WHH Board of Directors Meeting Part 1

Wednesday 30 November 2022
10.00am-12.30pm
Trust Conference Room WHH/Via MS Teams

SUPPLEMENTARY PACK

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/22/11/153**	
SUBJECT:	WHH GMC National Trainee Survey Results 2022 and GMC Enhanced Monitoring Status Update	
DATE OF MEETING:	30th November 2022	
AUTHOR(S):	Kate Davidson Medical Education Manager	
	Paula Chattington Director of Medical Education	
EXECUTIVE DIRECTOR SPONSOR:	Paul Fitzsimmons, Executive Medical Director	
LINK TO STRATEGIC OBJECTIVE: ***(Please select as appropriate)***	SO1 We will.. Always put our patients first delivering safe and effective care and an excellent patient experience.	X
EXECUTIVE SUMMARY ***(KEY ISSUES):***	The annual General Medical Council (GMC) National Trainee Survey (NTS) is the largest annual survey of doctors in the UK, providing a longitudinal view of trends by gathering feedback from medical trainees on their training experiences and working environments. Trainers are asked to share their perspectives on educational and clinical supervision. Together this allows the Trust, the GMC and other national bodies such as Health Education England North West (HEENW) to monitor the quality of Medical Education and Training. The 2022 survey was undertaken between March 2022 and May 2022 with results published in August 2022. The survey is comparable to surveys undertaken in previous years; the survey conducted in 2020 had a different series of questions which were directly linked to the impact of the COVID pandemic and results were therefore non-comparable. The 2022 GMC NTS concluded on Tuesday 17th May, which included a 2 week extension due to an unusually low national response rate. Despite numerous engagement opportunities and access provided to resource and time to complete the WHH completion rates were at 70.5% compared to last year's survey 97.5%. Feedback from HEE is that the removal of the survey mandate is likely to have caused the national reduction in completion something that they will review again prior to next year. The lower completion rate will have affected the feedback which if aggregated across all trainees tends to even out responses, especially, in smaller speciality cohorts. The GMC NTS is an important triangulation tool used by the Trust, HEENW and the Quality Team in reviewing medical educational quality and performance. GMC 'Enhanced Monitoring' was first applied to WHHFT in July 2015 as a result of concerns raised within the medicine specialties, and at the most recent Quality Visit (19.11.21) the	

	2022 GMC Results were identified as one of the 3 components in the Trusts Exit Mapping out of 'Enhanced monitoring'. The GMC had asked for Trust feedback on a series of free text comments received through the GMC survey. The specialties in question have fed back and action plans have been developed to address issues that have arisen because of the comments received. A response to these comments was provided to the GMC on 11.7.22. The results of the 2022 GMC NTS show promising improvements in some areas such as Geriatrics, Cardiology, Obstetrics and Gynaecology, Trauma and Orthopaedics and Paediatrics. The Trust also had several areas of outstanding including Anaesthesia, Radiology and ICU. However, there is still improvement work to be undertaken and those specialties requiring specific focus this year include Gastroenterology, ED, Diabetes and Endocrinology and General Medicine. Acute Medicine has seen significant improvements in a number of areas in particular those reflected in their 2021 action plan however there are still areas requiring ongoing monitoring following the most recent Quality Visit and GMC NTS results. A further area requiring ongoing review and action plan is the Trainee Specific Group results for IMT. Following a reduction in GPST colleagues due to the most recent curriculum change reducing their secondary care placements from 18months to 12months IMTs were affected by numerous gaps on the Medicine SHO rota from April 2022. The Trust Senior Leadership and Operational teams, Medical Education, Chief Registrar and trainee reps established a working group to find a solution with the best, operational and educational experience. Protection of certain areas such as clinics, teaching and annual leave along with additional support mechanisms helped us to limit effects on the trainee experience where possible. Also, an introduction of SDT time allowed trainees time required to revisit any missed teaching or portfolio requirements. Although these measures improved our outcomes there was still an impact, in particular on the rota design indicator for medicine specialties, which was to be expected.			
PURPOSE: ***(please select as appropriate)***	Information	Approval	To note	Decision
RECOMMENDATION:	The Trust Board is asked to noted the report.			
PREVIOUSLY CONSIDERED BY:	**Committee**	Strategic People Committee		

	Agenda Ref.	**SPC/22/09/99**
	Date of meeting	21/9/22
	Summary of Outcome	The Committee noted the report.
FREEDOM OF INFORMATION STATUS (FOIA):	Choose an item.	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	Choose an item.	

