups and others are aggregates of CCS groups. For more details please refer to the official SHMI definition (https://digital.nhs.uk/data-and-information/national-indicator-library/summary-hospital-level-mortality-indicator) .

The table below shows the SHMI diagnosis groups which fall outside a 95% poisson funnel plot using the last 12 months data.

SHMI - key diagnosis groups excluding small numbers

CATNO	SHMI diagnosis group	Observed deaths	Expected deaths	SHMI
36	36 :: Other endocrine disorders, Thyroid disorders	12	4.76	252.06
39	39 :: Acute posthemorrhagic anemia, Deficiency and other anemia	18	11.17	161.15
63	63 :: Cardiac dysrhythmias	12	6.51	184.39
138	138 :: Abdominal pain	5	1.68	297.07

4.2 Key (Standard 56 CCS) HSMR groups

The table below shows the HSMR CCS groups which fall outside a 95% Poisson funnel plot using the last 12 months data.

HSMR - key CCS groups

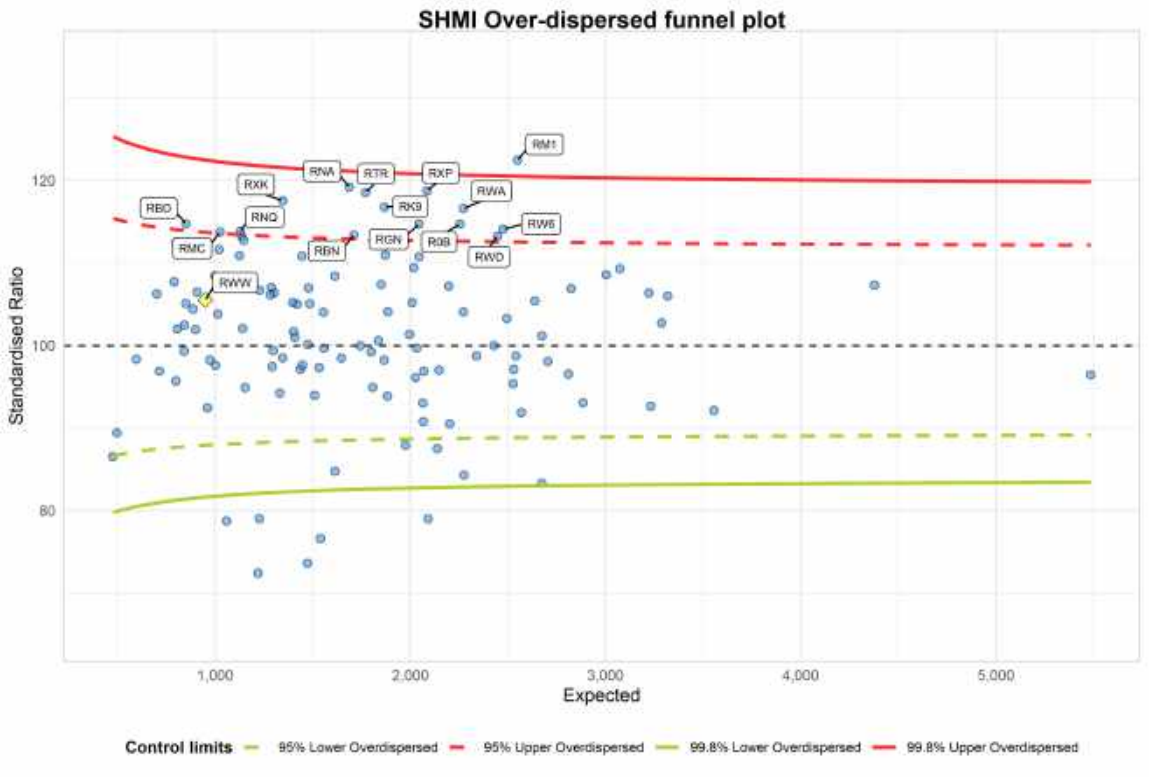
CCS	CCS group	Observed deaths	Expected deaths	HSMR
101	Coronary atherosclerosis and other heart disease	9	4.11	218.93
224	Other perinatal conditions	15	8.77	171.08

36 :: Other endocrine disorders, Thyroid disorders will be our case study this month.

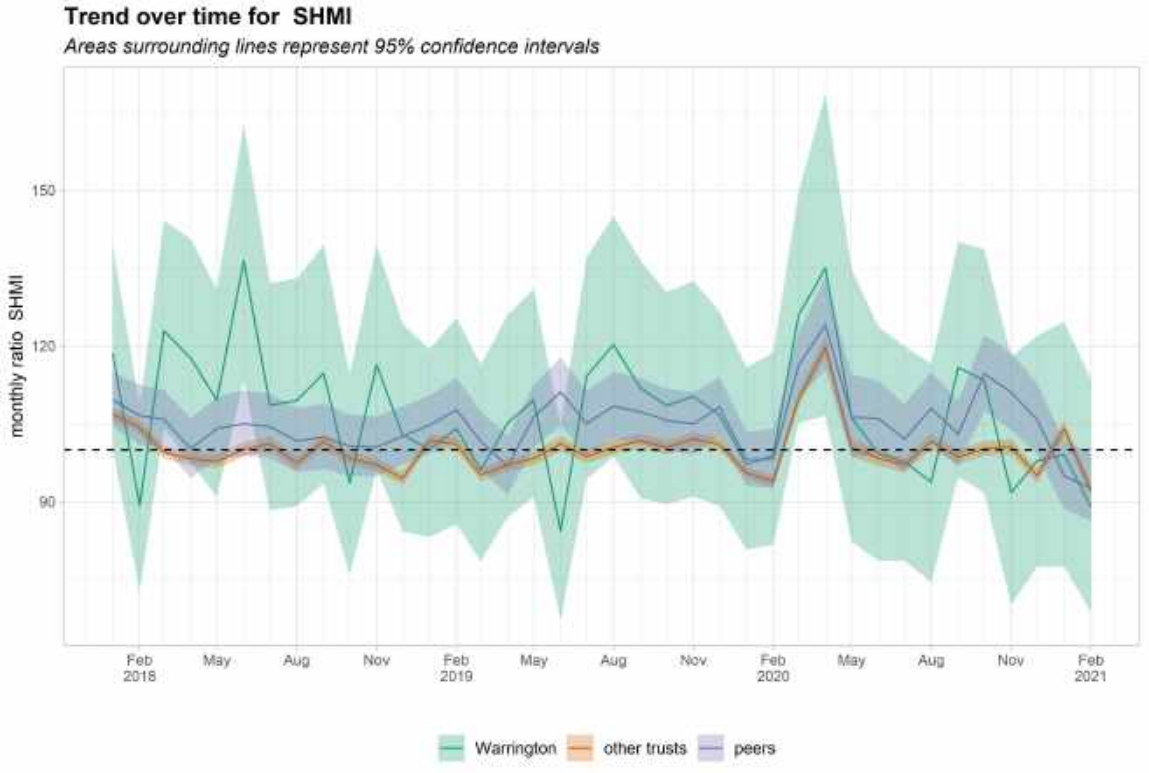
5 SHMI Review

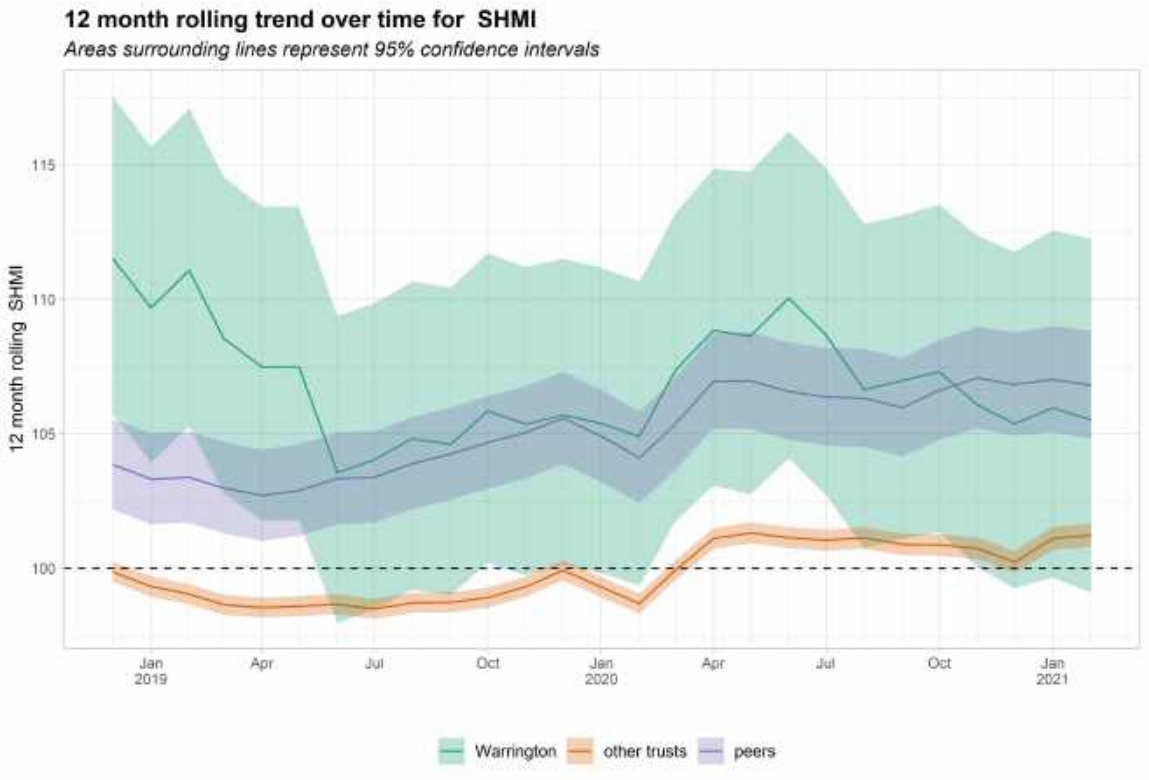
5.1 Funnel Plot

The trust is given a green rating for this indicator with a SHMI of 105.52 based on over-dispersed funnel plot limits.

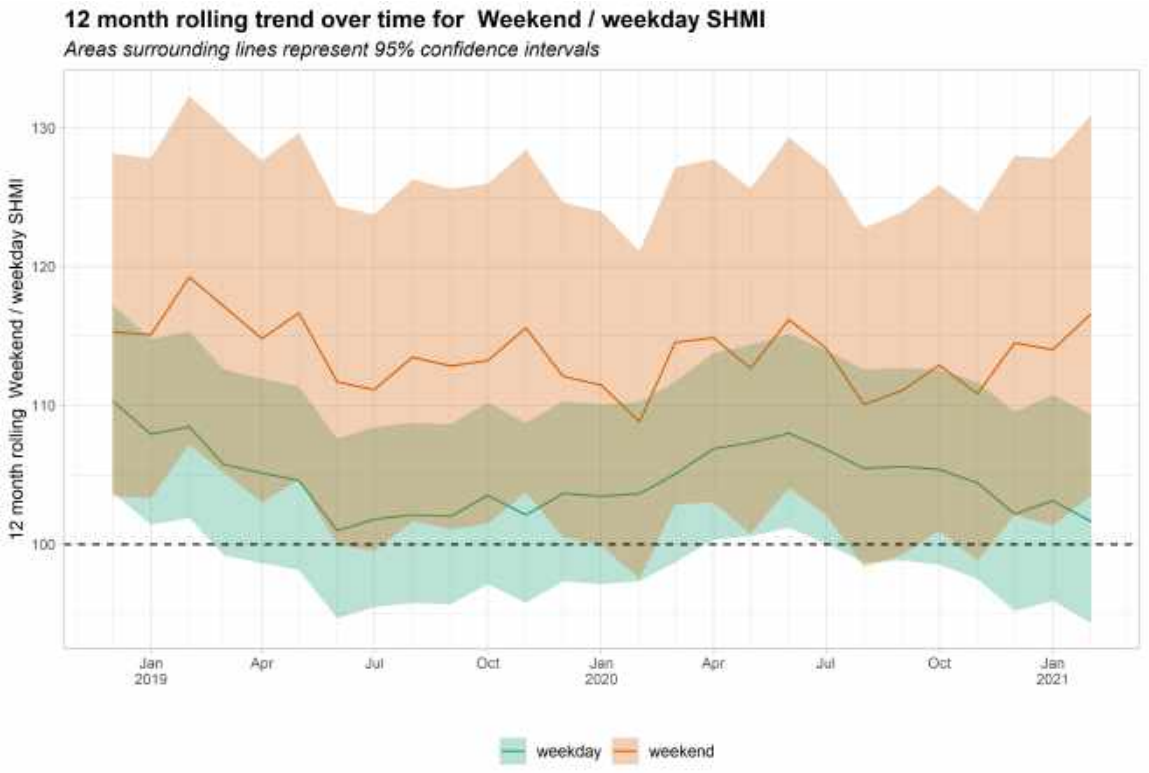


5.2 Supporting information

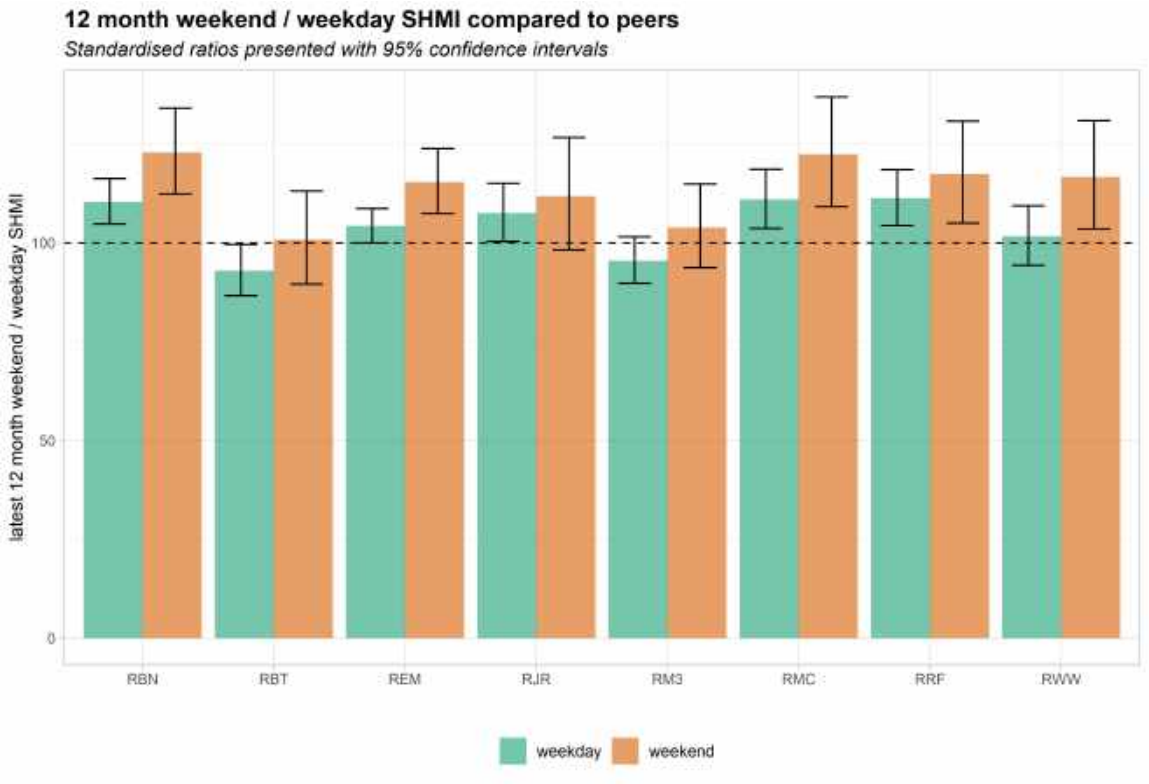




SHMI (which excludes recorded COVID) is slightly lower than the peer group although higher than the picture for other acute trusts.



Weekend SHMI is still consistently higher than weekday SHMI.There is improvement in weekday SHMI which is not evident in weekend SHMI.



- Weekend SHMI for the most recent 12 month period is statistically significantly high for :
    - RBN - ST HELENS AND KNOWSLEY TEACHING HOSPITALS NHS TRUST
    - REM - LIVERPOOL UNIVERSITY HOSPITALS NHS FOUNDATION TRUST
    - RMC - BOLTON NHS FOUNDATION TRUST
    - RRF - WRIGHTINGTON, WIGAN AND LEIGH NHS FOUNDATION TRUST
    - RWW - WARRINGTON AND HALTON TEACHING HOSPITALS NHS FOUNDATION TRUST
- Weekend SHMI for the most recent 12 month period is not statistically significantly low for any of the peers or Warrington
- Weekday SHMI for the most recent 12 month period is statistically significantly high for :
    - RBN - ST HELENS AND KNOWSLEY TEACHING HOSPITALS NHS TRUST
    - RJR - COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST
    - RMC - BOLTON NHS FOUNDATION TRUST
    - RRF - WRIGHTINGTON, WIGAN AND LEIGH NHS FOUNDATION TRUST
- Weekday SHMI for the most recent 12 month period is statistically significantly low for :
    - RBT - MID CHESHIRE HOSPITALS NHS FOUNDATION TRUST

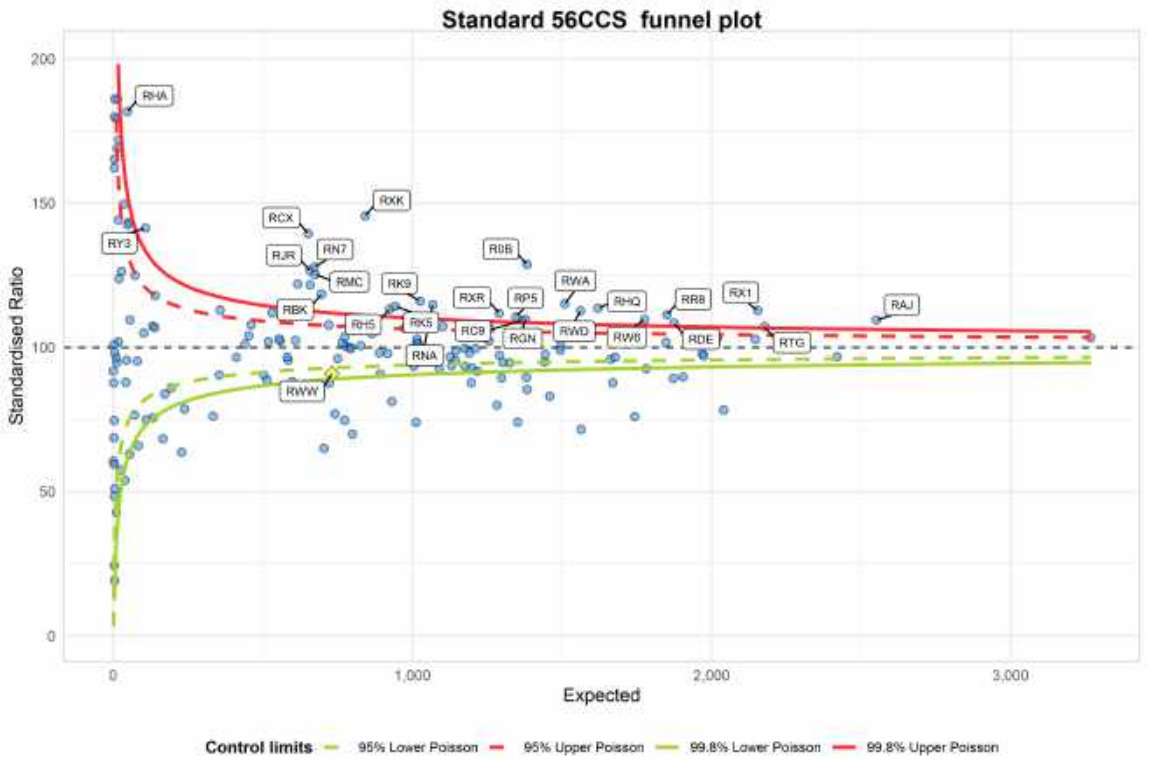
6 Variations of SHMI

- Recently, SHMI allowing for Palliative care has improved whilst out-of-hospital SHMI has deteriorated.

7 Standard 56 CCS HSMR Review

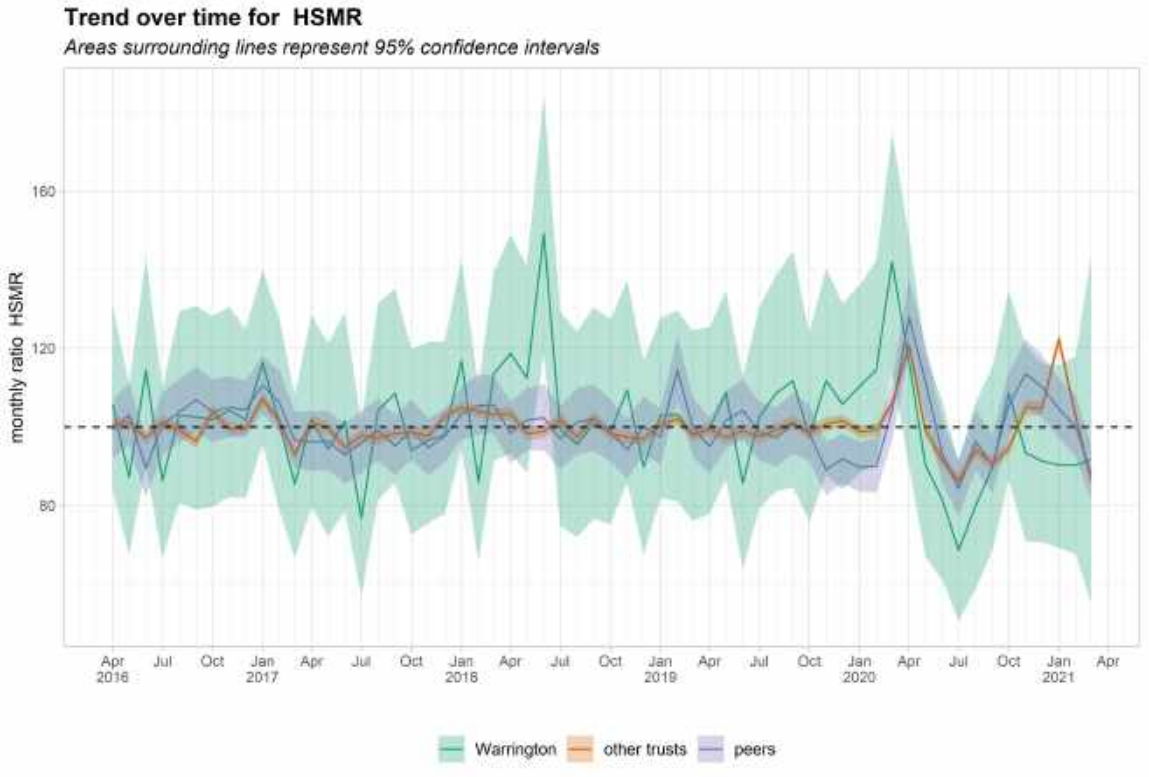
7.1 Funnel plot

- The trust is given a green rating for this indicator with an HSMR of 90.90 based on Poisson funnel plot limits.

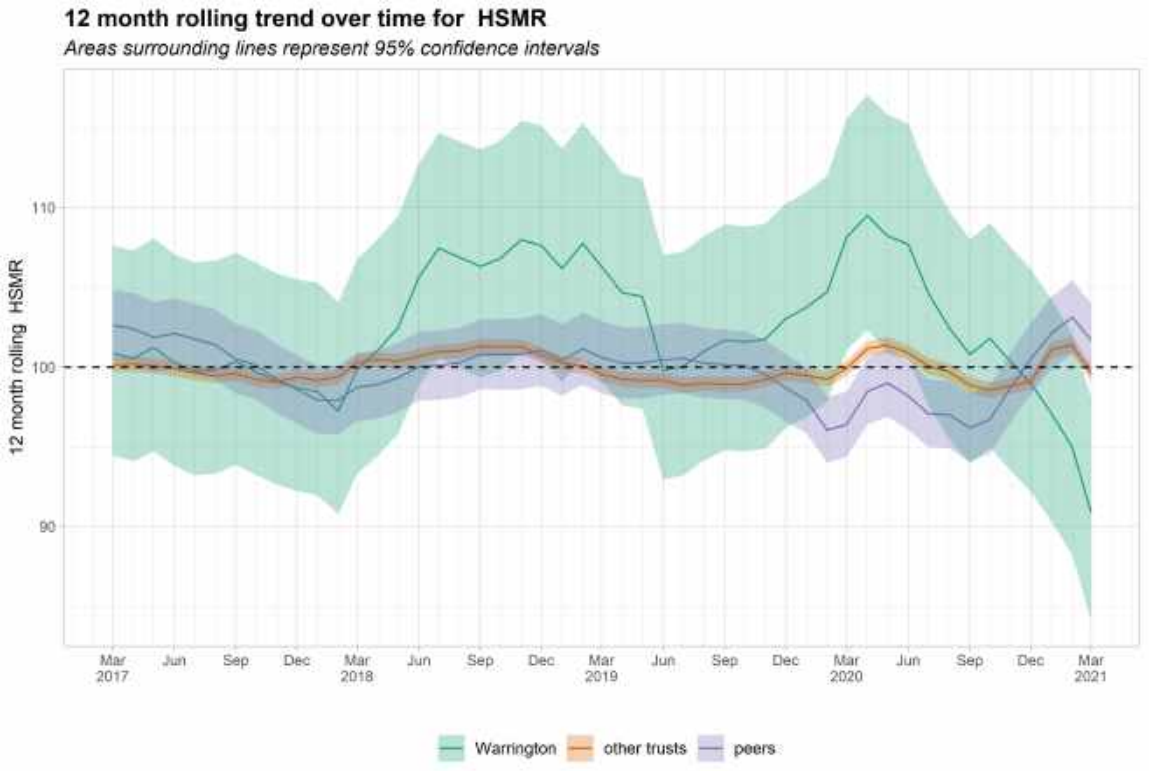


Warrington is well below the mean line in this funnel plot.

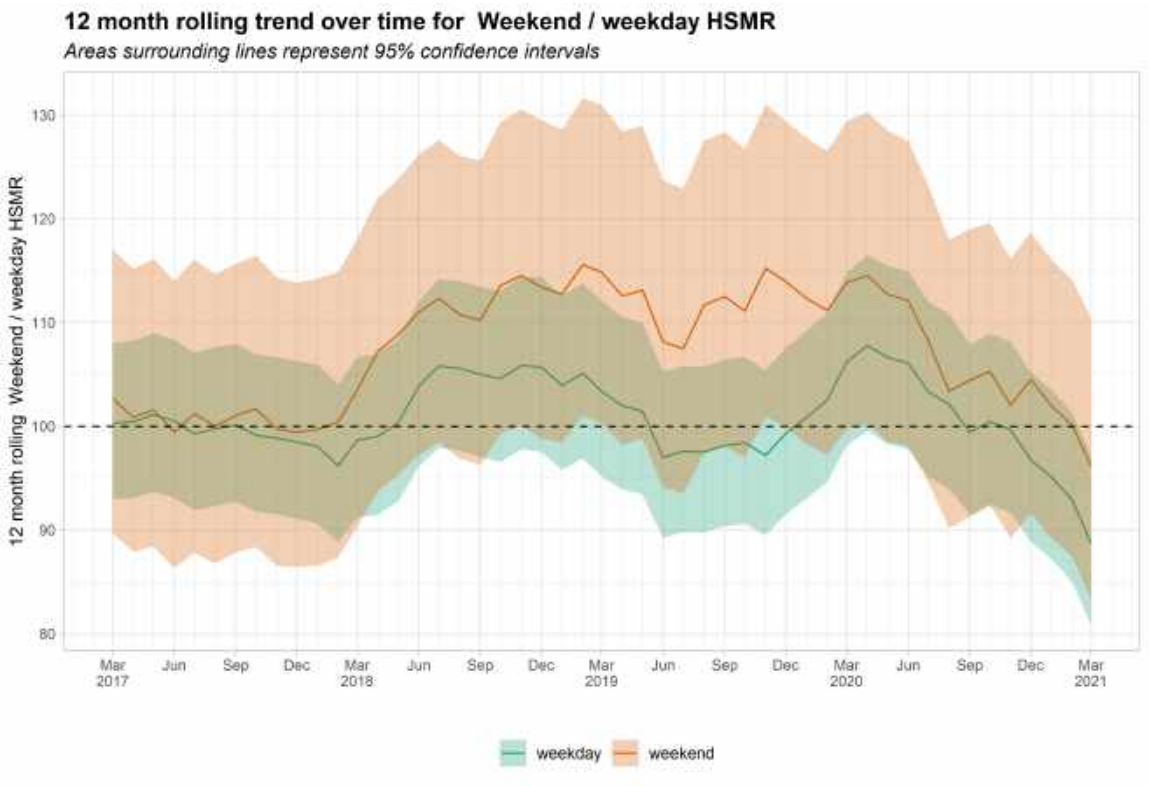
7.2 Supporting information



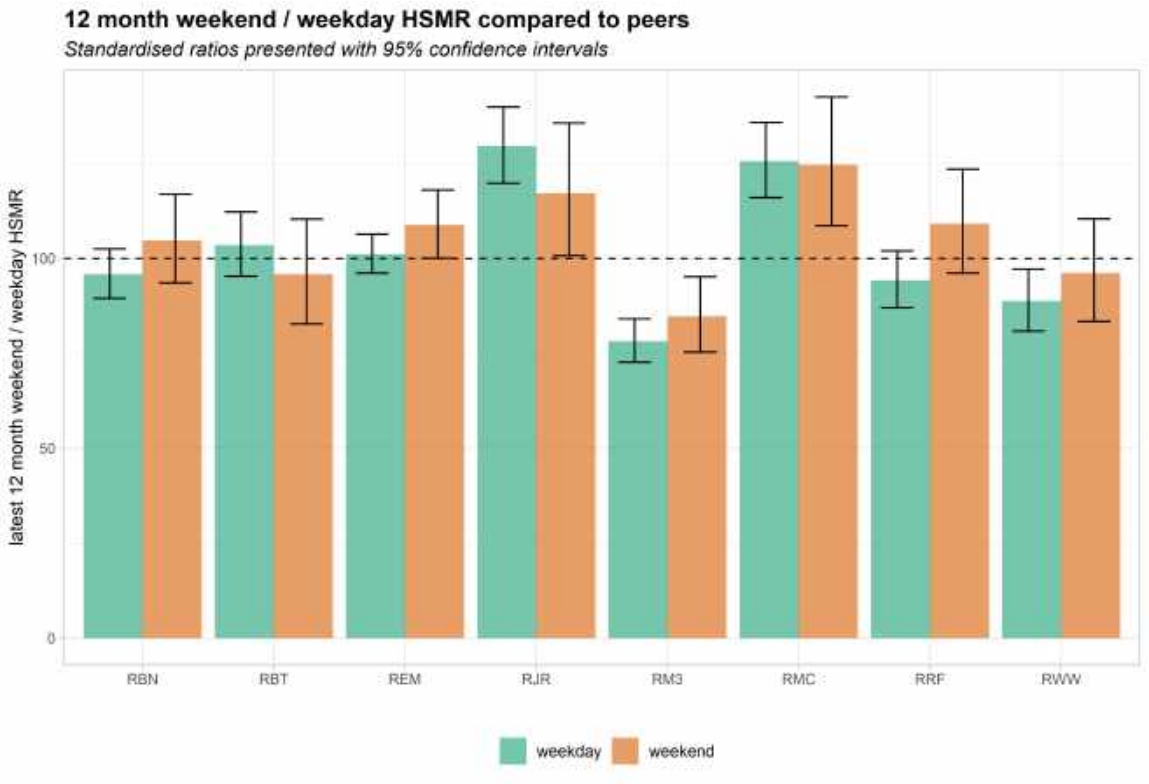
HSMR does not exclude COVID explicitly, although if it is the dominant diagnosis it is not part of the main 56 diagnosis groups. June - August 2020 shows a dip in HSMR for all trusts, but a particularly low HSMR for Warrington.



12 month rolling HSMR for Warrington continues to fall. THis is consistent with the improving trend seen in the SHMI variant allowing for recorded palliative care.



There is a reduction in both weekend and weekday HSMR in recent months.



- Weekend HSMR for the most recent 12 month period is statistically significantly high for :
    - REM - LIVERPOOL UNIVERSITY HOSPITALS NHS FOUNDATION TRUST
    - RJR - COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST
    - RMC - BOLTON NHS FOUNDATION TRUST
- Weekend HSMR for the most recent 12 month period is statistically significantly low for :
    - RM3 - SALFORD ROYAL NHS FOUNDATION TRUST
- Weekday HSMR for the most recent 12 month period is statistically significantly high for :
    - RJR - COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST
    - RMC - BOLTON NHS FOUNDATION TRUST
- Weekday HSMR for the most recent 12 month period is statistically significantly low for :
    - RM3 - SALFORD ROYAL NHS FOUNDATION TRUST
    - RWW - WARRINGTON AND HALTON TEACHING HOSPITALS NHS FOUNDATION TRUST

Please note all case study analysis in this current report is based on the SHMI. This is because the SHMI excludes COVID and so represents a clearer picture of non COVID patients at this time, assuming COVID has been accurately recorded. HSMR broadly excludes COVID because it is not included in the main 56 CCS groups, but depending on coding it can be present if it is not the primary diagnosis.

8 Case study: diagnosis group 36 :: Other endocrine disorders, Thyroid disorders

It has a SHMI value of 252.06 which is showing signs of special cause variation. In the last 12 months there are 135 discharges, 12 observed deaths and 4.8 expected deaths. Care should be taken when interpreting results as numbers are quite small.

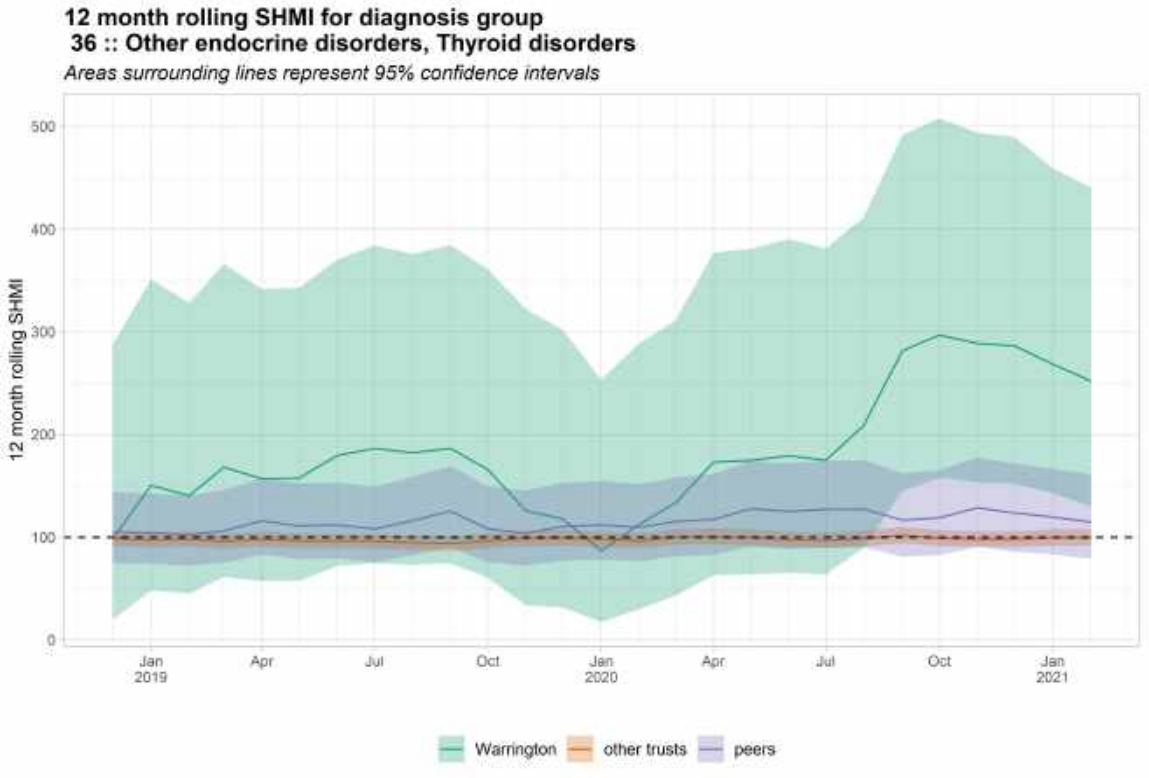
This diagnosis group (36 :: Other endocrine disorders, Thyroid disorders) is made of 2 CCS groups:

```
48  - Thyroid disorders
51  - Other endocrine disorders
```

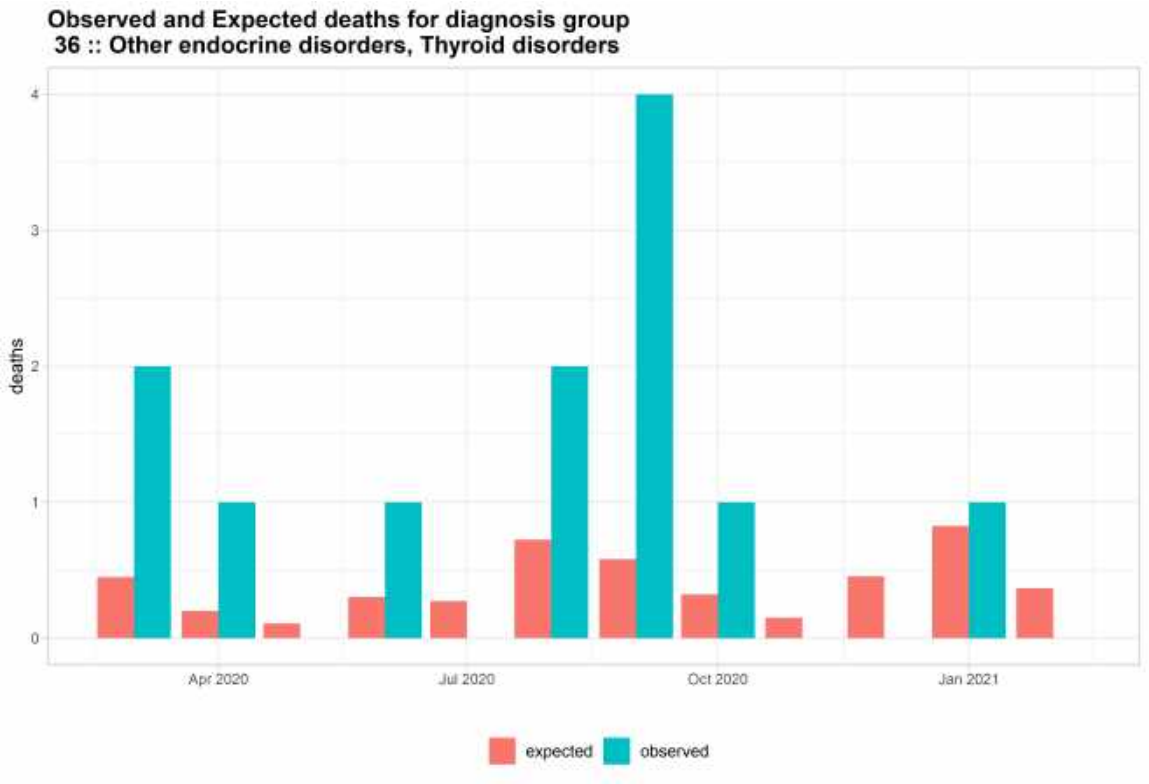
Results for the 2 CCS groups are as follows:

CCS diagnosis group	Discharges	Observed deaths	Expected deaths
48 - Thyroid disorders	26	0	0.36
51 - Other endocrine disorders	109	12	4.40

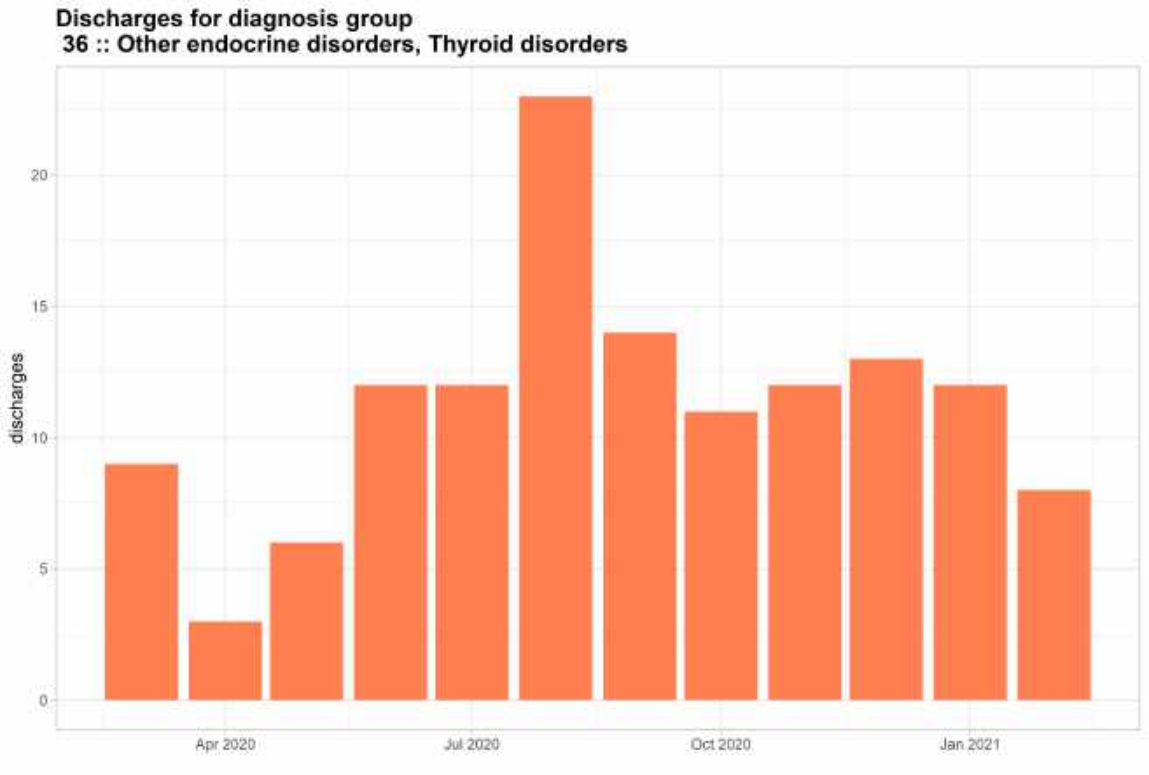
All the observed deaths are associated with the CCS group 51 - Other endocrine disorders.



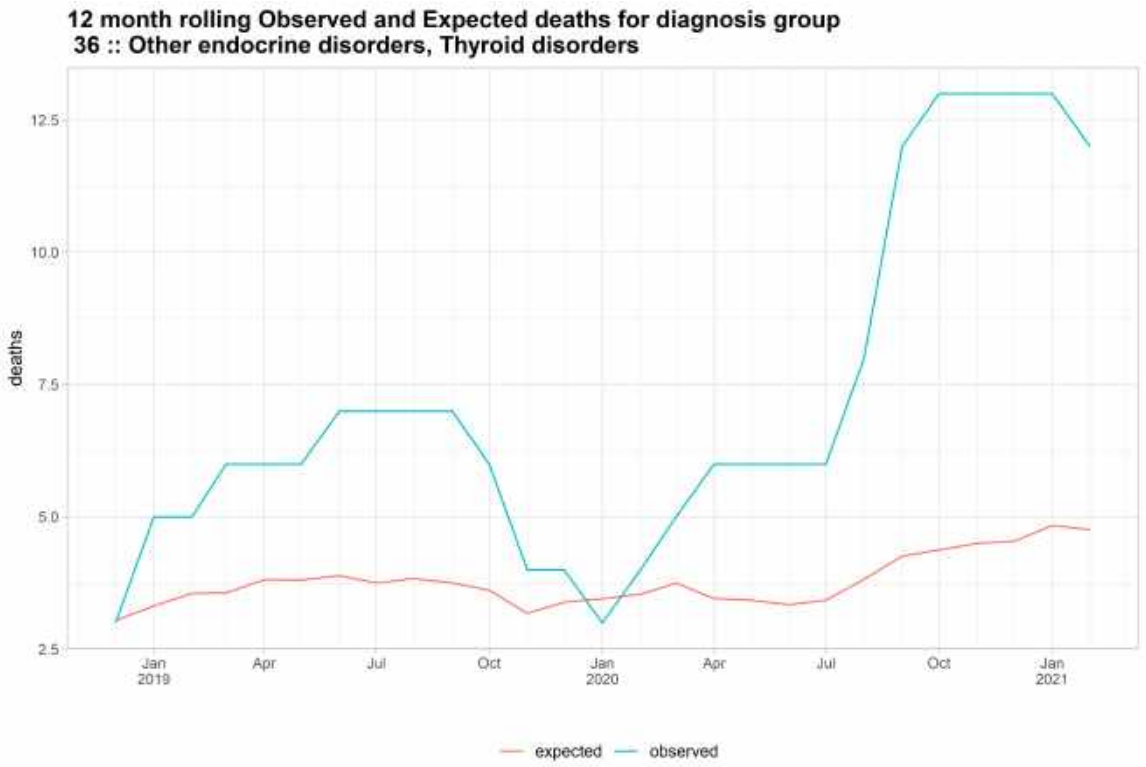
There is an increasing trend starting at the year ending August 2020 and a subsequent decline.