REPORT TO BOARD OF DIRECTORS

SUBJECT	WHH GMC National Trainee Survey Results 2022	**AGENDA REF:**	**BM/22/11/153**

1. BACKGROUND/CONTEXT

The paper provides an update on the General Medical Council (GMC) National Training Survey (NTS) results for Warrington and Halton Teaching Hospitals NHS Foundation Trust (WHH) for 2022.

Every year the GMC conducts an NTS asking postgraduate doctors in training for their views on the training they have received. They also ask trainers about the support they get in their role. Together these results help to improve training programmes, experience and posts across the UK.

The aim of this report is to:

- Provide an overview of the 2022 GMC National Training Survey (NTS) outcomes for trainees working at WHH
- Compare results by specialty and trainee group to previous years
- Summarise actions already taken
- Describe next steps for ongoing support of the medical trainee workforce.

2. KEY ELEMENTS

2.1 The General Medical Council National Training Survey (GMC NTS)

The GMC NTS is an annual survey which started in 2009 and is the largest annual survey of doctors in the UK providing a longitudinal view of trends. The survey gathers feedback from medical trainees on their training experiences and working environments. Trainers are asked to share their perspectives on educational and clinical supervision. Together this allows the GMC and other national bodies such as Health Education England North West (HEENW) to monitor the quality of medical education and training. The NTS supports Trusts to identify areas which may need to be improved and areas where improvements have been sustained and good practice developed. This report focuses on the trainee survey results only.

HEENW review results of individual medical education providers across the region compared to the national average. The survey also provides important triangulation information for provider trusts and for HEENW and the Quality Teams when reviewing educational performance.

In the 2021-22 academic year, Warrington and Halton Teaching Hospitals NHS Foundation Trust (WHH) had approximately (depending on time of year) 170 postgraduate medical trainees including: Foundation Doctors, Core Medical and Surgical Trainees, Specialty Trainees and GP Specialty Trainees. The NTS survey was completed by trainees in March- May 2022.

The 2020 NTS asked a different series of questions to previous years relating directly to the pandemic. The results were therefore not comparable to previous surveys and were interpreted in the context of the profound impact the pandemic had on medical education and training. In Sept 2021, Strategic People Committee received an update paper detailing the results of the 2021 GMC NTS. From 2021, the NTS survey reverted to the original and standardised questioning format and is therefore comparable to previous years.

Key Themes Explored in the 2022 GMC National Trainee Survey are as follows

- Overall Satisfaction
- Clinical Supervision
- Clinical Supervision (Out of Hours)
- Reporting Systems
- Work Load
- Teamwork
- Handover
- Supportive Environment
- Induction
- Adequate Experience
- Curriculum Coverage
- Educational Governance
- Educational Supervision
- Feedback
- Local Teaching
- Regional Teaching
- Study Leave
- Rota Design

2.2 Results of the 2021 GMC National Trainee Survey

The 2022 GMC NTS was concluded on Tuesday 17th May 2022. Despite the survey period being extended for 2 weeks, the national completion rate was considerably lower than the previous year with WHH completion rates reported as 70.5% compared to last year's survey 97.5%.

The results of the survey were published in July 2022. Appendix 1 details the full set of results by specialty.

There has been an overall reduction in the number of red and pink scores (i.e., those in the bottom quartile) compared to 2021 as detailed in Table 1 below.

Note: An Outlier is where the survey score falls into the bottom (negative outlier) or top (positive outlier) quartile and with a mean outside the 95% confidence intervals of the national mean. It is also important to note the impact of total number of responders for each clinical service; lower response rates have greater impact on survey score.

Table 1 – Describes the number or red and pink scores in 2022 compared to 2021. (NB only this with results comparable to 2021 are included). There has been a reduction in the number of red scores from 24 to 15 and a reduction in pink scores from 30 to 25.

	2021	2022	2021	2022
	Reds		Pinks	
Acute Medicine	1	0	9	4
Anaesthetics	1	0	2	0
Cardiology	4	0	2	2
Clinical Radiology	0	0	3	0
Emergency Medicine	3	4	3	2
Endocrinology and Diabetes Mellitus	0	4	1	4
Gastroenterology	0	5	0	6
General Internal Medicine	0	0	2	5
General Surgery	1	0	0	0
Geriatric Medicine	1	0	1	2
Obstetrics & Gynaecology	6	0	1	0
Paediatrics	3	1	2	0
Respiratory Medicine	0	1	2	0
Trauma & Orthopaedics	2	0	1	0
ICU	2	0	1	0
Totals	**24**	**15**	**30**	**25**

The results demonstrate the following trends compared to 2021 results:

Improvements since 2021 observed in: Acute Medicine, Cardiology, Geriatric Medicine, Obstetrics & Gynaecology, Trauma and Orthopaedics and Paediatrics