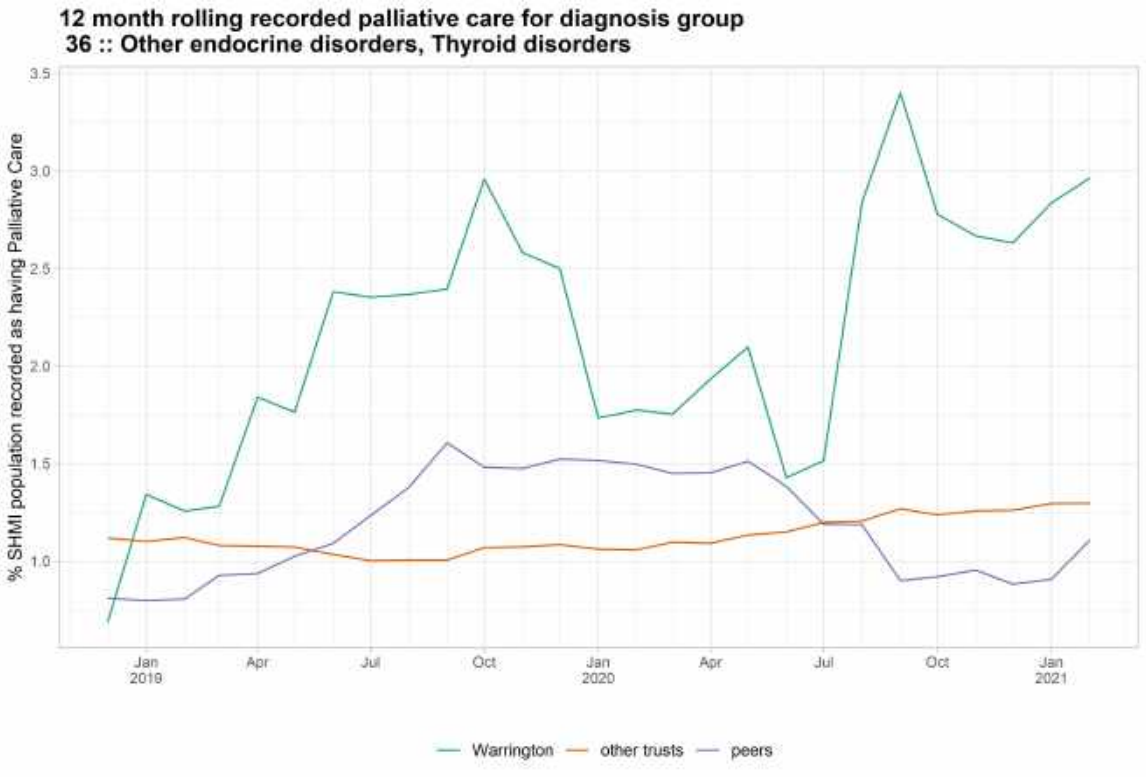
There is a particularly high number of observed deaths in September 2020.



Discharges were particularly high in August 2020 for this group.

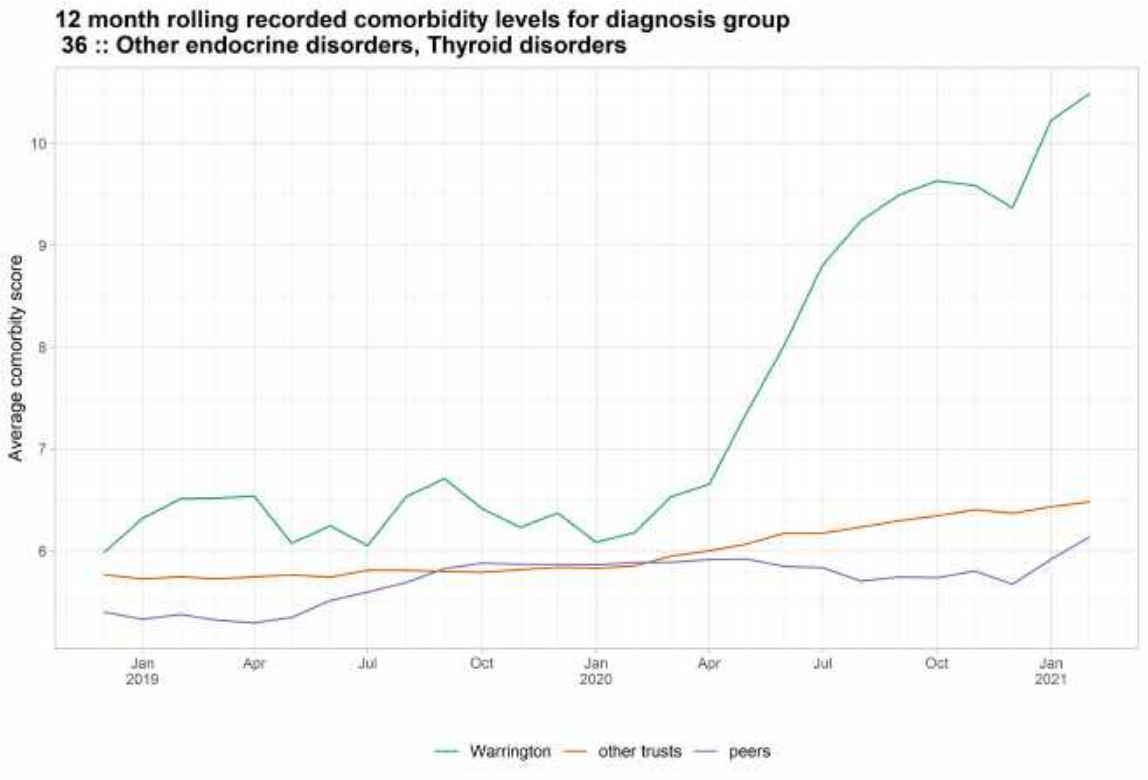


The increase in the 12 month rolling observed deaths for this diagnosis group over the last year is driven mainly by the higher number of observed deaths in August and September 2020. 12 month rolling expected deaths remain more level than the observed deaths.

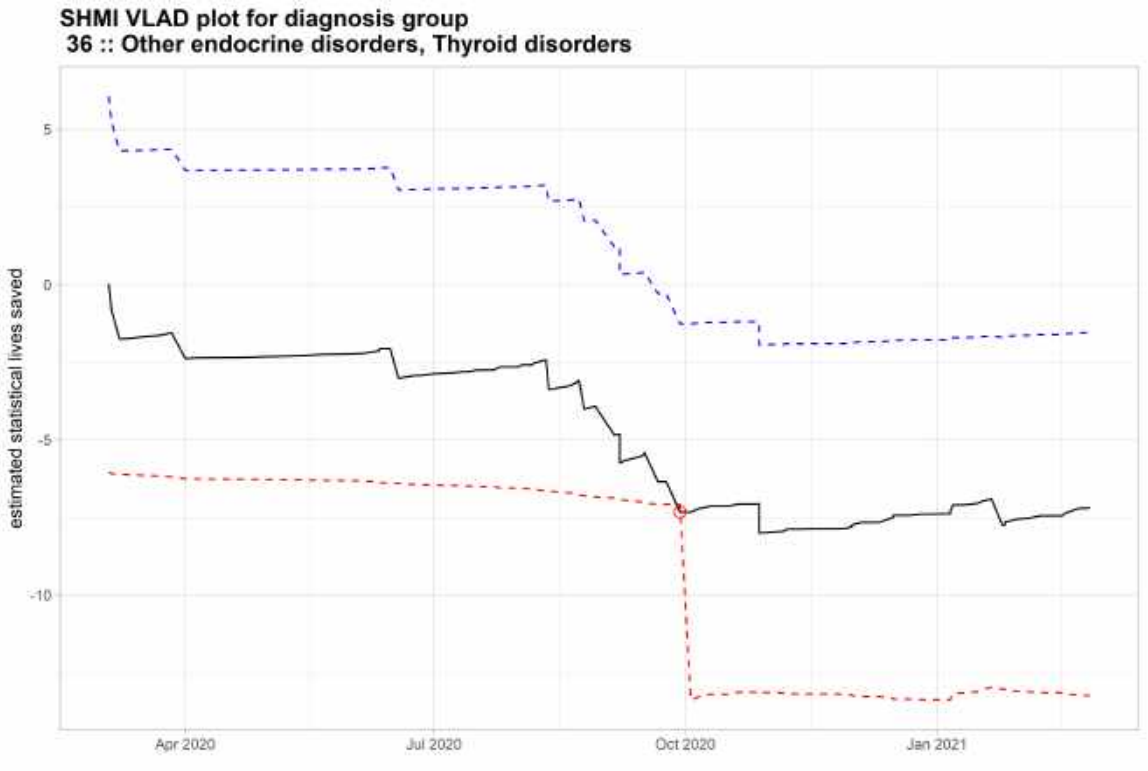


Palliative care is not included in the SHMI model, however changes in levels of recorded palliative care can help us understand changes in the complexities of the patient population.

Care should be taken since numbers are small, but recorded palliative care levels at Warrington were high in August and September 2020.



Care should be taken becuse numbers are small, but 12 month rolling recorded comorbidity levels at Warrington for 36 :: Other endocrine disorders, Thyroid disorders were rising from the year ending March 2020 and are considerably higher than that seen for the peer group, or other trusts on average.



SHMI VLAD plot for this diagnosis group shows an alert at the end of September 2020.

9 Conclusions

- HES SHMI is 105.52 . This result isn't an outlier and it is also not an outlier based on the stricter Poisson method.
- SHMI allowing for Palliative care has improved (this is consistent with results for HSMR)
- Out-of-hospital SHMI has deteriorated.
- Standard 56 CCS group HSMR is 90.90. This result is not an outlier based on the Poisson method.
- The latest month's discharges included in HSMR are about 2/3 what we would expect, which is related to the higher than expected number of cases coded as 'R69X - Unknown and unspecified causes of morbidity' as these are not included in the HSMR.
- Key Diagnosis groups showing as outliers for SHMI are:
    - 36 :: Other endocrine disorders, Thyroid disorders
    - 39 :: Acute posthemorrhagic anemia, Deficiency and other anemia
    - 63 :: Cardiac dysrhythmias
    - 138 :: Abdominal pain
- Key Diagnosis groups showing as outliers for HSMR are:
    - Coronary atherosclerosis and other heart disease
    - Other perinatal conditions

The case study focused on was 36 :: Other endocrine disorders, Thyroid disorders - showing high numbers of deaths August / September 2020. There was a SHMI VLAD alert in September 2020. Recorded Comorbidity and palliative care levels were higher at this time but observed deaths increased to a greater extent than expected deaths, leading to the VLAD alert. Care should be taken as numbers are low but it may be helpful to review the deaths in September 2020.

10 Disclaimer

Without Prejudice.

This information is based solely on official Summary Hosptial Mortality Indicator(SHMI) data set, Hospital Episode Statistics (HES) with linked ONS mortality data **[All ©NHS Digital – 2021, Reused with permission of NHS Digital].**

The comments in this document relate to the data available in HES and how these data interact with the methodologies applied. Whilst this may explain some of the trends in mortality, it is questionable as to what extent these represent quality of care delivered in an organisation. Clinical audit and investigations related to quality of care are better suited to assessing these questions. Mortality rates should be seen as one set of indicators, along with many others, that may alert medical teams and regulators to investigate these rates [i] rather than being used in isolation to assess quality of care. This report does not provide absolute assurance in relation to mortality at Warrington and Halton Teaching Hospitals NHS Foundation Trust, this report needs to be taken into account with a range of other processes including inspection and further independent analysis.

[i] Lilford R, Provonost P. Using hospital mortality rates to judge hospital performance: a bad idea that just won't go away. BMJ 2010;340:c2016

11 Appendix: Definitions

HSMR (Hospital Standardised Mortality Ratio) & SHMI (Summary Hospital-Level Mortality Indicator) Each ratio is of observed to expected deaths, multiplied by 100. If mortality levels are higher in the population being studied than would be expected, the ratio will be greater than 100. They are based on routinely collected administrative data; HES, SUS or CDS. The expected number of deaths is the sum of the estimated risks of death for every patient based upon the case mix. The differences between the measures are outlined in the table below. Measuring hospital performance is complex; these indicators should not be used in isolation, but considered with as part of a group of analytics.

Term	HSMR	SHMI
Deaths	Only in-patient hospital deaths are included.	In-patient and deaths within 30 days from discharge are included.
Spells	Deaths are attributed to every trust involved in the super-spell.	Deaths are counted once and are attributed to the last trust in the super-spell.
Diagnosis groups	Only the 56 diagnosis groups that account for 80% in-hospital mortality are included. Diagnosis group is assigned from the primary diagnosis of the first or second episode of the spell.	All diagnosis groups are included.
Other exclusions	None	• Specialist, community, mental health and independent sector hospitals. • Stillbirths. • Day cases, regular day and night attenders.
Modelling time period	Ten-year dataset used for risk modelling to calculate expected deaths.	Three-year dataset used for risk modelling to calculate expected deaths.
Model Adjustments (per diagnosis groups: 56 for HSMR, 142 for SHMI)	• Sex • Age in bands of five up to 90+ • Admission method • Source of admission • Month of admission • Interaction between co-morbidities and age band • Socio economic deprivation quintile (using Carstairs) • Number of previous emergency admissions • Palliative care • Year of discharge	• Sex • Age in bands of five up to 90+ • Admission method • Co-morbidities based on the Charlson score • Birth weight (neonatal) • Seasonality (admission month)

12 Peers

organisation
RBN - ST HELENS AND KNOWSLEY TEACHING HOSPITALS NHS TRUST
RBT - MID CHESHIRE HOSPITALS NHS FOUNDATION TRUST
REM - LIVERPOOL UNIVERSITY HOSPITALS NHS FOUNDATION TRUST
RJR - COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST
RM3 - SALFORD ROYAL NHS FOUNDATION TRUST
RMC - BOLTON NHS FOUNDATION TRUST
RRF - WRIGHTINGTON, WIGAN AND LEIGH NHS FOUNDATION TRUST

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/21/09/143**	
SUBJECT:	**Freedom to Speak up**	
DATE OF MEETING:	29 September 2021	
AUTHOR(S):	Jane Hurst, Deputy Chief Finance Officer	
EXECUTIVE DIRECTOR SPONSOR:	Kimberley Salmon-Jamieson, Chief Nurse & Deputy Chief Executive	
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	SO1 We will.. Always put our patients first delivering safe and effective care and an excellent patient experience. SO2 We will.. Be the best place to work with a diverse and engaged workforce that is fit for now and the future SO3 We will ..Work in partnership with others to achieve social and economic wellbeing in our communities.	x x
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): **(*Please DELETE as appropriate)***	**#115** Failure to provide adequate staffing levels in some specialities and wards. Caused by inability to fill vacancies, sickness. Resulting in pressure on ward staff, potential impact on patient care and impact on Trust access and financial targets.	
EXECUTIVE SUMMARY ***(KEY ISSUES):***	From the 1st April 2021 to 31 August 2021 the FTSU team has managed 11 disclosures. The majority of which relate to culture, allegations of bullying and relationship issues within teams. The FTSU team continues to work closely with HR and OD to support individuals and teams to resolve the issues that are highlighted. The FTSU team continues to engage with medical students and preceptorship nurses as they join the Trust to make them aware of FTSU. The wellbeing services across the Trust offer a good resource for FTSU to sign post staff to access further support.	

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

RECOMMENDATION:	The Trust Board is asked to note the progress of Freedom To Speak Up.	
PREVIOUSLY CONSIDERED BY:	**Committee**	Strategic People Committee
	Agenda Ref.	SPC/21/09/79
	Date of meeting	22 September 2021
	Summary of Outcome	Noted
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None	

REPORT TO BOARD OF DIRECTORS

SUBJECT	Freedom to Speak Up	AGENDA REF:	BM/21/09/143

1. BACKGROUND/CONTEXT

The purpose of this paper is to update the Board on the activity of the Freedom To Speak Up (FTSU) Team. From the 1st April 2021 to 31 August 2021 the FTSU team has managed 11 disclosures. April 2020 to 30 August 2020 saw higher levels with 17 however 7 of those related to the same issue in W&C.

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

2. DISCLOSURES

To date in 2021/22 (1 April to 31 August 2021) the FTSU team received the following disclosures.

Table 1 Disclosures in 2021/22

Quarter 1	4
July & August	7
Total	**11**

The cases can be grouped as follows:-

Table 2 Types of disclosures from a April 2021 to 31 August 2021

Behaviour, culture and relationships	8
Process	2
Patient safety	1
Total	**11**

There has been 1 patient safety concern raised relating to A&E demand and staffing, which was escalated immediately to the Chief Nurse & Deputy Chief Executive.

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

The national report was released May 2021. The Freedom to Speak Up Index continues to show an improvement in workers' perceptions of the speak up culture in NHS Trusts however the disparity between the highest performing organisations and the lowest is

increasing. The FTSU Index can help build a picture of what the speaking up culture feels like for workers. It is a metric for NHS Trusts, drawn from four questions in the NHS Annual Staff Survey, asking whether staff feel knowledgeable, encouraged and supported to raise concerns and if they agree they would be treated fairly if involved in an error, near miss or incident. The Report has been attached as **Appendix 1** and shows the Trust as 86th out of 220 with a FTSU index of 80.4%. The highest FTSU index was 87.6% and worst 66.6%. The average was 79.2%.

The FTSU Index once again showed a positive correlation between higher index scores and ratings received by the Care Quality Commission (CQC). Trusts with higher index scores were more likely to be rated 'good' or 'outstanding' by the CQC.

The 11 disclosures have been across a variety of operational and corporate areas. The professional groups of staff who have spoken up can be broken down as follows:-

- 2 midwives
- 2 administration / managers
- 5 nurses
- 1 Health Care Support Workers
- 1 Pharmacy

3. ACTIVITY

Face to face training has been limited during 2021 due to the ongoing COVID-19 pandemic. During the year, the team has presented to the Medical Student inductions. The team held a drop in day in July. FTSU Champions also attend induction for new student nurses and the international nurses to raise awareness.

4. LESSONS LEARNT

The ability to signpost staff to the various wellbeing offers has been key to providing support to staff who are struggling during this difficult year. Many who have spoken up have said that they will access the services highlighted to them.

Individuals who speak up are often feeling quite vulnerable or distressed about a situation and a prompt response helps to reduce this stress, there has been a couple of situations where due to operational pressures across the site this has not been possible and this has increased the anxiety of the individual. FTSU continues to promote the benefits of listening to our staff supporting prompt resolution.

5. RECOMMENDATIONS

The Trust Board is asked to note the progress of Freedom To Speak Up.

FREEDOM TO SPEAK UP INDEX REPORT 2021

National Guardian

Freedom to Speak Up

May 2021

Contents

Foreword

I am often asked by leaders: “How do we know when we’ve got it right?”. Culture can seem a nebulous concept and difficult to pin down. It is often described as ‘the way things are done around here’. But is the culture healthy or toxic?

Leaders wanting to learn how they can do better will be curious about their culture. They will ask questions, speak to workers and listen to their Freedom to Speak Up Guardian to get a sense of their organisation’s culture. They will also look at different data sets – including, potentially, staff survey results, sick days, grievances, retention. And they will listen to the silence – what is missing?

The Freedom to Speak Up (FTSU) Index is one of these indicators which can help build a picture of what the speaking up culture feels like for workers. It is a metric for NHS Trusts, drawn from four questions in the NHS Annual Staff Survey, asking whether staff feel knowledgeable, encouraged and supported to raise concerns, and if they agree they would be treated fairly if involved in an error, near miss or incident.

Since the introduction of Freedom to Speak Up Guardians in 2016 following the Francis Freedom to Speak Up Review, the FTSU Index has improved and risen 3.7 percentage points nationally from 75.5 per cent in 2015 to 79.2 per cent in 2020.

While we continue to see an upward trajectory, I am concerned with the continued disparity between the highest performing organisations and the lowest, with a 21-percentage point difference between the highest and lowest scoring trusts. More concerning is that this disparity has increased this year, with the lowest performing trust showing a 2.9 per cent decrease.

Within this report, we share case studies from some of those organisations who are among those with the most improved FTSU Index scores. They share their journeys to provide insight and learning to others who may be facing similar challenges. They illustrate some of the practical steps they have taken to improve workers’ trust in speaking up arrangements and their confidence that they will be safe and supported if they use them.

Do workers feel safe to speak up?

This year, a new question was included in the NHS Staff Survey, asking workers if they feel safe to speak up about anything that concerns them within their organisation.[1]

[1] This question has not been included in the FTSU Index scores to enable comparability to previous years. However, the answers to this question show a very strong positive correlation with the FTSU Index.

We welcome the inclusion of this question, because Freedom to Speak Up is about more than the ability to raise concerns about patient safety. It is about being able to speak up about anything which gets in the way of doing a great job, whether that's an idea for improvement, ways of working or behaviour.

The answers to this question show a very strong positive correlation with the FTSU Index, with 66 per cent of staff "agreeing" or "strongly agreeing" that they feel safe to speak up about anything that concerns them in their organisation. We will be looking in more depth into the details of the responses to this question in a future report.

All organisations should consider including this question in surveys of their workforce. The promoters and barriers to speaking up are common to all settings and organisations. Is it safe to speak up? Will I be listened to? Will action be taken?

Freedom to Speak Up is for everybody who works in health. It includes primary and secondary care, independent providers, hospices and national bodies. It goes beyond those surveyed in the NHS Staff Survey and to be truly inclusive needs to work for locum and agency workers, junior doctors, students, volunteers, contractors and all workers who may face additional barriers to speaking up.

The inclusivity at the heart of Freedom to Speak Up is why I ask leaders to take this question and use it to listen to the silence, to reduce the disenfranchisement of workers seen so starkly during the COVID-19 pandemic. Who is not represented in your survey responses?

As the health sector evolves to more integrated ways of working, it is essential that speaking up arrangements are consistent so workers can be confident that when they speak up, they will be supported, listened to, and the appropriate actions taken.

The Freedom to Speak Up e-learning modules we have developed in association with Health Education England are for everyone wherever they work in health. They explain in a clear and consistent way what speaking up is and its importance in creating an environment in which people are supported to deliver their best. The first module – Speak Up – is for everybody. The second module, Listen Up, for managers, builds upon the first and focuses on listening and understanding the barriers to speaking up. A final module – Follow Up – for senior leaders, will be launched later in the year to support the development of Freedom to Speak Up as part of the strategic vision for organisations and systems.

The pandemic has shown how vital Freedom to Speak Up is, not just to ensure that patients receive the best care, but also to protect the safety of workers. The NHS staff survey also showed that 18 per cent were considering leaving the NHS altogether. Everyone who works in health has been under tremendous strain over the past year, under the most challenging of circumstances. As the sector rebuilds following the pressures of the pandemic, retaining these highly skilled, dedicated workers has never been more essential.

Whatever role a worker plays in supporting the health of the nation, they should feel confident that their voice matters. That when they speak up, their voice will be heard and that it will be responded to. Just as patients expect the same level of care and

compassionate service across the system, a universal, integrated approach to Freedom to Speak Up will provide workers with the same consistency of worker experience, no matter what their role or where they work.

We need to work together to ensure that everyone feels safe to speak up, and that the right actions will be taken when they do. To do so shows through deeds, rather than words, that people and their wellbeing matters. Only by listening to the silence, can we work towards making speaking up business as usual.

Dr Henrietta Hughes OBE FRCGP

National Guardian for the NHS

May 2021

Acknowledgements

The 2020 NHS Staff Survey was carried out in the context of the ongoing COVID-19 pandemic. The National Guardian's Office (NGO) is aware of the pressures the healthcare sector is under during this time and we greatly appreciate all the work being done by healthcare workers.

We want to thank everyone who has helped with the preparation of the Freedom to Speak Up Index and this report. This includes everyone who completed the 2020 NHS Staff Survey, the trusts featured, the NHS Staff Survey team and NHS England and NHS Improvement, and members of the team at the National Guardian's Office.

National Guardian's Office

The National Guardian's Office (NGO) provides supports and challenges to the healthcare system in England on speaking up.

The NGO leads, trains and supports an expanding network of Freedom to Speak Up (FTSU) Guardians who support workers to speak up and work within their organisation to tackle barriers to speaking up.

At the time of publication, there were over 690 Freedom to Speak Up Guardians in a range of organisations, including NHS trusts, independent health care providers, primary care organisations, professional and systems regulators, and clinical commissioning groups.

Key Findings

- The national Freedom to Speak Up (FTSU) Index score (79.2%) continued to improve.
- Six of the top ten performing trusts from last year remained in the top ten list this year and three trusts from last year remained in the bottom ten scoring trusts this year.
- An increasing disparity has emerged this year between the highest and lowest performing trusts. The disparity was 21.0 percentage points in the 2020 NHS Staff Survey, up from 17.2 percentage points in 2019.
- The FTSU Index continues to be positively correlated with Care Quality Commission ratings.
- Ambulance trusts remain the lowest performing organisation type, though they were also the most improved from last year.
- The South East region saw the greatest improvement (1.3 percentage points) in FTSU Index score from 79.6% to 80.9% this year.
- A new speaking up question was included in the 2020 NHS Staff Survey. The new question showed that 65.6% of respondents felt safe to speak up about anything that concerns them in their organisation. The results of this question also showed a strong positive correlation with the FTSU Index.

Introduction

Working with NHS England, the National Guardian's Office (NGO) has brought together four questions from the NHS Staff Survey into a 'Freedom to Speak Up (FTSU) Index'. These questions ask whether staff feel knowledgeable, secure and encouraged to speak up, and whether they would be treated fairly after an incident.

The FTSU Index seeks to allow trusts to see how an aspect of their FTSU culture compares with other organisations so learning can be shared, and improvements made.[2]

This is the third year in a row that we are publishing the FTSU Index.[3] This year's index is based on the results from the 2020 NHS Staff Survey.[4]

Currently, the FTSU Index only includes data for NHS Trusts.[5]

This year's results show the national average for the FTSU Index has continued to rise.

The FTSU Index once again showed a positive correlation between higher index scores and ratings received by the Care Quality Commission (CQC).[6] Trusts with higher index scores were more likely to be rated 'good' or 'outstanding' by the CQC.[7]

NHS Staff Survey questions and the Freedom to Speak Up Index

The FTSU index was calculated as the mean average of responses to the following four questions from the 2020 NHS Staff Survey:

- % of staff "agreeing" or "strongly agreeing" that their organisation treats staff who are involved in an error, near miss or incident fairly (question 16a)
- % of staff "agreeing" or "strongly agreeing" that their organisation encourages them to report errors, near misses or incidents (question 16b)
- % of staff "agreeing" or "strongly agreeing" that if they were concerned about unsafe clinical practice, they would know how to report it (question 17a)
- % of staff "agreeing" or "strongly agreeing" that they would feel secure raising concerns about unsafe clinical practice (question 17b)

[2] The FTSU Index's purpose is not to benchmark trusts for their speaking up culture.
[3] Please see here (2020) and here (2019) for the previous FTSU Index reports.
[4] NHS England and NHS Improvement Staff Survey, https://www.nhsstaffsurveys.com/Page/1105/Latest-Results/NHS-Staff-Survey-Results/
[5] The NGO's remit extends beyond trusts. However, NHS trust workers make up the majority of those who take part in the NHS Staff Survey, though non-trusts (e.g. some clinical commissioning groups) also participate in the annual survey.
[6] The Care Quality Commission (CQC) regulates and inspects many of the organisations where Freedom to Speak Up Guardians support workers to speak up and challenge barriers to speaking up. There are four ratings the CQC give health and social care services they regulate and inspects: outstanding, good, requires improvement and inadequate.
[7] Please see below (Annex) for a table with each NHS trusts FTSU Index score (2021) and CQC rating (as of 4 May 2021).

The results of the index are representative of those who answered the 2020 NHS Staff Survey, not the full workforce in these trusts.

The four questions used in the FTSU Index are clinical- and incident-centric and may not have the same applicability to all staff groups and trust types. Moreover, while they give an indication of FTSU culture, a healthy speaking up culture is about more than these issues and includes making improvement suggestions.

There was an additional question included in the 2020 NHS Staff Survey which focused on workers feeling safe to speak up more generally:

- % of staff "agreeing" or "strongly agreeing" that they would feel safe to speak up about anything that concerns them in their organisation (question 18f)

Question 18f was not included in this year's FTSU Index – to allow for comparability to previous years – but has been analysed alongside the index score for this report.

Please note all figures in this report are rounded to one decimal place which may show small discrepancies in figures.

The Model Health System

The FTSU Index is also available on the Model Health System.[8]

Using the Model Health System, trusts can access data on their culture and engagement, including their FTSU Index and data from their Freedom to Speak Up Guardian on speaking up cases raised to them, to help build a comprehensive picture of their organisational culture and identify opportunities to improve.

[8] The Model Health System is a data-driven improvement tool that enables NHS health systems and trusts to benchmark quality and productivity. By identifying opportunities for improvement, the Model Health System empowers NHS teams to continuously improve care for patients. The Model Health System incorporates the Model Hospital, which provides hospital provider-level benchmarking.

Summary of results

A. FTSU Index – National Averages

The national average for the Freedom to Speak Up (FTSU) Index score has improved by 0.5 percentage points over the past year, up to 79.2 per cent. The improvement has slowed over recent years from a 1.4 percentage point increase between 2017 and 2018 to a 0.5 percentage point increase between 2019 and 2020.

2016	2017	2018	2019	2020
76.7%	76.8%	78.1%	78.7%	**79.2%**

The FTSU Index is based on four questions from the annual NHS Staff Survey (16a, 16b, 17a and 17b). The highest performing trust for this year's index was Cambridgeshire Community Services NHS Trust at 87.6 per cent; this was 21.0 percentage points higher than the lowest performing trust. The disparity between highest and lowest performing trusts increased from 17.2 percentage points in 2019 to 21.0 percentage points in 2020.

Question 16a

Question 16a asked staff whether they agreed their organisation treated staff who were involved in an error, near miss or incident fairly.

Question	2016	2017	2018	2019	2020
% of staff agreeing that their organisation treats staff who are involved in an error, near miss or incident fairly (16a)	53.9%	54.2%	58.3%	59.7%	**60.9%**

Over 60 per cent of respondents agreed their organisation treated staff involved in an error, near miss or incident fairly.

There was a 1.2 percentage point improvement in this question over the past year. This is the biggest improvement of the four questions on which the index is based. However, almost 40 per cent of respondents to the survey still did not agree with the statement that staff were treated fairly when involved in an error, near miss or incident.

This question saw the largest disparity in trust performance of all four questions. The highest scoring trust, Solent NHS Trust, scored 74.1 per cent, compared to 36.9 per cent at the lowest scoring trust.

Question 16b

Question 16b asked staff whether they agreed their organisation encouraged them to report errors, near misses or incidents.

Question	2016	2017	2018	2019	2020
% of staff "agreeing" or "strongly agreeing" that their organisation encourages them to report errors, near misses or incidents (16b)	87.7%	87.6%	88.1%	88.4%	**88.3%**

There was a 0.1 percentage point decline in performance for this question over the past year.

The highest performing trust in this question was the same as 16a, Solent NHS Trust (95.1 per cent). The lowest performing trust result was 77.3 per cent.

Question 17a

Question 17a asked staff whether they agreed that they would know how to report a concern about unsafe clinical practice.

Question	2016	2017	2018	2019	2020
% of staff "agreeing" or "strongly agreeing" that if they were concerned about unsafe clinical practice, they would know how to report it (17a)	95.1%	95.2%	94.8%	94.7%	**94.9%**

There was a 0.2 percentage point improvement in performance for this question over the past year. The highest performing year remains 2017.

This question showed the smallest variation in trust performance of all four questions (7.3 per cent). The highest performing trust was Isle of Wight NHS Trust (mental health sector), at 98.6 per cent. The lowest performing trust result was 91.3 per cent.

Question 17b

Question 17b asked whether staff agreed that they would feel secure raising concerns about unsafe clinical practice.

Question	2016	2017	2018	2019	2020
% of staff "agreeing" or "strongly agreeing" that they would feel secure raising concerns about unsafe clinical practice (17b)	70.4%	70.2%	70.7%	71.7%	**72.5%**

There was a 0.8 percentage point improvement for this question over the past year, with 2020 also being the highest performing of the past five years.

The highest performing trust was Cambridgeshire Community Services NHS Trust (83.7 per cent).

Cambridgeshire Community Services NHS Trust was also the highest performing trust last year for this question. The lowest performing trust for this question had a result of 58.0 per cent.

Question 18f – not included in Index

In the 2020 NHS Staff Survey, there was an additional question about speaking up. This question has not been included in the index scores to allow comparability to previous years. However, the results of this question have been included in this report for consideration alongside the index due to the question's relevance to Freedom to Speak Up.

Question	2020
% of staff "agreeing" or "strongly agreeing" that they feel safe to speak up about anything that concerns them in their organisation (18f)	**65.6%**

The highest performing trust was Solent NHS Trust (78.3 per cent).

The lowest performing trust for this question had a result of 43.7 per cent.

Name of trust	2020
Solent NHS Trust	78.3%
Cambridgeshire Community Services NHS Trust	77.9%
Northumbria Healthcare NHS Foundation Trust	77.6%
Hertfordshire Community NHS Trust	76.9%
Kent Community Health NHS Foundation Trust	76.4%
Northamptonshire Healthcare NHS Foundation Trust	75.8%

Chesterfield Royal Hospital NHS Foundation Trust	75.4%
Isle of Wight NHS Trust (ambulance sector)	75.1%
Derbyshire Community Health Services NHS Foundation Trust	75.0%
St Helens and Knowsley Teaching Hospitals NHS Trust	74.9%

The results showed a very strong positive correlation between question 18f and the FTSU Index[9]. Eight of the 10 lowest scoring trusts for this question were in the 10 lowest scoring trusts for the FTSU Index. Five of the 10 highest scoring trusts for this question were in the 10 highest scoring trusts for the FTSU Index.

The results also showed a strong to very strong positive correlation between question 18f and each individual question for the index. The strongest positive correlation was with question 17b[10]: *"% of staff "agreeing" or "strongly agreeing" that they would feel secure raising concerns about unsafe clinical practice".*

B. FTSU Index – By region

Performance in the index was reviewed by region.

The region with the highest index score was the South East (80.9 per cent), followed by the South West (80.1 per cent).

The region with the lowest index score was East of England (78.6 per cent). The East of England was also the only part of the country which did not see an improvement in its regional index score from 2019 to 2020.

The South East saw the biggest improvement in their index score over the last year (1.3 percentage points), followed by the Midlands (0.9 percentage points).

Region	**2016**	**2017**	**2018**	**2019**	**2020**
South East	76.3%	77.1%	78.6%	79.6%	**80.9%**
South West	76.9%	77.4%	78.7%	79.7%	**80.1%**
North West	77.3%	77.1%	78.6%	79.2%	**79.9%**
Midlands	76.4%	76.5%	78.0%	78.7%	**79.6%**
North East and Yorkshire	76.7%	76.6%	78.5%	78.9%	**79.5%**
London	77.1%	77.5%	78.3%	78.6%	**78.9%**
East of England	76.5%	77.0%	78.5%	78.7%	**78.6%**

[9] Pearson's correlation 0.91
[10] Pearson's correlation 0.87

C. FTSU Index – By trust type

Index scores varied by trust type and these variations were more pronounced than the regional differences.

Community trusts had the highest score (84.6 per cent), with ambulance trusts scoring the lowest at 75.9 per cent. These two trust types were also the highest and lowest scoring trust types in 2019.

All trust types saw an improvement in their index score over the last year. The biggest improvement was for ambulance trusts (2.1 percentage points). Ambulance trusts have also seen the largest improvement over the five-year period (7.2 percentage points).

Trust Type	2016	2017	2018	2019	2020
Community Trusts	80.6%	81.5%	82.7%	83.9%	**84.6%**
Acute Specialist Trusts	79.2%	79.4%	81.7%	81.2%	**82.0%**
Mental Health & Learning Disability and Mental Health, Learning Disability & Community Trusts	77.3%	77.8%	79.3%	79.5%	**80.8%**
Acute and Acute & Community Trusts	76.4%	76.5%	78.1%	78.5%	**79.0%**
Ambulance Trusts	68.7%	68.8%	73.7%	73.7%	**75.9%**

D. Trusts with the highest FTSU Index scores

The following were the ten trusts with the highest score in the Freedom to Speak Up Index 2021:

Name of trust[11]	2016	2017	2018	2019	2020
Cambridgeshire Community Services NHS Trust	82.9%	85.1%	87.0%	86.7%	**87.6%**
Kent Community Health NHS Foundation Trust	79.7%	80.1%	81.5%	84.2%	**87.0%**
Solent NHS Trust	82.9%	83.1%	86.1%	86.1%	**86.9%**
Hounslow and Richmond Community Healthcare NHS Trust	81.3%	82.3%	85.2%	85.1%	**85.9%**
Lincolnshire Community Health Services NHS Trust	78.4%	81.9%	83.6%	83.6%	**85.5%**
Northamptonshire Healthcare NHS Foundation Trust	80.2%	81.0%	84.9%	85.3%	**85.5%**

[11] Trusts highlighted are new entries into the top ten trusts with the highest score in the Freedom to Speak Up index.

Hertfordshire Community NHS Trust	81.6%	81.2%	83.2%	84.0%	**85.0%**
Leeds Community Healthcare NHS Trust	81.6%	83.1%	84.2%	85.1%	**84.9%**
Sussex Community NHS Foundation Trust	81.1%	82.6%	83.2%	83.9%	**84.9%**
Liverpool Heart and Chest Hospital NHS Foundation Trust	83.1%	83.2%	85.6%	84.7%	**84.7%**

Cambridgeshire Community Services NHS Trust remained the trust with the highest score in the FTSU Index for the fourth year running. Six of the top 10 trusts were in the top 10 last year.

E. Trusts with the greatest overall increase and decrease in FTSU Index scores

The following were the 10 trusts which had the greatest overall increase in their FTSU Index score from 2019 to 2020:

Name of trust	2019	2020	Percentage Point Change
Isle of Wight NHS Trust (ambulance sector)	77.7%	84.6%	6.9%
East Midlands Ambulance Service NHS Trust	71.8%	76.9%	5.0%
South Tees Hospitals NHS Foundation Trust	73.2%	77.9%	4.6%
Alder Hey Children's NHS Foundation Trust	77.2%	81.7%	4.4%
Isle of Wight NHS Trust (mental health sector)	78.6%	82.9%	4.3%
Nottinghamshire Healthcare NHS Foundation Trust	75.9%	79.9%	4.0%
Bridgewater Community Healthcare NHS Foundation Trust	78.7%	82.7%	4.0%
Birmingham and Solihull Mental Health NHS Foundation Trust	74.4%	78.0%	3.7%
Isle of Wight NHS Trust (acute sector)	76.2%	79.8%	3.6%
Central London Community Healthcare NHS Trust	80.6%	83.7%	3.2%

The following were the ten trusts which had the greatest overall decrease in their FTSU Index score:

Name of trust	2019	2020	Percentage Point Change
North Cumbria Integrated Care NHS Foundation Trust	80.2%	75.4%	-4.8%
The Royal Orthopaedic Hospital NHS Foundation Trust	83.7%	79.1%	-4.7%
West Suffolk NHS Foundation Trust	81.6%	77.4%	-4.2%
Mid and South Essex NHS Foundation Trust	80.1%	76.3%	-3.9%
South Warwickshire NHS Foundation Trust	84.4%	81.5%	-2.9%
East of England Ambulance Service NHS Trust	69.5%	66.6%	-2.9%
East Kent Hospitals University NHS Foundation Trust	77.3%	74.4%	-2.8%
Harrogate and District NHS Foundation Trust	81.0%	78.4%	-2.6%
Great Western Hospitals NHS Foundation Trust	82.0%	79.6%	-2.4%
Barking, Havering and Redbridge University Hospitals NHS Trust	76.6%	74.3%	-2.3%

F. FTSU Index by Ethnicity

In his report on the Freedom to Speak Up review, Sir Robert Francis found that some groups faced barriers to speaking up, including black and ethnic minority workers.

We reviewed the FTSU Index results by ethnicity.

From 2016 to 2019, respondents from black and minority ethnic groups were, as a group at a national level, more likely than white respondents to agree or strongly agree with the statement questions that make up the FTSU Index (see figure 1, below). Over this period, the difference in the responses of black and minority ethnic staff and white staff decreased and, in 2020, white respondents were more likely to agree with the statement questions in the FTSU Index.

Compared to the previous index, black and minority ethnic staff taking part in the 2020 NHS Staff Survey were less likely to agree with the questions in the FTSU index.

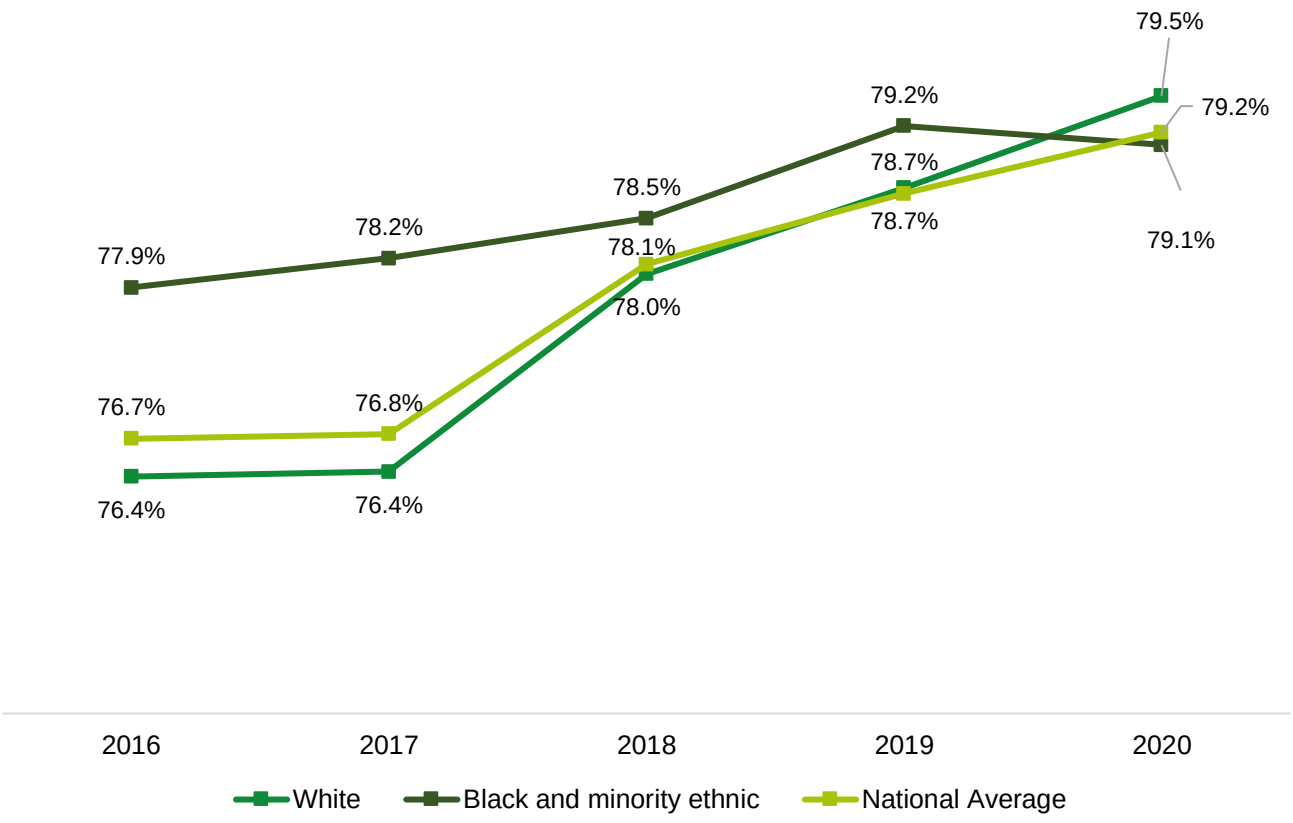


Figure 1. FTSU Index by ethnicity

We delved further into the results to understand differences among the groups of workers that were collectively grouped as ‘black and minority ethnic’.

As a group at the national level, Asian/Asian British respondents were – compared to the other ethnic groups – more likely to agree with the statement questions in the FTSU Index. This was consistently the case between 2016 to 2019 (see figure 2, below).