Areas of Outstanding (positive outlier) observed in: Clinical Radiology, Anaesthetics and ICU

Deterioration since 2021 observed in: Gastroenterology, Diabetes and Endocrinology and General Internal Medicine

No/little Change since 2021 or no comparable data: Emergency Medicine (still remaining negative outlier), General Surgery, Trauma and Orthopaedics, and Respiratory Medicine

Action Plans required for improvement: Emergency Medicine, Gastroenterology, Diabetes and Endocrinology and General Internal Medicine. Update on current action plan requested from Acute Medicine

Specialty to note results – no formal action plan required: Cardiology, Radiology, General Surgery, Geriatric Medicine, Obstetrics & Gynaecology, Paediatrics, Respiratory Medicine, Trauma and Orthopaedics and ICU

Further action plans have been created for specific trainee grades in particular, IMT where changes implemented in April 2022 will continue to be monitored by the Royal Colleague Tutor for Medicine, Director of Medical Education and Medical Education Manager. Also in Trauma and Orthopaedics an action plan was developed to support the Foundation Doctors which will be monitored by the Speciality Tutor, reporting to the Medical Education Quality Committee and Junior Doctors forum.

3. ACTIONS REQUIRED/RESPONSIBLE OFFICER

3.1 Actions Already Undertaken

In recognition of feedback provided via the most recent HEENW/GMC Quality Visit on the 19/11/22 the Medical Education Service and clinical colleagues have already embarked on areas of improvement work.

In April 2022 Medical Education was made aware of significant gaps in the Medicine SHO rota caused by a change in curriculum for the GPST posts reducing their secondary care placements from 18months to 12months ongoing. Directly affected by this change in the first instance (effects will move depending on rotation annually) were IMT colleagues and in order to develop a collaborative approach to tackling the gaps a working group was established. The working group included Executive Medical Directors, Medical Education, Rota/Operational Management, Chief Registrar, and IMT colleagues including the IMT Representative, and the main objective was to develop a rota solution that balanced patient safety, trainee safety and wellbeing, and educational experience. It also worked to determine important supportive measures and reinforcement of opportunities to enhance the trainee experience during a difficult time. Outcomes when the group concluded was a rota designed by IMTs and rota managers to best suit the objectives above, protection given to clinics, teaching (where possible), and annual leave. Finally, it was decided to introduce SDT time for IMTs prior to this being mandated (academic year 2022-23) in line with that given to Foundation Doctors and GPSTs which would allow them to catch up on missed teaching, study opportunities and ensure portfolio requirements were met. On the conclusion of the group regular feedback was provided via the Junior Doctors forum via the IMT rep and directly to the Medical Education Manager, Chief Registrar, and Royal Colleague Tutor at scheduled catch ups which, consistently captured a positive shift in trainee experience overall. Although currently the IMT rota is not affected by the GPST gaps

all areas that were protected have continued and regular engagement with the group should allow early preventative support measures where required.

There has also been a very successful continuation of the Chief Registrar role which has seem a clear improvement in engagement from the trainees including increased attendance at the Junior Doctors Forum, identification of trainee reps from all grades and specialities to ensure feedback and discussion is fully inclusive. Supported by this role there has been an introduction of additional teaching/learning opportunities and finally improved communication when issues arise to allow us to undertake a collaborative approach to tackling things with our Junior Doctors workforce.

Medical Education has also established a Trainee Governance Teaching led by the Chief Registrar to review clinical incident themes and trends across the trust, focusing on areas identified from Datix, Complaints, Risk registers and through Root Cause Analysis and

encouraging trainees to actively engage in presenting information and findings to peers on the above-mentioned themes.

Further additional teaching and learning opportunities include the introduction of Junior Doctor attendance at Mortality and Structured judgement review and finally our extremely successful Mock coroners court which was a ticketed event with all places taken. Led by our Chief registrar and Dr Saagar Patel Medical Education hosted a 4 hour mock session with attendance from a local coroner and solicitor with a real (anonymised) case and consultant/witness statements etc.

In July 2021 Medical Education received £60k of Post Graduate Medical Education (PGME) funding from HEENW to fund any developments which support gaps in training which have come as a result of the COVID pandemic. The funding has been used to support the following areas following discussion and feedback from the trainees via the Junior Doctors Forum.