In 2020, a larger percentage of Asian/Asian British, White and Mixed/Multiple ethnic background respondents agreed with the statement questions that make up the FTSU Index than other groups.

Respondents from Mixed/Multiple ethnic background groups had a 2.6 percentage point increase in the FTSU Index from 2019 to 2020. However, Black/African/Caribbean/Black British, Asian/Asian British and Other ethnic group respondents saw a decline in their FTSU Index score from 2019 to 2020.

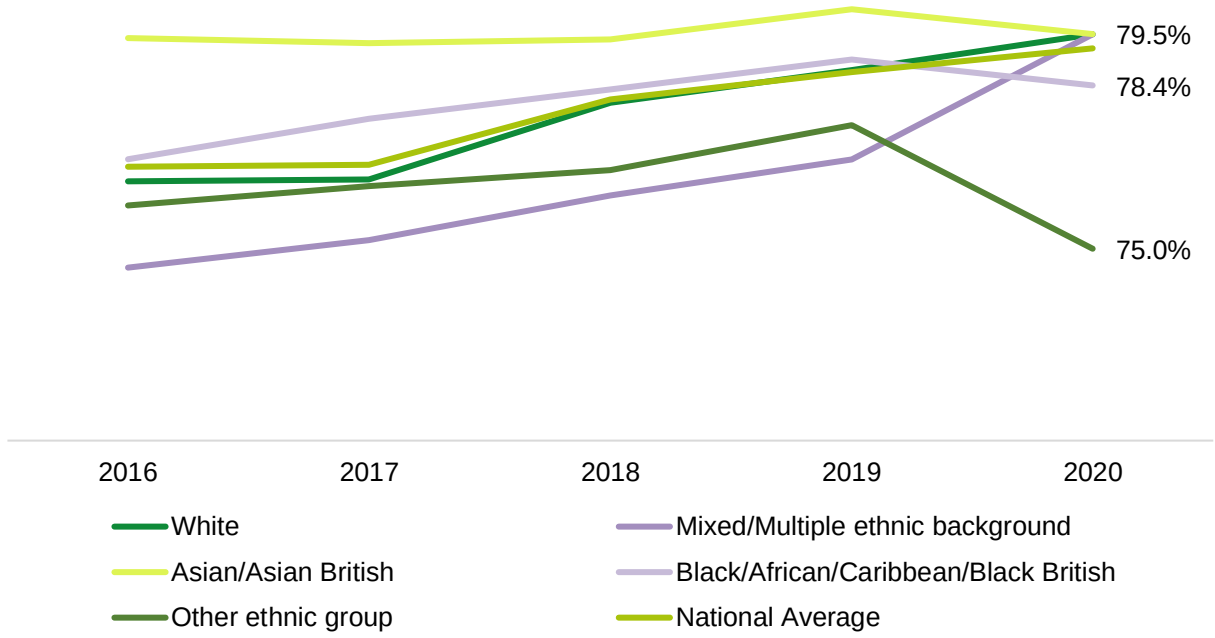


Figure 2. FTSU Index by ethnicity

G. Q18f by Ethnicity

The results for the additional question in the 2020 staff survey – *"% of staff "agreeing" or "strongly agreeing" that they feel safe to speak up about anything that concerns them in their organisation"* – were also analysed by ethnicity of respondents.

Compared to black and minority ethnic respondents, white respondents (67.0 per cent) were more likely to agree that they felt safe to speak up about anything that concerns them in their organisation (see figure 3, below). This was a much greater difference (4.9 percentage points) than the FTSU Index (0.4 percentage points).

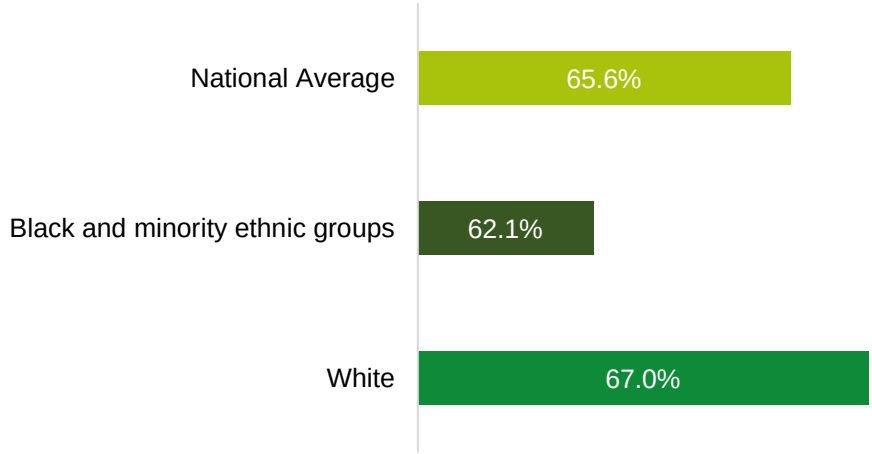


Figure 3. Q18f by ethnicity

There were further variations when respondents from black and minority ethnic groups were split into smaller groups.

Asian/Asian British respondents had the highest rate of these groups for this question, at 63.9 per cent. Fifty-seven per cent (57.0%) of respondents in the 'other ethnic group' category agreed that they felt safe to speak up about anything that concerns them in their organisation - 10 percentage points less than white respondents.

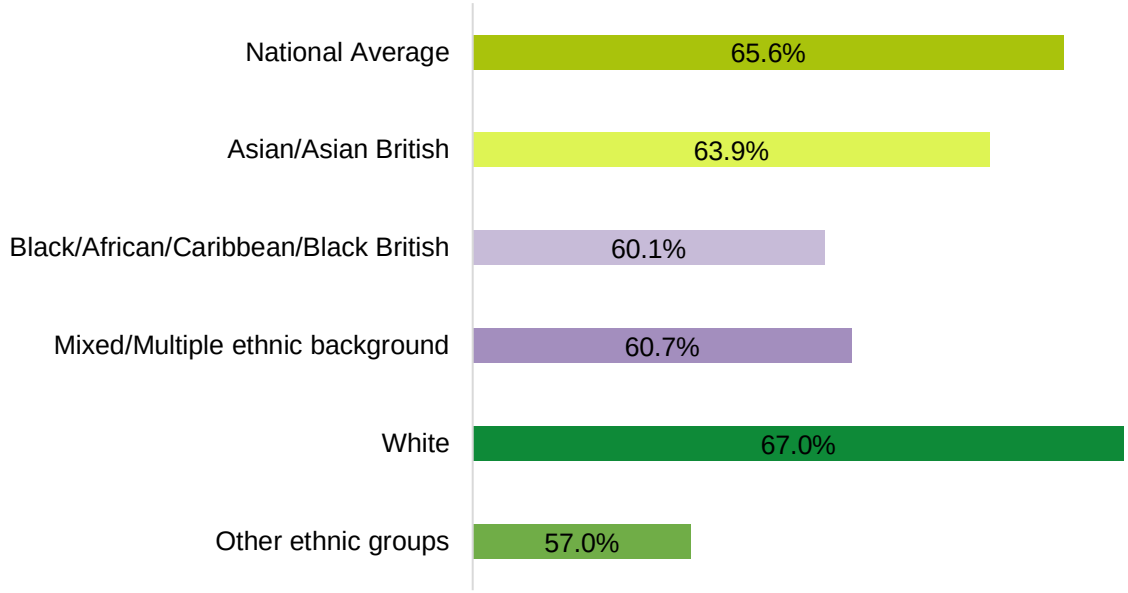


Figure 4. Q18f by ethnicity

H. FTSU Index by Gender

We reviewed the FTSU Index by gender.

Data from 2016 to 2020 showed females responding to the NHS Staff Survey had a more positive FTSU Index than males, those who prefer to self-describe or to not state their gender.

The disparity between females and males was 2.9 percentage points in 2016 and has lowered to 2.5 percentage points in 2020.

The FTSU Index for respondents who prefer to self-describe their gender has fallen since 2018, from 74.4 per cent to 72.5 per cent. However, it remains 6.1 percentage points higher than the FTSU Index for respondents who preferred not to state their gender.

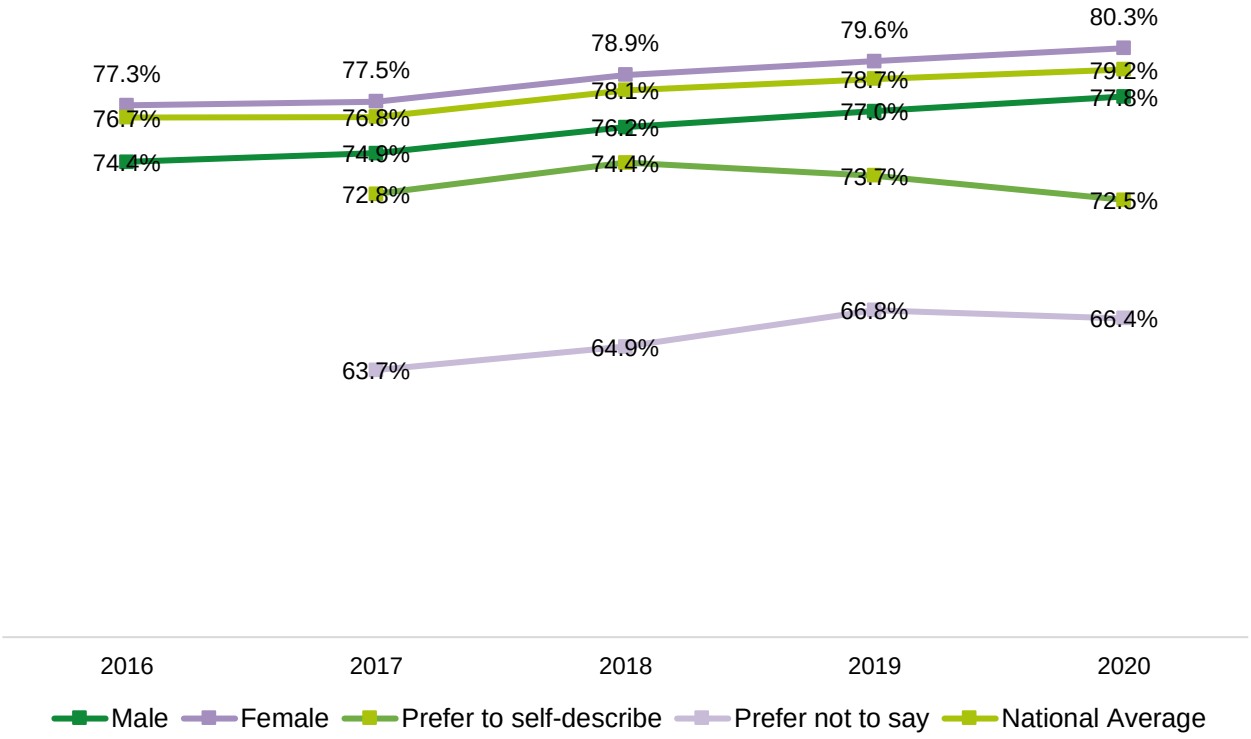


Figure 5. FTSU Index by gender

I. 18f by Gender

The variation by gender was much less pronounced between males and females for Q18f than the FTSU Index in the 2020 NHS Staff Survey. The result for female respondents was 0.3 percentage points higher than male respondents.

Results were lower again for those who prefer to self-describe or to not state their gender. There was a wider disparity between these two groups and the male and female respondents than the disparity shown in the FTSU Index.

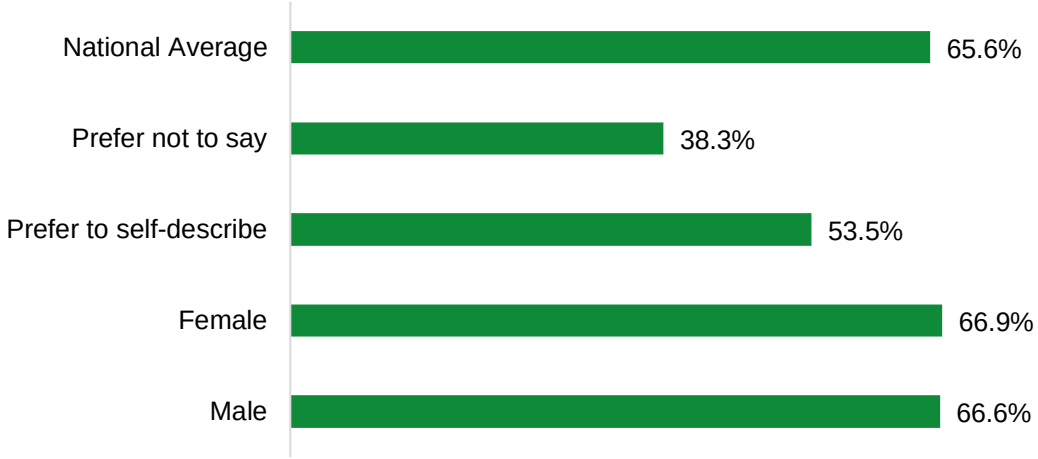


Figure 6. Q18f by gender

Conclusions and next steps

Overall, performance in the FTSU Index has improved. However, the disparity between the highest and lowest performing trusts has increased. By and large, the trusts towards the top and bottom of the index have remained the same, suggesting a lack of upward mobility with regards to staff perceptions of aspects of their speaking up culture.

Freedom to Speak Up Index

Freedom to Speak Up is about more than the ability to raise concerns about patient safety. It is about being able to speak up about anything which gets in the way of doing a great job, whether that's an idea for improvement, or ways of working, or behaviour. Therefore, we welcome the new, broader question in the 2020 NHS Staff Survey, which asked respondents if they feel safe to speak up about anything that concerns them in their organisation.

We are looking in more depth into the details of the responses to this question.

We invite all organisations to consider using this question, which is not clinically focused and is applicable to a wider range of organisations, as an additional measure of their speaking up culture.

Personal characteristics

We will be publishing a further report this year (2021/22) on the potential impact of personal characteristics on speaking up, with further analysis of results from the 2020 NHS Staff Survey and the 2020 FTSU Guardian Survey.

Speaking up review of ambulance trusts

The FTSU Index suggests a positive speaking up culture is associated with higher performing organisations as rated by the CQC. This correlation is less apparent with ambulance trusts which tend to perform less well in the index despite most of them receiving 'good' ratings by the CQC.

In the 2020 FTSU Index report, we committed to working with ambulance trusts and others to shed light on why ambulance trusts tend to score less well in the index. We said we would also be working with ambulance trusts and partners to develop a better understanding of the relationship between the FTSU Index and CQC ratings.

We will commence this work in Q2 2021/22.

Case Studies

We asked some of the Freedom to Speak Up Guardians whose organisations had seen the biggest improvements in their FTSU Index from the 2019 to 2020 NHS Staff surveys to share the work they have been doing to improve their FTSU Index and speaking up culture.

Isle of Wight NHS Trust

Leisa Gardiner of the Isle of Wight NHS Trust provided a case study of the trust's recent performance in the FTSU Index.

The Isle of Wight NHS Trust is the only integrated acute, community, mental health and ambulance health care provider in England.

Our latest NHS Staff Survey results show that workers feel there has been a significant improvement in the quality of care, safety, and the health and wellbeing support on offer to all staff. Morale and engagement have improved with more people recommending the Trust as a place to work. Importantly we have also seen improvements across all four divisions in the safety culture.

There has been a real focus on creating an open and honest culture where communication is free flowing. Our aim is that everyone has an equal opportunity to speak up, no one is treated differently or discriminated against, that workers feel safe to speak up and action is taken. This has led to workers feeling valued and supported. This has been a real IOW NHS Team effort.

The past 12 months have proved challenging, coping with a pandemic, but by ensuring workers know how and where to raise concerns and that they are appropriately supported has led to deeper engagement.

During October's Speak Up Month, I hosted Microsoft Teams sessions for workers focusing on the importance of speaking up and patient safety. I felt this was crucial at that time due to the pandemic as workers naturally were concerned about patient safety and their working environment. Sessions included understanding how Freedom to Speak Up can influence an open and inclusive culture, psychological safety at work, and 'silence isn't safe' – involving our people to inspire an open, honest and just culture.

I also joined the Health and Wellbeing Group and worked closely with the team to ensure we were doing everything we could to support workers during these challenging times.

As a Freedom to Speak Up Guardian, being visible and available to workers and to listen to them when they speak up is key. I ensure I attend staff meetings including the junior doctors' forum where I get an opportunity to listen and offer support where needed. I also recorded a video about how to raise a concern for workers and this is also shared at staff induction.

Maggie Oldham, Chief Executive at Isle of Wight NHS Trust, said:

“Supporting our people to deliver high quality, compassionate care is a key part of our culture here.

“We are proactive, open and honest and this approach ensures that people can speak up when something isn’t right.

“It is so important that we create an environment where people are confident to question things because it helps us to learn and improve and in the end that is what delivers better care for our community.”

East Midlands Ambulance Service

East Midlands Ambulance Service provided a case study to the NGO following their 5.0 percentage point improvement in the FTSU Index.

In the 2018 FTSU Index Report, East Midlands Ambulance Service (EMAS) had the dubious honour of being the worst performing Trust with an FTSU Index of only 68.2 per cent.

We knew from our NHS Staff Opinion Survey results and internal cultural audits that we had issues with our culture.

Some staff told us that they were fearful of reporting incidents and speaking up as they did not believe that they would be treated fairly. They also did not feel that action would be taken as a result. This perception of our workers was reflected in our low rates of Freedom to Speak Up referrals and the high proportion that spoke up anonymously.

Although our FTSU Index increased to 71.9 per cent in the 2019 Report, placing us in the top 10 most improved Trusts, we still remained second from bottom of all Trusts.

We knew that this needed to be urgently addressed. We have been working hard to create a just and learning culture for all our workers, putting our Trust Values of Respect, Integrity, Contribution, Teamwork and Competence into practice.

In 2020, we launched a new five-year Quality Improvement Strategy which in conjunction with our People and Organisational Development Strategy and Communications Strategy was aimed at improving our culture, making EMAS a place where people are proud to work.

In addition to recruiting a new Freedom to Speak Up Guardian and launching a Freedom to Speak Up Online Training module, we have introduced several initiatives to help support this.

Conversation Café

Pre-pandemic, the Chief Executive and executive team, along with department leads, visited various sites across our region on the “Café bus” with tea, coffee and biscuits to meet workers. The cafés are an informal opportunity for people to speak openly about concerns or issues that affect their working environment.

Once the pandemic began, the cafés changed to virtual meetings using a Facebook Live platform and allowed more people to attend. Workers are encouraged to ask anything they wish. Questions are answered live in the sessions where possible or responses are included in our weekly bulletin if not.

Learning from Events

The Clinical and Quality Directorate facilitate 45 minute fortnightly sessions via Microsoft Teams that all staff and volunteers can join. Cases are presented to share learning from when things go well as well as when they have gone wrong. Workers involved in the cases are supported to take part if they wish and the focus is very much on learning and supporting excellence in practice. A panel of subject matter experts are available, and questions are encouraged.

We continue to support a just culture where we will learn from incidents and concerns, supporting our journey towards a Care Quality Commission rating of ‘outstanding’.

We still have a long way to go but we are proud of just how far we have come.

It was a friend and colleague that signposted me to FTSU and I would highly recommend the same to another colleague.

- Worker feedback

South Tees NHS Foundation Trust

At South Tees NHS Foundation Trust, we have some of the most talented and experienced workers in the country, but they haven’t always been listened to when it comes to the way services should be organised.

This was something the Care Quality Commission told us in 2019 that we needed to fix. Since then, we’ve been on a journey to get back to our best.

Following a report by Freedom to Speak Up Guardians in June 2020, the Trust has embarked on developing a new model. The guardians’ report suggested that Freedom to Speak Up Guardians who were expected to undertake other more senior roles may seem less approachable to workers and that a team of guardians recruited from all levels of the Trust with a variety of backgrounds would be better able to meet the needs of workers.

This new model has seen a shift in both the way Freedom to Speak Up is implemented and the views of the 9,000 workers the guardians are supporting. The Board members, from Chair down, have been proactive in ensuring the Freedom to Speak Up service was strengthened, and that guardians had access to senior people whenever they needed.

To achieve the aim of having a truly representative team, following an open selection process, a team of four Freedom to Speak Up Guardians working on a part time basis were appointed in September 2020, giving 75 hours of protected time for the role. This was felt to be essential if the Trust and the team were to meet their objectives.

The team's first priority was to raise the profile of Freedom to Speak Up across the whole of the Trust and its satellite sites, to inform all workers about the role and how to access the confidential and impartial service on offer.

To achieve this, the team engaged in a number of strategies, including personal visits to all Trust sites, marketing materials, attending training and meetings and forging links with Union representatives, Equality and Diversity and Chaplaincy groups. The team have also been working with the Trust's Leadership and Quality team to embed compassionate leadership throughout the organisation and supporting our managers to be better leaders.

Other successes in the first six months have included:

- A new Freedom to Speak Up Policy for the Trust.
- Developing a robust communications strategy.
- Having Freedom to Speak Up training included as part of mandatory training for all staff based on the National Guardian's Office training for workers and for middle managers.
- A network of 17 Freedom to Speak Up Champions to support the work of the guardians, with ring-fenced time for Champions to train and get regular updates.
- Setting up a secure reporting system for staff with multiple avenues to access the service.

Over the last six months, verbal and written feedback has shown that workers feel secure in speaking up and are confident that we will deal with their concerns in an impartial and fair way whilst respecting their confidentiality at all steps of the process.

I have been impressed with the process and how I have been dealt with since raising my concerns. I am hopeful that there will be significant changes in my place of work, going forward from this. I am glad I spoke to Guardians and would be willing to do so again

- Worker feedback

Annex 1

FTSU Index including CQC Overall and Well Led Ratings[12]

The Care Quality Commission (CQC) regulates and inspects many of the organisations where FTSU Guardians support workers to speak up and challenge barriers to speaking up.

There are four ratings the CQC give health and social care services they regulate and inspect: outstanding, good, requires improvement and inadequate.

Outstanding	
Good	
Requires improvement	
Inadequate	

FTSU Index	Q18f	Trust Name	CQC Overall	Well Led
87.6%	77.9%	Cambridgeshire Community Services NHS Trust		
87.0%	76.4%	Kent Community Health NHS Foundation Trust		
86.9%	78.3%	Solent NHS Trust		
85.9%	70.4%	Hounslow and Richmond Community Healthcare NHS Trust		
85.5%	74.3%	Lincolnshire Community Health Services NHS Trust		
85.5%	75.8%	Northamptonshire Healthcare NHS Foundation Trust		
85.0%	76.9%	Hertfordshire Community NHS Trust		
84.9%	72.1%	Leeds Community Healthcare NHS Trust		
84.9%	74.5%	Sussex Community NHS Foundation Trust		
84.7%	73.3%	Liverpool Heart and Chest Hospital NHS Foundation Trust		
84.6%	75.1%	Isle of Wight NHS Trust (ambulance sector)		
84.6%	75.0%	Derbyshire Community Health Services NHS Foundation Trust		
84.3%	74.7%	Berkshire Healthcare NHS Foundation Trust		
84.2%	69.6%	Wirral Community Health and Care NHS Foundation Trust		
84.2%	74.7%	Norfolk Community Health and Care NHS Trust		
84.1%	72.9%	The Clatterbridge Cancer Centre NHS Foundation Trust		
83.7%	68.4%	Central London Community Healthcare NHS Trust		

[12] Ratings correct as of 4 May 2021

FTSU Index	Q18f	Trust Name	CQC Overall	Well Led
83.7%	70.6%	Royal Surrey County Hospital NHS Foundation Trust		
83.6%	74.1%	Midlands Partnership NHS Foundation Trust		
83.4%	71.6%	Hertfordshire Partnership University NHS Foundation Trust		
83.2%	72.2%	Surrey and Borders Partnership NHS Foundation Trust		
83.1%	74.2%	The Walton Centre NHS Foundation Trust		
83.1%	71.6%	The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust[13]		
83.1%	70.3%	The Royal Marsden NHS Foundation Trust		
83.1%	73.6%	Oxford Health NHS Foundation Trust		
83.0%	71.5%	Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust		
82.9%	72.3%	Mersey Care NHS Foundation Trust		
82.9%	70.9%	Isle of Wight NHS Trust (mental health sector)		
82.9%	72.8%	North Staffordshire Combined Healthcare NHS Trust		
82.8%	77.6%	Northumbria Healthcare NHS Foundation Trust		
82.7%	73.1%	Somerset NHS Foundation Trust		
82.7%	68.1%	Bridgewater Community Healthcare NHS Foundation Trust		
82.7%	71.0%	Southern Health NHS Foundation Trust		
82.7%	68.8%	Herefordshire and Worcestershire Health and Care NHS Trust		
82.6%	71.3%	Northern Devon Healthcare NHS Trust		
82.5%	68.3%	Gloucestershire Health and Care NHS Foundation Trust		
82.4%	72.9%	Lincolnshire Partnership NHS Foundation Trust		
82.3%	74.9%	St Helens and Knowsley Teaching Hospitals NHS Trust		
82.3%	72.8%	Surrey and Sussex Healthcare NHS Trust		
82.3%	65.8%	Royal Brompton and Harefield NHS Foundation Trust[14]		
82.3%	71.1%	Yeovil District Hospital NHS Foundation Trust		
82.3%	73.9%	Guy's and St Thomas' NHS Foundation Trust		
82.3%	70.9%	Cambridgeshire and Peterborough NHS Foundation Trust		
82.2%	71.5%	Sherwood Forest Hospitals NHS Foundation Trust		
82.2%	72.3%	The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust		
82.1%	68.2%	Royal Papworth Hospital NHS Foundation Trust		
82.1%	69.5%	Cambridge University Hospitals NHS Foundation Trust		

[13] Merged in October 2020 to form University Hospitals Dorset NHS Foundation Trust
[14] Merged in February 2021 to form Guy's and St Thomas's NHS Foundation Trust

FTSU Index	Q18f	Trust Name	CQC Overall	Well Led
82.0%	73.4%	Dorset Healthcare University NHS Foundation Trust		
81.9%	73.2%	Derbyshire Healthcare NHS Foundation Trust		
81.9%	69.8%	North West Boroughs Healthcare NHS Foundation Trust		
81.8%	70.0%	Shropshire Community Health NHS Trust		
81.8%	72.1%	Queen Victoria Hospital NHS Foundation Trust		
81.8%	72.8%	Airedale NHS Foundation Trust		
81.7%	71.3%	Alder Hey Children's NHS Foundation Trust		
81.6%	70.8%	Cheshire and Wirral Partnership NHS Foundation Trust		
81.6%	68.3%	North East London NHS Foundation Trust		
81.6%	68.2%	Portsmouth Hospitals University NHS Trust		
81.5%	70.9%	South Warwickshire NHS Foundation Trust		
81.5%	69.8%	Rotherham Doncaster and South Humber NHS Foundation Trust		
81.4%	66.4%	Gateshead Health NHS Foundation Trust		
81.3%	71.7%	Mid Cheshire Hospitals NHS Foundation Trust		
81.3%	66.7%	Devon Partnership NHS Trust		
81.2%	68.0%	Bolton NHS Foundation Trust		
81.2%	66.4%	North Tees and Hartlepool NHS Foundation Trust		
81.1%	67.0%	Isle of Wight NHS Trust (community sector)		
81.1%	70.3%	Sheffield Children's NHS Foundation Trust		
81.1%	65.1%	Central and North West London NHS Foundation Trust		
81.1%	67.8%	Bradford District Care NHS Foundation Trust		
81.0%	70.9%	Royal Berkshire NHS Foundation Trust		
81.0%	75.4%	Chesterfield Royal Hospital NHS Foundation Trust		
81.0%	68.0%	Royal National Orthopaedic Hospital NHS Trust		
81.0%	72.4%	The Christie NHS Foundation Trust		
80.9%	71.3%	University Hospital Southampton NHS Foundation Trust		
80.9%	66.9%	Coventry and Warwickshire Partnership NHS Trust		
80.9%	68.4%	Birmingham Women's and Children's NHS Foundation Trust		
80.8%	69.1%	East Lancashire Hospitals NHS Trust		
80.8%	67.1%	Oxleas NHS Foundation Trust		
80.8%	70.1%	Sussex Partnership NHS Foundation Trust		
80.8%	68.2%	University College London Hospitals NHS Foundation Trust		
80.8%	72.5%	Leeds and York Partnership NHS Foundation Trust		
80.7%	66.9%	Frimley Health NHS Foundation Trust		
80.5%	66.1%	Camden and Islington NHS Foundation Trust		
80.5%	68.0%	Great Ormond Street Hospital for Children NHS Foundation Trust		

FTSU Index	Q18f	Trust Name	CQC Overall	Well Led
80.5%	63.4%	Birmingham Community Healthcare NHS Foundation Trust		
80.4%	69.6%	University Hospitals Bristol and Weston NHS Foundation Trust		
80.4%	69.3%	Warrington and Halton Teaching Hospitals NHS Foundation Trust		
80.4%	68.0%	Leicestershire Partnership NHS Trust		
80.3%	67.1%	Ashford and St Peter's Hospitals NHS Foundation Trust		
80.3%	68.2%	Oxford University Hospitals NHS Foundation Trust		
80.3%	64.3%	Moorfields Eye Hospital NHS Foundation Trust		
80.3%	70.1%	Poole Hospital NHS Foundation Trust[15]		
80.2%	65.4%	Cornwall Partnership NHS Foundation Trust		
80.2%	67.1%	Humber Teaching NHS Foundation Trust		
80.2%	68.7%	The Newcastle upon Tyne Hospitals NHS Foundation Trust		
80.2%	69.4%	Pennine Care NHS Foundation Trust		
80.2%	66.5%	East London NHS Foundation Trust		
80.2%	70.7%	Tees, Esk and Wear Valleys NHS Foundation Trust		
80.1%	69.4%	Leeds Teaching Hospitals NHS Trust		
80.0%	64.1%	South Tyneside and Sunderland NHS Foundation Trust		
80.0%	61.7%	County Durham and Darlington NHS Foundation Trust		
80.0%	66.9%	East Sussex Healthcare NHS Trust		
79.9%	68.5%	Nottinghamshire Healthcare NHS Foundation Trust		
79.9%	68.2%	Nottingham University Hospitals NHS Trust		
79.9%	66.7%	Essex Partnership University NHS Foundation Trust		
79.9%	71.1%	Barnsley Hospital NHS Foundation Trust		
79.8%	66.5%	Kent and Medway NHS and Social Care Partnership Trust		
79.8%	61.8%	Isle of Wight NHS Trust (acute sector)		
79.8%	67.2%	South West Yorkshire Partnership NHS Foundation Trust		
79.8%	68.2%	Salisbury NHS Foundation Trust		
79.7%	66.8%	Blackpool Teaching Hospitals NHS Foundation Trust		
79.7%	64.3%	West London NHS Trust		
79.7%	66.2%	Hampshire Hospitals NHS Foundation Trust		
79.7%	69.3%	Milton Keynes University Hospital NHS Foundation Trust		

[15] Merged in October 2020 to form University Hospitals Dorset NHS Foundation Trust

FTSU Index	Q18f	Trust Name	CQC Overall	Well Led
79.7%	68.5%	Sheffield Teaching Hospitals NHS Foundation Trust		
79.7%	67.0%	Buckinghamshire Healthcare NHS Trust		
79.7%	67.0%	Kingston Hospital NHS Foundation Trust		
79.7%	68.6%	Royal Devon and Exeter NHS Foundation Trust		
79.6%	65.1%	Great Western Hospitals NHS Foundation Trust		
79.6%	62.3%	University Hospitals Coventry and Warwickshire NHS Trust		
79.5%	60.3%	Homerton University Hospital NHS Foundation Trust		
79.5%	67.3%	Wye Valley NHS Trust		
79.4%	66.4%	Calderdale and Huddersfield NHS Foundation Trust		
79.4%	63.7%	Chelsea and Westminster Hospital NHS Foundation Trust		
79.4%	64.4%	Countess of Chester Hospital NHS Foundation Trust		
79.4%	67.0%	Greater Manchester Mental Health NHS Foundation Trust		
79.3%	64.1%	Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust		
79.3%	64.6%	Black Country Healthcare NHS Foundation Trust		
79.2%	62.9%	Royal Cornwall Hospitals NHS Trust		
79.2%	66.7%	University Hospitals Plymouth NHS Trust		
79.2%	67.5%	Lancashire Teaching Hospitals NHS Foundation Trust		
79.2%	65.9%	Dorset County Hospital NHS Foundation Trust		
79.1%	66.7%	The Royal Orthopaedic Hospital NHS Foundation Trust		
79.1%	65.9%	Hull University Teaching Hospitals NHS Trust		
79.1%	63.5%	Kettering General Hospital NHS Foundation Trust		
79.1%	68.2%	Western Sussex Hospitals NHS Foundation Trust		
79.0%	65.4%	Bradford Teaching Hospitals NHS Foundation Trust		
79.0%	68.2%	Maidstone and Tunbridge Wells NHS Trust		
78.9%	67.2%	Lancashire and South Cumbria NHS Foundation Trust		
78.9%	67.9%	The Rotherham NHS Foundation Trust		
78.9%	67.7%	Royal United Hospitals Bath NHS Foundation Trust		
78.8%	68.1%	Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust		
78.8%	65.0%	Avon and Wiltshire Mental Health Partnership NHS Trust		
78.8%	68.6%	Salford Royal NHS Foundation Trust		
78.7%	65.3%	Torbay and South Devon NHS Foundation Trust		
78.6%	65.0%	Worcestershire Acute Hospitals NHS Trust		

FTSU Index	Q18f	Trust Name	CQC Overall	Well Led
78.5%	67.6%	North Bristol NHS Trust		
78.4%	70.0%	The Royal Wolverhampton NHS Trust		
78.4%	62.2%	The Mid Yorkshire Hospitals NHS Trust		
78.4%	62.9%	Gloucestershire Hospitals NHS Foundation Trust		
78.4%	61.6%	Harrogate and District NHS Foundation Trust		
78.3%	63.6%	Manchester University NHS Foundation Trust		
78.3%	60.4%	South London and Maudsley NHS Foundation Trust		
78.2%	62.3%	Tameside and Glossop Integrated Care NHS Foundation Trust		
78.2%	62.9%	Stockport NHS Foundation Trust		
78.0%	61.7%	Birmingham and Solihull Mental Health NHS Foundation Trust		
78.0%	63.8%	Brighton and Sussex University Hospitals NHS Trust		
78.0%	64.4%	Dartford and Gravesham NHS Trust		
78.0%	64.8%	East Cheshire NHS Trust		
78.0%	59.0%	George Eliot Hospital NHS Trust		
77.9%	60.1%	Sandwell and West Birmingham Hospitals NHS Trust		
77.9%	64.4%	South Central Ambulance Service NHS Foundation Trust		
77.9%	63.8%	South Tees Hospitals NHS Foundation Trust		
77.8%	61.1%	Epsom and St Helier University Hospitals NHS Trust		
77.8%	63.9%	South West London and St George's Mental Health NHS Trust		
77.8%	66.7%	Liverpool Women's NHS Foundation Trust		
77.8%	63.9%	University Hospitals of Leicester NHS Trust		
77.7%	60.1%	Whittington Health NHS Trust		
77.7%	59.8%	The Dudley Group NHS Foundation Trust		
77.7%	65.4%	University Hospitals of Derby and Burton NHS Foundation Trust		
77.6%	60.8%	Norfolk and Norwich University Hospitals NHS Foundation Trust		
77.5%	61.8%	Imperial College Healthcare NHS Trust		
77.4%	59.0%	Lewisham and Greenwich NHS Trust		
77.4%	63.3%	West Suffolk NHS Foundation Trust		
77.4%	61.7%	Bedfordshire Hospitals NHS Foundation Trust		
77.4%	62.0%	North West Anglia NHS Foundation Trust		
77.3%	61.3%	Royal Free London NHS Foundation Trust		
77.3%	62.1%	Northampton General Hospital NHS Trust		
77.3%	61.7%	Pennine Acute Hospitals NHS Trust		
77.2%	59.0%	Barnet, Enfield and Haringey Mental Health NHS Trust		
77.2%	63.1%	York Teaching Hospital NHS Foundation Trust		

FTSU Index	Q18f	Trust Name	CQC Overall	Well Led
77.0%	61.6%	Southport and Ormskirk Hospital NHS Trust		
76.9%	60.8%	East Midlands Ambulance Service NHS Trust		
76.8%	63.6%	University Hospitals of North Midlands NHS Trust		
76.8%	65.0%	Liverpool University Hospitals NHS Foundation Trust		
76.7%	61.7%	University Hospitals of Morecambe Bay NHS Foundation Trust		
76.7%	60.3%	Tavistock and Portman NHS Foundation Trust		
76.7%	56.3%	London Ambulance Service NHS Trust		
76.6%	59.3%	Croydon Health Services NHS Trust		
76.6%	60.8%	East Suffolk and North Essex NHS Foundation Trust		
76.5%	55.5%	London North West University Healthcare NHS Trust		
76.5%	61.5%	James Paget University Hospitals NHS Foundation Trust		
76.3%	57.6%	Mid and South Essex NHS Foundation Trust		
76.2%	59.1%	The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust		
76.1%	59.2%	West Hertfordshire Hospitals NHS Trust		
76.1%	61.3%	St George's University Hospitals NHS Foundation Trust		
76.0%	62.3%	South Western Ambulance Service NHS Foundation Trust		
75.9%	59.3%	Barts Health NHS Trust		
75.9%	61.3%	University Hospitals Birmingham NHS Foundation Trust		
75.9%	59.1%	West Midlands Ambulance Service University NHS Foundation Trust		
75.7%	60.5%	Wirral University Teaching Hospital NHS Foundation Trust		
75.7%	59.7%	Norfolk and Suffolk NHS Foundation Trust		
75.4%	58.7%	Northern Lincolnshire and Goole NHS Foundation Trust		
75.4%	57.4%	North Cumbria Integrated Care NHS Foundation Trust		
75.3%	57.6%	North East Ambulance Service NHS Foundation Trust		
75.3%	58.8%	Yorkshire Ambulance Service NHS Trust		
75.1%	56.1%	Medway NHS Foundation Trust		
75.1%	60.7%	East and North Hertfordshire NHS Trust		
75.0%	59.6%	Sheffield Health and Social Care NHS Foundation Trust		
74.9%	57.7%	South East Coast Ambulance Service NHS Foundation Trust		
74.8%	56.4%	King's College Hospital NHS Foundation Trust		

FTSU Index	Q18f	Trust Name	CQC Overall	Well Led
74.8%	55.8%	North Middlesex University Hospital NHS Trust		
74.6%	56.2%	The Princess Alexandra Hospital NHS Trust		
74.4%	55.3%	East Kent Hospitals University NHS Foundation Trust		
74.4%	59.0%	Walsall Healthcare NHS Trust		
74.3%	54.4%	Barking, Havering and Redbridge University Hospitals NHS Trust		
74.2%	58.3%	North West Ambulance Service NHS Trust		
73.8%	53.6%	The Hillingdon Hospitals NHS Foundation Trust		
73.6%	54.3%	United Lincolnshire Hospitals NHS Trust		
71.9%	53.4%	The Shrewsbury and Telford Hospital NHS Trust		
66.6%	43.7%	East of England Ambulance Service NHS Trust		

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/21/09/144**	
SUBJECT:	**Guardian of Safe Working for Junior Doctors Combined report for Q1 2021-22**	
DATE OF MEETING:	29th September 2021	
AUTHOR(S):	Mark Tighe, Guardian of Safe Working	
EXECUTIVE DIRECTOR SPONSOR:	Alex Crowe, Executive Medical Director	
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	SO1 We will.. Always put our patients first delivering safe and effective care and an excellent patient experience. SO2 We will.. Be the best place to work with a diverse and engaged workforce that is fit for now and the future SO3 We will ..Work in partnership with others to achieve social and economic wellbeing in our communities.	x
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): **(*Please DELETE as appropriate)***	**#115** Failure to provide adequate staffing levels in some specialities and wards. Caused by inability to fill vacancies, sickness. Resulting in pressure on ward staff, potential impact on patient care and impact on Trust access and financial targets. **#1108** Failure to maintain staffing levels, caused by high sickness and absence, including those affected by COVID-19, those who are extremely vulnerable, those who are assessed as only able to work on a green pathway, resulting in inability to fill midwifery shifts. This also currently affects the CBU management team.	
EXECUTIVE SUMMARY ***(KEY ISSUES):***	The 2016 Junior Doctor Contract is fully established at WHH for all Foundation Doctors and most of the CT/ST grades. The monitoring of the safe implementation of the contract is the responsibility of the Medical Education Department/Guardian of Safe Working (GSW). Issues regarding safe working hours, rota problems, educational or patient safety issues are recorded by Junior Doctors in the form of Exception Reporting via the Allocate System, which are then escalated to their responsible Educational Supervisors and monitored by the GSW. During Quarter 1 2021-22 (April – June 2021), 62 Exception Reports (ERs) were submitted – this represents a 20% rise compared to Q4 which is a reflection on the busier workload for the junior doctors this year. – Over 95% of ERs relate to excess hours worked. – Only one ER was submitted because of missed educational opportunities. – One Immediate Safety Concern was reported by a medical F1 due to a perceived lack of cover while on call. Since the last report, assurances can be provided that, rotas remain compliant, and the majority of Junior Doctors are accepting of their allocations.	

	This is the last report from the current Guardian of Safe Working Hours, who is stepping down after 5 years in post. Ms Frances Oldfield will take over this appointment from October 2021.			
PURPOSE: ***(please select as appropriate)***	Information ✓	Approval	To note	Decision
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. Any concerns that the Committee have should be reported back to the Guardian of Safe Working for his attention, consideration and actions accordingly.			
PREVIOUSLY CONSIDERED BY:	**Committee**	Strategic People Committee		
	Agenda Ref.	**SPC/21/09/81**		
	Date of meeting	22nd September 2021		
	Summary of Outcome	Noted		
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None			

REPORT TO BOARD OF DIRECTORS

SUBJECT	Guardian of Safe Working for Junior Doctors Quarterly Report – Quarter 1 2021-22 (1st April – 30th June 2021)	**AGENDA REF:**	**BM/21/09/144**

1. BACKGROUND/CONTEXT

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

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

It is important to remember that most of the Junior Doctors (employed by the Lead Employer) have now transitioned onto the new 2016 Contracts. However, some will retain the 2002 pay protection until the end of their Training Contract.

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

2. KEY ELEMENTS

During Quarter 1 2021-22 (April - June 2021), 62 Exception Reports were submitted, which is a high number for Spring/Summer Quarter. This reflects the high acuity and turnover of patients during this period in unplanned care.

The majority of the ERs relate to Foundation Doctors working past their allocated time (>95%), usually on an ad-hoc basis. There were more in surgical specialties (50%) than medicine, and this is likely due to the fluctuating nature of the workload. Only one ER related to missed educational opportunities, which is encouraging. There was one immediate safety concern, (ISC) submitted in this quarter, and the doctor has not reported any subsequent issues.

Looking for themes, persistent ER submission has occurred in respiratory (A7) due to some under-staffing, which has been addressed with the lead consultants and rota managers. In addition, the out of hours orthopaedic on-call appears particularly onerous for the F1 and F2 grade, especially on Saturdays, where there have been several ERs. Discussion with the CBU

clinical lead and CBU managers are ongoing. A potential issue in elderly medicine (A9) has also been raised recently and requires further investigation.

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

Historically, there have been significant delays in the review meetings between the ES and Junior Doctor, once an ER has been submitted. At the end of Q1, there were 29 ERs outstanding (down from 56 and 32 in the last two quarters). However, after prompting from the Guardian and Medical Trainees Workforce Administrator, there are now only 12 outstanding (at time of writing). Junior Doctors are now receiving an email reminder to have their ER signed off within 2 weeks, if they want to receive compensatory payment or time off in lieu (TOIL). Any difficulties with the sign-off process are be escalated to the Medical Education Service and / or the Guardian of Safe Working.

Exception Reports (ER) over past quarter	
Reference period of report	01/04/21 - 30/06/21
Total number of exception reports received	62
Number relating to immediate patient safety issues	1
Number relating to hours of working	60
Number relating to pattern of work	0
Number relating to educational opportunities	1
Number relating to service support available to the doctor	1

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

ER outcomes: resolutions	
Total number of exceptions where TOIL was granted	7
Total number of overtime payments	22
Total number of work schedule reviews	0
Total number of reports resulting in no action	2
Total number of organisation changes	0
Compensation	0
Unresolved	29
Total number of resolutions	**31**
Total resolved exceptions	**32**

Note :

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

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

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

Reasons for ER over last quarter by specialty & grade

ER relating to:	Specialty	Grade	No. ERs carried over from last report	No. ERs raised	No. ERs closed	No. ERs outstanding
Immediate	Diabetes & endocrinology	CT1	0	1	0	0
Total			**0**	**1**	**0**	**0**
No. relating to hours/pattern	Acute Medicine	FY1	2	9	9	1
	Diabetes & endocrinology	FY1	1	0	1	0
	Gastroenterology	FY1	0	2	0	2
	General surgery	FY1	0	30	15	12
	Geriatric medicine	FY1	3	4	2	3
	Obstetrics and gynaecology	ST2	0	3	0	0
	Otolaryngology (ENT)	FY2	2	0	2	0
	Paediatrics	ST1	0	1	0	1
	Respiratory Medicine	FY1	0	2	1	1
	Trauma & Orthopaedic Surgery	FY1	0	8	0	8
	Urology	FY1	0	1	1	0
Total			**8**	**60**	**31**	**28**
No. relating to educational opportunities	Acute Medicine	FY1	1	0	0	0
	Diabetes & endocrinology	FY1	1	0	1	0
	General surgery	FY1	0	1	0	1
Total			**2**	**1**	**1**	**1**
No. relating to	Diabetes & endocrinology	CT1	0	1	0	0
Total			**0**	**1**	**0**	**0**

Summary

- number of exception reports raised = 62
- number of work schedule reviews that have taken place = 0
- immediate safety concerns = 1
- fines that were levied by the Guardian = NIL

- The majority of ERs have been submitted by FY1 doctors (90%) reflecting the busy workload of medical trainees on the wards. Highest numbers have been reported from general surgery (50%) than medicine (25%). Although the general workload in medicine is considered higher, junior doctors encounter variable work patterns in the surgical specialties.

Over 95% of ERs relate to excess hours worked. Trainees comment that they stay late to complete ward duties or for review and management of sick inpatients, which they feel they cannot handover to the on-call teams. This is entirely understandable and predictable, although routine duties should not need to be done out of hours generally.

Only 1 ER was submitted as a missed educational opportunity.

An Immediate Safety Concern (ISC) was reported from a medical F1. The junior reported understaffing due to gaps on the on-call rota on an evening shift. This is currently being addressed, and further discussed at Junior Doctors' Forum.

Usually, compensation for extra work is usually allocated as time-off in lieu. However, over 75% of compensation in this quarter was taken as payment. This reflects the juniors coming to the end of their rotation and being unable to carry time-off over to next year (trend also seen in previous years).

3. ACTIONS REQUIRED/RESPONSIBLE OFFICER

The rotas at WHH are all compliant – the ophthalmology middle grade on-call rota was recently adjusted to account for increased weekend workload.

Adjustments may be needed in Trauma & Orthopaedics junior cover at weekends (update to be provided in next report).

A cluster of ERs have been filed from A9 (elderly medicine) ward. This was raised by the F1 rep at the recent Junior Doctors' Forum. There seems to be insufficient junior doctor cover during the day on the ward. This will be discussed with the Clinical Director for Integrated Medicine and Community and the triumvirate.

Longstanding issues with the delay in sign-off of Exception Reports has improved significantly in the last 6 months and we hope to see this continue.

The issue of Foundation Year 1 Doctors having adequate time off for mandatory training has been addressed and as with compliance rates for completion, this too has been evidenced in the ER's submitted. The Medical Trainees' Workforce Administrator has formulated a Standard Operating Procedure for completion of mandatory training, which has been disseminated to junior doctor representatives and CBU Rota Managers for comment.

No further issues have been raised related to break times in the Emergency Department (previously a fine was issued in 2019).

4. MEASUREMENTS/EVALUATIONS

Exception Report submitted by Lead Employer doctors – Q4 2020-21

Only 5 ERs were submitted by trainees with central contracts from the Lead Employer 2019/20. No significant events or issues related to these ERs

5. TRAJECTORIES/OBJECTIVES AGREED

1. Exception Reports should be completed as soon as possible and but no later than 14 days of the Exception being submitted through Allocate.
2. Where the trainee is seeking payment as compensation, the report should be submitted within 7 days.
3. For every Exception Report submitted, ether for payment or TOIL, it is the Educational Supervisor who is required to respond to the Exception Report within 7 days.
4. The Trainees need to indicate 'acceptance' or 'escalate to the next stage (Level 1 Review). It is only following confirmation of acceptance, that the Exception Report can be closed.
5. If an ER is not actioned within 7 days, the GSW will issue an email to expedite sign-off.

The GSW will be provided with timely data reports to support his role in the coming year, with particular 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 corporate responses to the issued raised by the Guardian of Safe Working and to provide relevant advice.

It is also considered 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:

- Q2 – (end of Sept 2021) – submitted November 2021
- Q3 - (end of Dec 2021) – submitted January 2022
- Q4 – (end of March 2022) – submitted May 2022
- Q1 – (end of June 2022) - submitted July 2022

This is the last report from the current Guardian of Safe Working Hours, who is stepping down after 5 years in post. Ms Frances Oldfield will take over this appointment from October 2021.

8. ASSURANCE COMMITTEE

N/A

9. RECOMMENDATIONS

This Report covers Q1 of the 2021-22 the financial year. 62 ERs were received during this quarter (average 20-25 per month, total 1035 since introduction of New Contract in October 2016). There was only one immediate safety concern raised in April 2021 within medicine but does not reflect a recurring concern. The work schedule review has been completed for Ophthalmology ST3+ trainees earlier this year. No fines were submitted by the Guardian in Q1.

To conclude, The Trust will continue to monitor all exception reports, to ensure any persistent issues in departments 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. Persistent issues are dealt with in a timely manner.

Please note the findings of the report and consider the assurances made accordingly. It is anticipated that the new Guardian of Safe Working Hours will be in post for the Q2 report.

To: Trust Board

CC: Chief Finance Officer and Deputy Chief Executive

From: Michelle Moss AFS

Date: 30/07/2021

Re: Bribery Act 2010 & Trust Anti-Bribery Strategy

1 Introduction and Background

1.1. The Bribery Act 2010, which came into force on 1st July 2011, reformed the criminal law of bribery making it easier to tackle this offence proactively in the public and private sectors. In additional to the main offences under Sections 1, 2 and 6 of the Act, which carry custodial sentences of up to 10 years and potentially unlimited fines, it introduced a corporate offence (under Section 7), exposing commercial organisations to criminal liability, punishable by an unlimited fine, for failing to prevent bribery.

1.2. Any organisation that is incorporated under the law in the United Kingdom falls under Section 7 of the Act, including NHS bodies such as CCGs, NHS trusts, foundation trusts, and special health authorities are all deemed to be relevant corporate bodies. Applicable organisations must ensure 'adequate preventative procedures' are in place for acts of bribery and corruption committed by 'persons associated' with them, in the course of their work, else the organisation will become liable.

1.3. 'Persons associated' can mean employees, temporary and agency personnel, contractors, agents, suppliers, partners and Joint Ventures, as well as other individuals or organisations (whether incorporated or not) that may provide a service.

1.4. For the purposes of the Bribery Act, a 'trade' or 'profession' is considered a business. This means that, whether individually or in partnership, GPs, pharmacists, dental practitioners, opticians, finance professionals etc will also be subject to, and personally liable under, the Bribery Act.

2 Definition

2.1. Bribery is generally defined as an inducement or reward offered, promised or provided to someone to perform their functions or activities improperly in order to

gain a personal, commercial, regulatory and/or contractual advantage, on behalf of oneself or another.

3 Risks of Non-Compliance

3.1. There are a number of risks entailed in breaching the Bribery Act. These include:

3.1.1. Criminal justice sanctions against directors, board members and other senior staff (under Section 14);

3.1.2. Damage to the organisation's reputation;

3.1.3. Conviction of bribery or corruption may lead to the organisation being precluded from future public procurement contracts. *[Under the Public Contracts Regulations 2006 (which gives effect to EU law in the UK), a company is automatically and perpetually debarred from competing for public contracts where it is convicted of a corruption offence. There are no current plans to amend the 2006 Regulations for this to include the crime of failure to prevent bribery. Organisations which are convicted of failing to prevent bribery are not automatically barred from participating in tenders for public contracts; however, there is discretion to exclude organisations convicted of this offence if it is deemed appropriate.]*

3.1.4. Potential diversion and/or loss of resources;

3.1.5. Unforeseen and unbudgeted costs of investigations and/or defence of any legal action;

3.1.6. Negative impact on patient/stakeholder perceptions.

4 Bribery Act Offences

4.1. In summary, there are 5 key offences under the Act:

4.1.1. **Section 1** - Offering, promising or giving a bribe to another person to perform a relevant 'function or activity' improperly, or to reward a person for the improper performance of such a function or activity.

4.1.2. **Section 2** - Requesting, agreeing to receive or accepting a bribe to perform a function or activity improperly, irrespective of whether the recipient of the bribe requests or receives it directly or through a third party, and irrespective of whether it is for the recipient's benefit.

4.1.3. **Section 6** - Bribing a foreign public official (probably of limited applicability to most NHS organisations/staff).

4.1.4. **Section 7** - Failure of a commercial organisation to prevent bribery (the corporate offence). This is a 'strict liability'* offence and an organisation can be found guilty of 'attempted' or 'actual' bribery on the organisation's behalf, even if the organisation and its officers were not aware of the bribery itself. It should be noted that a

corresponding Section 1 or Section 6 offence needs to be proven for a section 7 offence to apply.

** Strict liability offences do not require proof of intention or recklessness – in other words, it is not necessary for the prosecution to show that the organisation intended to make the bribe in bad faith, or that it was negligent as to whether any bribery activity took place.*

4.1.5. **Section 14** - where an offence under sections 1, 2 or 6 is committed with the consent or connivance of a 'senior officer' of an organisation, that person (as well as the organisation) is guilty of the offence and liable to be proceeded against and punished accordingly.

4.2. An organisation has a defence to the corporate offence if it can show that it had in place 'adequate procedures' as part of a cohesive and integrated corporate Anti-Bribery Strategy designed to prevent bribery by, or of, persons associated with the organisation.

5 Adequate Procedures

5.1. The Act is not prescriptive as to what constitutes 'adequate procedures', although both the Ministry of Justice (MoJ) and NHS Counter Fraud Authority have provided guidance as to what form these procedures might take, depending on the nature, size and type of organisation. Adequate procedures need to be applied proportionally, based on the level of risk of bribery across the organisation, and form part of an NHS body's overall governance arrangements.

5.2. Adequate procedures relate to relevant compliance protocols and transparent procedures and measures which an organisation can put in place to prevent bribery by individuals associated with it. These might include training, briefings or new internal controls and procedures. Whether the procedures are adequate will ultimately be a matter for the courts to decide on a case by case basis.

5.3. The MoJ suggests that an effective Anti-Bribery Strategy framework could be informed by six principles:

5.3.1. **Principle 1 – Proportionate Procedures.** An organisation's procedures to prevent bribery by persons associated with it are proportionate to the bribery risks it faces and to the nature, scale and complexity of the organisation's activities. They are also clear, practical, accessible, effectively implemented and enforced.

5.3.2. **Principle 2 – Top-Level Commitment.** The top-level management of an organisation (be it a board of directors, the owners or any other equivalent body or person) are committed to preventing bribery by persons associated with it. They foster a culture within the organisation in which bribery is never acceptable.

5.3.3. **Principle 3 – Risk Assessment.** The organisation assesses the nature and extent of its exposure to potential external and internal risks of bribery on its behalf by persons associated with it. The assessment is periodic, informed and documented.

5.3.4. **Principle 4 – Due Diligence.** The organisation applies due diligence procedures, taking a proportionate and risk based approach, in respect of persons who perform or will perform services for or on behalf of the organisation, in order to mitigate identified bribery risks.

5.3.5. **Principle 5 – Communication (inc. Training).** The organisation seeks to ensure that its bribery prevention policies and procedures are embedded and understood throughout the organisation via internal and external communication, including training, which is proportionate to the risks faced.

5.3.6. **Principle 6 – Monitoring & Review.** The organisation monitors and reviews procedures designed to prevent bribery by persons associated with it and makes improvements where necessary. It considers independent assessment and/or certification of its arrangements.

6 Existing Counter Measures & Action Required

6.1. Bribery should be seen as another business risk to the organisation and should be treated accordingly. It is the responsibility of everyone in the organisation playing their part to ensure both the likelihood of bribery occurring, and its adverse impact if it does, are kept to an absolute minimum. However, as with the counter fraud strategy, the implementation of an anti-bribery agenda backed by a zero tolerance culture should be driven from the very top of the organisation, at Board level.

6.2. MIAA's Internal Audit and Counter Fraud Services directly assist and support the Trust and its senior management with maintaining adequate procedures on an ongoing basis, primarily through existing IA and CF plans.

6.3. However, changes to the environment in which the Trust operates such as the introduction of new legislation and global pandemics, as well as organisational and operational changes for the Trust over time, can result in alterations to risk exposure. As a consequence, this brings the need for a more thorough review of the appropriateness of the anti-bribery measures in place.

6.4. The most significant change to the Trust's operating environment in recent times is the COVID-19 global pandemic, which has affected all organisations, and the NHS in particular. It is therefore timely for the Trust to reflect on whether changes in recent years, particularly the response to the COVID-19 pandemic, have had impact on the Trust 's bribery risks, such as procuring PPE from non-typical sources and restricted procurement processes.

6.5. An anti-bribery review has been conducted by MIAA, which was primarily structured around the MoJ's six principles, and also gave consideration to the Trust's response to the COVID-19 pandemic, to identify and evaluate any additional or increased bribery risks for the Trust.

6.6. The anti-bribery review resulted in a report on findings and an action plan, aimed to support the Trust to strengthen controls and arrangements around bribery, thereby improving the adequacy of procedures in place. The actions proposed are not exhaustive and should be subject to periodic review in light of experience, practice and any relevant developments, internally or externally.

6.7. A key step in this process is ensuring that the Anti-Bribery Strategy is driven from the very top of the organisation. To this end, it is requested that the Board note this paper, and continue to support the Trust's Top-Level Commitment with respect to adopting and applying bribery counter measures on an organisation-wide basis.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/21/09/146**	
SUBJECT:	**Digital Board update**	
DATE OF MEETING:	29th September 2021	
AUTHOR(S):	Tom Poulter, Chief Information Officer	
EXECUTIVE DIRECTOR SPONSOR:	Alex Crowe, Executive Medical Director	
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	SO1 We will.. Always put our patients first delivering safe and effective care and an excellent patient experience. SO2 We will.. Be the best place to work with a diverse and engaged workforce that is fit for now and the future SO3 We will ..Work in partnership with others to achieve social and economic wellbeing in our communities.	X
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): **(*Please DELETE as appropriate)***	**#1114** FAILURE TO provide essential and effective Digital Services CAUSED BY increasing demands upon resources (e.g. cyber defences), new technology skillsets (e.g. Cloud), unfit solutions (e.g. Maternity), end-of-life solutions (e.g. Telephony), poor performance (e.g. Lorenzo EPR)RESULTING in a potentially reduced quality of care, data quality, a potential failure to meet statutory obligations (e.g. Civil Contingency measures) and subsequent reputational damage.	
EXECUTIVE SUMMARY ***(KEY ISSUES):***	The Digital Board met on 13/09/2021, and minutes of the meeting are provided alongside this briefing paper. The following assurance status for key delivery areas was noted: - **Digital Programme**. **Good assurance**. Deployments in August included : Lorenzo Cloud Migration; ORMIS Cloud Migration; Amnity PHR Proof of Concept, CDC Deontics and WASP/NHS111. **Dedalus (formerly DXC) Vendor management**. **Moderate assurance**. The cloud migration of ORMIS and Lorenzo was completed successfully on 11th/12th September 2021. The planned outage was approximately two hours longer than expected and a root cause analysis and lessons learned review will be conducted. Some minor residual issues to be resolved but the migration was successful, allowing for tactical EPR contract issues to be progressed. **Information and business intelligence**. **Good assurance**. Statutory reporting remains a challenge due to frequent new and changing requirements from NHS Digital, CIPHA and other external agencies. A reduction in weekend reporting has been achieved via intervention with NHSE representatives reducing seven day working demand. The latest Corporate Information and BI deployments/developments included 10 items reported to Digital Board, summarised in this paper. - **IT services update.** **Moderate assurance**. During COVID we turned off the password reset function on the domain to support Agile working. We now need to turn the	

function back on as part of security measures. This will mean everyone will need to reset their password, over 4000 members of staff. We are working on a plan to implement the activity and address extra resource needed on the Service Desk with a target to complete this change in October 2021 (tbc).
To ensure we have full infrastructure protection against Cyber-attacks we are required to Patch all network switch equipment. A patching schedule to agree a programme of downtime that will minimise disruption to operational services and ensure we meet our Cyber compliancy is under development in consultation with CCIO.

- **Digital Compliance and Risk.**
  Good assurance. Routine monitoring showing continued good progress in managing risk of cyber-attacks.
- **Strategic Electronic Patient Record (including tactical solution).**
  Moderate assurance.
  The Outline Business Case for the strategic solution was approved at Trust Board in July 2021 and procurement planning started in August with plans to issue the tender in October 2021. A review by NHS Digital has generated 127 comments which are being reviewed. Feedback from NHSE/I has proposed further work on benefits. This will be
  undertaken with a view to representing the updated outline business case to Trust Board in November 2021. A revised business case for the tactical solution, showing a saving, will be presented to Trust Board in September 2021 and is presented to FSC in a separate paper.
  Clinical safety and risk review.
  Good assurance (for Lorenzo).
  An issue was reported that within a CDC form (new or existing), if the user makes use of the 'Last Captured Value' function (see Screenshot 1 below) to Copy text from a previous form, and either of the characters '&' or '. Assessed as very low risk by Dedalus clinical safety team and fix now expected 15/09/21 following cloud migration.

Digital Maternity.
Good assurance. The Digital Maternity Project Group (DMPG) meeting was held 23/08/2021 and the Project Initiation Document (PID) was approved between meetings after clarification items resolved. Project status remains Green - on track for go-live in March 2022 with manageable risks.

Items escalated to FSC:
The position on Cloud migration has been resolved, enabling resolution of the Lorenzo tactical contract position. Updated information and recommendations related to this are detailed in a separate report to Trust Board.

	With regards to cyber security compliance actions are planned to reintroduce forced password changes and the inclusion of network switch equipment in patching schedules.			
PURPOSE: ***(please select as appropriate)***	Information X	Approval	To note	Decision
RECOMMENDATION:	The Trust Board is asked to approve the business case presented that provides a new contract to extend the Lorenzo EPR through to November 2024.			
PREVIOUSLY CONSIDERED BY:	**Committee**	Finance + Sustainability Committee		
	Agenda Ref.			
	Date of meeting	22/09/2021		
	Summary of Outcome	Assurance report noted.		
FREEDOM OF INFORMATION STATUS (FOIA):	Whole FOIA Exemption			
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	Section 43 – prejudice to commercial interests			

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS

SUBJECT	Digital Board update	AGENDA REF:	BM/21/09/146

1. BACKGROUND/CONTEXT

This report provides an update on the programmes of work in Digital Services and Digital Analytics, with the latest assurance assessment, and includes the minutes of the latest meeting (September 2021).

2. KEY ELEMENTS

1.1 Digital Programme
Good Assurance.
An update on progress for the Paperless Care Programme was presented. The initial projects for the first half of the year continue with 5 on track, 1 postponed (Cloud migration) and 1 slightly delayed, but all due to deliver by end of September 2021. Progress continues with recruitment for programme resources which are vital for delivering the next wave of projects, with the Benefits Lead post re-advertised. There are ongoing discussions with the Patient Flow Operational Group to confirm digital support required to underpin this new programme, and with expectations that this will effect quarter three planning.

Deployments in August and early September included:

- Lorenzo Cloud Migration
- ORMIS Cloud Migration
- Amnity Patient Held Record Proof of Concept (Diabetes)
- CDC Deontics
- WASP/NHS111.

A post deployment issue with the CDC forms has been reported to Dedalus. A fix has been developed for this, due for deployment into live service following successful cloud migration.

1.2 Dedalus (formerly DXC) Vendor management
Limited Assurance.

The vendor management group met on 01/09/2021 and considered the following issues.

A concern was raised regarding the use of the Microsoft Silverlight plug in application, which Lorenzo uses as a component of the system architecture. This application goes end of life and out of support with Microsoft at the end of October 2021. This means it will no longer receive security patches from Microsoft and as such it may become a cyber security vulnerability. Dedalus advised that they are in discussion with Microsoft regarding an extension of support for continued use of Silverlight beyond the official end date.

The scope of the next Lorenzo release, 2.21, includes seven Trust change requests. One outstanding request for ED senior review was escalated to Dedalus last month, Dedalus report that this item is “under discussion”, with no date confirmed.

A project initiation document (PID) for the new OneED tool was presented at Digital Board. Following feedback, a further detailed review of the PID is to be conducted in September to clarify resource requirements and validate project plans. It is expected that this module will be funded nationally, with a contract change notice being negotiated by NHS Digital but this delayed whilst negotiations take place at a national level. Further details are provided in a separate report concerning the tactical Lorenzo contract extension.

The projects to migrate Lorenzo and ORMIS (theatre system) to the Cloud were delayed due to operational pressures with the 1st August 2021 date with a revised date of 12th September confirmed. Following approvals by Tactical Board the migration process went ahead and was completed successfully. As previously reported to FSC, this change now allows further progress with Lorenzo upgrades and conclusion of the contract renewal due in November 2021.

The work on the Lorenzo Digital Exemplar (LDE) programme is now moving to closure, with a national Blueprint for the Trust work on eTriage submitted to NHSX. Dedalus support for the LDE pathway projects is now complete. Paperless Care Programme planning is complete, with a plan to complete the LDE projects by September 2021.

1.3 Information and business intelligence.
Good assurance.

Statutory reporting remains a challenge due to frequent new and changing requirements from NHS Digital, CIPHA and other external agencies. A reduction in weekend reporting has been achieved via intervention with NHSE representatives reducing seven day working demand.
The latest Corporate Information and BI deployments/developments include :

- Ward Dashboard Specialty Level and Updates
- Exec Summary - Version 2
- Elective Recovery Outpatient Collection (EROC)
- Patient booked into Clinic late
- Recovery Dashboard - Trajectory updates
- Diagnostics dataset - new national weekly upload via csv file
- Maternity DQ - Estimated Blood Loss data issues (SCN)

- Maternity Pre-eclampsia Reporting
- Outpatient Consecutive Cancellation Report
- ED Control Room Live Dashboard - Admissions monitoring

1.4 IT services update.
Moderate assurance.

During COVID we turned off the password reset function on the domain to support Agile working. We now need to turn the function back on as part of security measures. This will mean everyone will need to reset their password, over 4000 members of staff. We are working on a plan to implement the activity and address extra resource needed on the Service Desk with a target to complete this change in October 2021 (tbc).

To ensure we have full infrastructure protection against Cyber-attacks we are required to Patch all network switch equipment. A patching schedule to agree a programme of downtime that will minimise disruption to operational services and ensure we meet our Cyber compliancy is under development in consultation with CCIO.

1.5 Digital Compliance and Risk.
Good assurance

Routine monitoring is showing continued good progress in managing risk of cyber-attacks.

1.6 Strategic Electronic Patient Care Management System (including tactical solution).
Moderate assurance

The Outline Business Case for the strategic solution was approved at Trust Board in July 2021 and procurement planning started in August with plans to issue the tender in October 2021. A review by NHS Digital has generated 127 comments which are being reviewed. Feedback from NHSE/I has proposed further work on benefits. This will be undertaken with a view to representing the updated outline business case to Trust Board in November 2021. A revised business case for the tactical solution, showing a saving, will be presented to Trust Board in September 2021 and is presented to FSC in a separate paper.

1.7 Clinical safety and risk review.
Good assurance (for Lorenzo).

An issue was reported that within a CDC form (new or existing), if the user makes use of the 'Last Captured Value' function (see Screenshot 1 below) to Copy text from a previous form, and either of the characters '&' or '. Assessed as very low risk by Dedalus clinical safety team and fix now expected 15/09/21 following cloud migration.

1.8 Digital Maternity.
Good assurance.

The Digital Maternity Project Group (DMPG) meeting was held 23/08/2021 and the Project Initiation Document (PID) was approved between meetings after clarification items resolved.
Project status remains Green - on track for go-live in March 2022 with manageable risks.

1.9 Governance.

The Terms of Reference for Digital Board were reviewed in September 2021 and it was noted that the permanent Chief Information Officer (Dr. Tom Poulter) started on 16th August 2021 and the Deputy CIO appointment was also confirmed on a permanent basis.

Items escalated to FSC:

The position on Cloud migration has been resolved, enabling resolution of Lorenzo and Ormis tactical contract positions. Updated information and recommendations related to this are detailed in a separate report to FSC.

With regards to cyber security compliance actions are planned to reintroduce forced password changes and the inclusion of network switch equipment in patching schedules.

3. RECOMMENDATIONS

The Trust Board is asked to note the contents of the report, including assurance levels and successful completion of the Lorenzo and Ormis cloud migrations, enabling tactical contract proposals to be finalised.

Appendix:
Minutes of the Digital Board, 13/09/2021.

DIGITAL BOARD
Minutes of the Meeting: Monday 13th September 2021 13:30-15:30
Microsoft Teams Meeting

Attendees:

Emma	O'Brien	Acting Head of ePR and Digital Programmes	EO'B
Roy	Bhati	Clinical Specialists - Associate Specialist ED/ CCIO	RB
Alex	Crowe	Executive Medical Director (chair)	AC
Jason	Bradley	Interim CIO	JB
Andrea	McGee	Chief Finance Officer & Deputy Chief Executive	AMc
Diane	Matthew	Chief Pharmacist	DM
Stephen	Deacon	Head of Digital Compliance	SD
Sue	Caisley	Deputy Chief Information Officer	SC
Tom	Poulter	CIO	TP

In Attendance:

Ipsit	Saha	NHS Digital Programme Manager	IS
Michelle	Smith	Therapy Manager	MS
Jackie	Matthews	Digital Programme Manager	JM
Daniel	Bousfield	Project Support Officer (Minute taker)	DB
Ian	Ormsby	Business Intelligence Manager	IO
Mark	Jones	Interim CBU Manager	MJ
Howard	Gray	IT Project Manager for infrastructure	HG

Apologies

Tracie	Waterfield	Head of IT Services	TW
Rita	Arya	Consultant Obstetrician and Gynaecologist & ACIO	RA
Alison	Jordan	Associate Director for Information	AJ

Agenda items.	Action
Introductions and Apologies Noted above.	
Notes of Previous Meeting All agreed. **Action Log:** Action 367: - CDC Form issue. Feedback from Dedalus was forwarded to EO'B, EO'B mentioned they have tested on cloud environment, waiting for the date to upgrade. Using special characters on the CDC form is causing the issues. RB asked they need to know how the problem occurred in the first place and what is the issue with the code. Dedalus have been asked for a root cause analysis and RB has not had feedback from Dedalus. IS will ask the service management for an update on the root cause analysis. TP mentioned a date to implement the fix is needed. The fix will be moved to the live environment hopefully after Wednesday now the Trust has moved to the cloud, and post stabilisation. There is also a date and time field that is fixed to Greenwich mean time not BST on the CDC form and is causing issues when filling out the form. IS will follow up on RCA and request a lessons learnt from Dedalus and will escalate the GMT time issue on the form. Action 368: - Cloud migration risk. CLOSED. Cloud migration completed.	

Action 369: - Pharmacy invited to the detailed weighting and scoring meeting on the 15th September 2021. Pharmacy have been asked to help with OBS documents and support with the tender and the collateral has been shared, DM confirms this is the case. Action 370: - Radiology update. CLOSED. On today's agenda.	
Terms of Reference RB status to be changed to CCIO and not the executive medical director. ToR validated and ratified.	
Digital Programme update EO'B Presented the slides. Tranche 2 Paperless Care Programme – Project Update – Four Optimisation projects completed; • PoC - Cardiology eDT of GP outpatient clinical correspondence live – Roll out to all other services has commenced. • CIS successful migration to the Cloud this is care identity services used for smart cards. • Trust Logo and Letterhead rebranding on all templates are stored in Lorenzo. • Sign off of full regression testing complete for the AWS Lorenzo and ORMIS move to the Cloud which has now happened. HIMMS EMRAM Assessment was shared at the Digital Optimisation Group – there are 6 Outstanding Requirements for WHH to reach Level 5. These will be incorporated into the Paperless Care Programme Plan. • 5 Projects on Track to be delivered Q1 and Q2 (July – Sept 21). • 1 Project on Track to be delivered Q3 (Oct – Dec 21). • 1 Project on Track to be delivered Q4 (Jan – March 22). Tranche 2 Q3/4 Planning – Resources have been identified for a further 6 projects and will be added to the Programme Plan timelines. The remaining projects will need confirmation of resources from the EPR Team, Support Services; Integration, Analytics and 3rd Party Suppliers and planned for Q3/4. Programme risks including resources to be monitored closely with escalation to Digital Board if applicable and/or appropriate RfC for re-prioritisation. Patient Flow Oversight Group (PFOG) Meetings have commenced and the first workstream has been identified – Right to Reside. We welcome a new EPR Project Manager who started in August and we are re-advertising for the Benefits Lead post and hope to fill the role over the coming weeks. Digital Optimisation Next steps: • Align new 6 projects resourced with dates onto the PCP Plan. • Prioritisation for the remaining 10 projects and resources required. • Prioritisation of 6 HIMMS Projects and align to the PCP Plan. Happy with EPR resources for the 6 projects, need to work the project teams to plot the dates out in the programme plan. The 10 remaining projects have enough capacity as part of the paperless care programme to successfully implement those before the end of March.	

JM mentioned the go-live for ePMA ICU may be delayed due to pharmacy resources, this was meant to go-live on week commencing 27th September 2021. DM stated a paper has been prepared highlighting the issues and a number of potential options that may be available. Discussions will be taking place tomorrow in a meeting at 9am. TP mentioned once the options assessment has been worked through it will be reported back to Digital Board. RB is invited to the meeting. There was a successful cloud migration for Lorenzo and Ormis. There were initial technical issues which were resolved throughout the morning. A root cause analysis has been asked to be provided by Dedalus. Ormis had a 13-hour 44 minutes downtime outage. Lorenzo had an 8 hours of 44 minutes downtime outage. There are reports of Lorenzo being slow in some areas and should see improvements throughout the day. RB mentioned the Trust was within minutes of rolling back and it took 3 hours of the combined user acceptance testing and for Dedalus to fix the bug. The performance does seem to be an improvement of what it used to be. It would also be interesting to see how Dedalus present this to other Trusts. SC said there are lessons to be learnt, and these will be incorporated in the business continuity tabletop exercise. DM stated it would be interesting to find out why our downtime was longer than other trust's. There also needs to be a better understanding of the risks of rolling back. DM would like to be involved in the lessons learnt process and the way of working needs to be changed instead of RB and DM putting in long hours of work. RB mentioned making sure the outage is made a never event. To also look at different levels of back up in the electronic systems. TP mentioned the problem found at UAT was an issue known to the Dedalus team that had occurred previously and there needs to be robust criteria for considering rollback for future downtime planning. There were no assurances on the timeline for a fix to be implemented from Dedalus.	
Dedalus Vendor Management meeting update EO'B Presented the slides The Dedalus Vendor Management Group met on 01/09/2021. The focus of the meeting was on the below points; **Issue Management:** • Previous escalated issue for ED messaging now has a proposed release for 2.22 which is February 2023. • One Response Outage – root cause identified and awaiting analysis paperwork. • CDC Form – special character issue when using LCV. Fix is in test. Implementation will take place following migration to the Cloud. The implementation is scheduled for next Wednesday • Silverlight Error box in production when using CDC Forms. Issue being investigated by Dedalus support team. • Silverlight – MS Silverlight used by Lorenzo will reach end of support on 12/10/21. Dedalus are working with MS to establish extension. **ONE ED Update**: • PID to be approved by Digital Board and attached to agenda. **LDE Update:** LDE and Innovation Fund Status • 1 On Track for Go Live September 21.	

- 2 Off Track with Issues – including Clinical Aide. V6, which is not compatible with WHH Complex Business Logic within the CDC Form.
- 1 awaiting testing following cloud migration.

One ED PID

The current vision from Warrington is that a standard clinical user will solely use OneED in their ED, without the use of smartcards, access will be via OpenID OneED therefore does not update the Spine.

OneED provides the equivalent of a new 'front end' for Lorenzo in the ED. It sits in front of Lorenzo allowing users to interact with a modern app-style user interface whilst still recording the information in the Lorenzo system of record in real time. This gives the dual advantage of a mobile, easy to use, high performance app for ED clinical users whilst all the information is still available in core Lorenzo for other clinical and admin users, downstream systems and reporting.

Project Objectives

- To deploy mobile functionality to the WHHT Emergency Department (ED) as part of the unplanned patient processes, to enable more efficient and immediate care
- To allow faster access to patient records for busy ED clinicians, improving performance, whilst still recording all necessary information for other clinical and admin users.
- To work collaborative with Dedalus on the first of type project to validate the software for future trusts to deploy.
- To start the journey on which OneED will replace main Lorenzo app as the new user interface (system of engagement).

Dedalus are fully committed to OneED as the strategic product moving forward for all Emergency Department customers. Funding for the OneED software licence, deployment, and enhancements within release 1.0, 1.1, 1.2, 1.3 and 1.4 is expected to be provided from the RPA committed repurpose fund.

RB mentioned it is a way of getting a new EPR for ED without changing Lorenzo. One ED will always be in sync with Lorenzo.

AMG asked about the resources and funding for the project and what they are for the project as it is not clear.

EO'B mentioned the resource constraints are not in the PID due to being picked up with the EPR team.

SC said the funding is covered in the Lorenzo business case and are still working with NHSD and Dedalus regarding the funding of One ED. The reclaiming of VAT can be used if the Trust has to pay for this project but NHSD are expecting to pay for the One ED Project.

IS mentioned the discussions are still on-going regarding the funding. One ED will be funded by the committed repurpose fund and can be used after the Warrington contract expires.

AMG said the VAT funding is not mentioned in the business case and in any financial plan and is concerned regarding the financial membership and procurement membership of a project team and need to clarify the resources implicants of this project.

JB said the business case has been updated to reflect the one ED position. The contract will not specifically state One ED, it is predicated on the national funding, if the Trust did have to pay for it themselves, this is the impact on the business case.

AMG stated this will cause the business case a bit of trouble and it needs to be escalated.

Action 371: TP to work with RB, EO'B and SC regarding the resources of the One ED project and gain some clarity.

AC needs clarity before going to executives.

DM mentioned that One ED PID references ePMA administer and prescribe, if smartcards are not being used, how does the system ensure the security of who is using the system. RB replied stating it uses Dedalus one ID and log in with a username and password. DM asked if there is any time out functionality for the ePMA side. RB said the ePMA side has yet to be built and the timeout can be built into the requirements. The considerations can be considered.	**371: TP**
Information and Business intelligence update AMG presented the document Paper taken as read and no questions or comments were raised. AC stated there were some discussion about the principle information analysts, there does appear to be a response to that variant. AMG is not envisaging any concerns at the moment.	
IT Services Update HG presented the slides. Whilst IT have taken more calls this month, they have been able to retain their 1st time fix level at 60% and also maintain the calls resolved within 1-hour standard. IT are facing a significant password reset issue. During COVID IT disabled the change password function to support agile working and the need to support the business with service reconfigurations. IT now needs to enable this function which will mean over 4000 password resets. IT are working on a plan to implement the activity, provide extra resource on the service desk and provide comprehensive communications to the Trust. The plan is in process of being formulated. IT are reporting a backlog of telephony requests in the Network Team, as of today, that figure is around mid-50s. Since 2015 the Trust telephony has transitioned from traditional analogue infrastructure to a digital platform. IT are working on a proposal with estates to transfer the pay and non-pay elements of telephony over to Digital Services to address the activity backlog. **IT Service Project Activity:** 6 projects Completed, 10 on track, 1 off track. 1 Project completed since last Digital Board which was the SAN upgrade. The project off track is the service desk upgrade, this was scheduled for the weekend of 5th/6th September, due to issues with migration this was aborted. IT are looking to undertake the upgrade for the new helpdesk system on the 24/25th September. **Change Control Activity:** There was 10 requests during August, 7 of those requests have been completed, 2 are pending and 1 is waiting CAB approval. 74 Change requests have been undertaken since the calendar year. **N365 Phase 2:** The Trust has around 2TB of PST files (Archive files) on our SAN, only a small percentage of PST's are used within the Trust. We are planning to migrate this data into the cloud O365 Archive solution freeing up local SAN storage.We have setup over 72 Teams and have migrated data into the Teams covering over 1200 members of staff, providing collaborative workspaces and freeing up local SAN storage. Decommissioning of old email archive servers, freeing up 25TB of SAN disk Space (20% reduction on local SAN storage). Trying to asses the use of H,P and S drives over to the office 365 cloud. **<u>Device Compliance Activity</u>** **Windows 10:** IT have only 5 outstanding devices on the Trust network to migrate to Windows 10 to be fully compliant. IT are working with the departments and vendors to resolve.	

Windows Server migration: Since last Digital Board, IT have reduced the High Risk Windows 2003 servers from 5 to 1. The remaining server is Medicorr, old clinical correspondence server. IT are working on an action plan to decommission this server. **Anti-Virus:** All servers and desktop devices have the latest antivirus patches. **Device Patching Activity** **Desktop patching:** IT has a number of devices that are not receiving windows security patches. 200 devices are on an old build of windows 10 and has started a recovery plan for these devices. IT are reporting there are 30 devices left to rebuild. **Network Patching:** To ensure we have full infrastructure compliancy and protection against cyber-attacks we are required to patch all network Infrastructure. IT are meeting with our CCIO to start discussions around a patching schedule to agree a programme of downtime that will minimise disruption to operational services and ensure we meet our cyber compliancy. TP is keen to set a date to turn back on the change password functionality, the longer the situation is left the greater the security risk to the Trust. There will be a date set for the change to happen once the final plans have been sent to the digital SLT meeting. There also needs to be a solution for the network patching to be done as there are 17 edge switches affecting all different parts of the hospital. There needs to be planning to maintain the patching going forward so it does not build up towards the end. **Action 372: HG to provide information back to next Digital Board meeting from the follow up meeting regarding the network patching.**	**372:HG**
Digital Compliance and risk update SD Presented the slides. New dashboard report shows an internal vulnerability threat score. This score is generated by what the Trust does and doesn't do and what has happened regarding new vulnerabilities. These scores will be going up and down periodically. There were no high critical certs issued by NHSD last month. 4 high care certs are still outstanding, these are deployment stock waiting to be deployed. No new alerts on the ATP in the last 30 days rolling. No new alerts on the network penetrating tests. No urgency or advisory alerts to report. BitSight score is still 780. McAfee, Microsoft and Adobe are still the 3-vulnerability software's but these are classed as low. 1 action is due to be completed in December for the MIAA change control. Digital Services currently have: • 11 open risks. • 1 BAF risks, 4 Corporate risks & 6 Departmental risks. • 2 extreme, 8 high & 1 moderate risks. • 37 outstanding risk actions. Risk Highlights • Closed a total 4 actions in August 21. • Opened 6 new actions August 21. • New emerging risk regarding on-call 24/7 risk to be approved before being documented on Datix	

• Approved new risk regarding the reduction of paper-based processes to an absolute minimum in line with NHSX directives • Closure of action regarding the upgrade of the SAN space (NIS Risk). • New actions regarding to agree network patching schedule with the Trust (143 & 1114 cyber-based risks) Top risks Risk 1114 – Cyber BAF risk Risk 1372 – Future of patient care management system. Risk 143 - Departmental version of cyber security issues. Actions to be undertaken before next Digital Board. • To obtain timeframes regarding obtaining patching schedule for the network equipment with the Trust; • To review the frequency of the desktop gold image & virtual desktop gold image; • To look at the process of the of the stock in deployment and how whether they should be recorded in our IT Health Assurance Dashboard. TP mentioned the switching back on password functionality is relevant to the cyber security and a cyber security risk. The password change is an action relevant to cyber security and compliance. AC asked if the Trust is in a better position than what was it 3 months ago. SD confirmed the Trust is in a better position than it was 3 months ago. The vulnerability score was high and has gone down to mid-40s from mid-50s.	
Strategic Electronic Patient Record Procurement Tactical Lorenzo Continuation SC Presented the slides. **Tactical** **Lorenzo:** A revised business case with covering paper will be submitted to September FSC and Trust Board to request approval of positive business case change in terms of a lower cost. The pre-requisite cloud migration re-scheduled for 12th September was completed. **Ormis:** Lorenzo Theatres position has been reviewed with options appraisal concluding that preferred approach is to continue with ORMIS until strategic EPR supplier confirmed. This will require a 3-year extension aligned with core Lorenzo tactical contract. Has been referred to the Executive Team for approval in parallel with final approvals of core Lorenzo contract via FSC and Trust Board. Digital Board members proposed that the options appraisal and recommendation be presented to the Executive Team for consideration and approval. **Action: TP to submit a paper on theatre systems options appraisal to the Executive Team.** **Strategic**: Initial review has been completed by NHSE/I required re-profiling of costs and review of capital plans to address affordability issues in specific financial years. Further work is also required on benefits identification and detailed benefits realisation planning. The OBC review was completed by NHS Digital with 127 items of feedback analysed and processed for an updated version. Procurement approach was approved, and planning is progressing with an updated OBC scheduled for review and approval at November 2021 Trust Board. **Recommendations and Next Steps** **Tactical:** • Submit revised business case with covering paper to September FSC and Trust Board to request approval of positive business case changes. • Conclude Lorenzo contract schedules and contract signature by 31st October 2021.	**TP**

• Award a 3-year contract extension for continued use of ORMIS, aligned with core Lorenzo contract, until strategic EPCMS preferred supplier is confirmed (subject to Executive Team approval). **Strategic:** • Continue EPCMS procurement planning and preparation in accordance with timetable. • Update OBC to reflect NHS E/I initial feedback, NHS Digital feedback and cost re-profiling. • Prepare summary cover letter to clarify rationale for business case and procurement. • Complete OBS documentation ensuring lead Executive sign off with owners and SMEs assigned to each OBS section for participation in the evaluation process.	
Clinical Safety and Risk Review EC Presented the document No change from last month, no other CSN's or PAN's have been received since last month's Digital Board. The ward round CSN is the only one outstanding at the moment.	
Digital Maternity SC Presented the paper The main challenges to successful go-live were reported to the Digital Board in August and progress made has been presented in the Digital Maternity Project Group and Clinical Working Group. Project status remains green with a go live of March 2022. The PID was approved by project group on the 23rd August and is provided in this Month's Digital Board for information. Progress made so far includes: • Training: training dates agreed, resources allocated without compromising service levels and Attensi demo arranged. • Data migration: data mapping complete 2nd September; test data to be imported. • Go-live support: availability of Clinical and Digital support identified to support 4 week go live plan • Synchronising information: workshop held 9 September; information requirements reviewed. • Project timeline; Green on track for go live March 2022. Demonstration has been arranged for the 17th September from Attensi. This is a new way to deliver training. There will be a deep dive in the next DOG Meeting to add the level of assurance. DM mentioned we must not overlook the facts that other sections of the hospital do need to able to access the information that is contained within maternity notes, it would good to see how that side of things are addressed. **Action 373 : How other sections of the organisation access information contained within maternity notes to be covered in the deep dive in the next DOG Meeting**	**373: SC**
RIS Procurement MJ gave an update Radiology have selected wellbeing as the supplier who is currently the existing supplier. A business case has been submitted which will be taken to execs this week. There is a cost saving for this new procurement of 13.6k. Wellbeing have stated that they can offer a fully manned service, this has been costed up and will reduce the cost savings to £6,100.	

Two trusts within the region which are Alder Hay and St Helens have stated that the hosting servers should be done by competitive tender, they have until this Wednesday to submit the tender to take the hosting service on and provide the costs. This will be reviewed by a mini tender process and this will be fed back to the Trust. PACS replacement is looking to re-award the tender in 2022 with a plan to go live July 2023. This will be through a competitive tender process. Supplier presentations are lined up for next week. 7 suppliers will be presenting in these meetings. Procurement Lead and Finance Lead have been lined up. Clinical Lead, IG and corporate records manager, IT manager and ePR manager have also been lined up as representation. PACS manager has been lined up and will start in 2 months and is currently working as a deputy PACS manager in LUHFT. TP mentioned it is important to make sure the RIS and PACS plans are aligned with the EPR plans, there might be some element of the output business specification for the EPR, which could be impacted by the selection of the new PACS solution. Updates will be provided every 2 months or earlier if the needs arise by MJ and will communicate with TP regarding this.	
AOB None Tabled	
Items for escalation for FSC Reference to the cloud migration from a digital operational perspective. Business case and clarification of support from NHSD and the use of VAT needs to be clear. Response to the patching rollout.	
Meeting Review AC commended the measured detail in the papers, making it easier to manage time, and allowing time for discussion.	
Date and Time of Next Meeting Monday 11th October 2021 13:35-15:25 Microsoft Teams	