- Purchasing filming equipment to help capture missed teaching opportunities
- Funding for leadership roles to explore areas of improvement raised. Medical Improvement Lead (ST Task and finish group chair), ED Improvement group Chair
- Obs and Gynae teaching equipment to support gaps in previous learning caused by the pandemic
- Radiology Recovery training – Which allowed us to support trainees in achieving required attainment previously compromised by gaps in training caused by the pandemic
- Shared trainee laptops for Medicine and Surgery to allow IT access when in placement settings
- Upgrades to the teaching facilities in Medical Education to support new hybrid methods of learning.

Also previously established were two improvement groups the first being an Emergency Department Improvement Group which continues to look at a number of workstreams, one

of which will be trainee-related issues and the themes which have arisen as a result of the GMC Survey.

The second was the ST Task and Finish group formed following feedback from ST colleagues in 2021 which recently concluded following the successful implementation of its workstreams which included improvements to the Junior Doctor Induction and Good Practice guidance for Speciality Induction documentation.

Speciality Action plans were also implemented prior to the HEENW/GMC Quality visit focussing on areas highlighted in the GMCNTS 2021 and these were developed and amended following the Quality visit report. They have been maintained as a working document for ongoing monitoring and evaluation of improvements. Areas where improvements have been reflected in the 2022 results are as follows.

In Acute Medicine following the increase in consultant establishment an action noted was to increase the numbers of Education Supervisors available to support the Junior Doctor workforce. There are 6 out of 6 consultants who have completed formal training and available to supervise the newest intake of trainees. There has also been significant work on consultant presence at handover, ward round, on call etc which has seen improvements in teamwork and supportive environment scoring. Local teaching has now been established weekly and results demonstrate improvements accordingly with trainees outside the speciality also invited to attend. Finally significant improvements have been made to clinical supervision which is no longer a negative outlier for the first time since 2018 with onsite consultant presence from 08:00 to 21:30 and then on-call consultant cover from home every day, including weekends and bank hoidays. Trainees encouraged to approach the consultants at handovers in the morning with any concerns and for any further learning opportunities.

Within ED 2021 Action plan some of the following areas were captured and improvements can be seen within the most recent results

1. Feedback and Reporting systems

- Governance Lead disseminates a monthly update around lessons learned from all sources, with links to each document on the main screen of the ED website. This website is used by the trainees every day for pathways, leaflets and learning, therefore placing the lessons learned as well as missed fractures/abnormal radiology upon this medium allows trainees to read and reflect on cases.

2. Local Teaching

- The Emergency Medicine Higher Specialty Trainees have been allocated additional hours per week for their protected educational development time (EDT) which the Educational Supervisors and Specialty Training and Education Lead are monitoring to ensure trainees actively engage with training delivered and offered during those sessions.
- There has been a programme of local ED teaching implemented once per week, with protected times for junior clinicians and then higher specialty trainees. This is a mixture of trainee led and delivered, as well as knowledge experts both internally and externally to the Emergency Department.
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- The trainees have also been empowered to deliver a biweekly journal club, which was started by consultants, delivering weekly teaching and critical appraisal to the junior team.
- Provision and funding for 2PA for Clinical Educator roles in the Emergency Department to provide dedicated educational time, shop floor teaching including completion of WBA for trainees to ensure training needs are met despite pressures of service provision.

3. Workload

- There has been a recruitment drive for junior and middle grade equivalents, with successful candidates in the disciplines of Physician Associates, Advanced Clinical Practitioners, Specialty Doctors and Locum Consultants. These appointments boost the rota for both the junior and middle tiers, with the aim of reducing the frequency of high intensity shifts, but also to reduce the intensity of work required by improving overall staffing numbers.

- Two specialty doctors have joined the ED team in December 2021 with 2 Physician Assistants starting in April 2022.

One area which has seen significant improvement work already was around the ED Handover however unfortunately this remains an area of concern within the most recent results. Previous actions include

- Change of Handover time 8-8.15am and 22.45-2300
- Consultant Lead
- Template to allow structured format which includes a final section on educational opportunity

Trainees on internal review still note variability on the handover process and therefore further action in required on to ensure ED senior team understand the value of effective handover between shifts to ensure patient safety and enrich trainees' educational development. Trainees will be surveyed internally for their feedback on the handover process and concerns will be addressed proactively in line with the most recent ED Action plan.

The GMC had asked the Trust feedback on a series of comments received through the GMC survey. The specialties in question which include Acute/Emergency Medicine, Haematology and Obstetrics & Gynaecology, have fed back and action plans have been developed to address issues that have arisen as a result of the comments received.

3.2 Actions Required / Next Steps

The Medical Education Team have triangulated the survey findings with existing knowledge and evidence of trainee related issues including the SHO rota gaps and will engage with specialty educational and clinical leads to discuss issues in more detail, agree action plans for improvement with clear timelines, establish monitoring processes and provide accountability through the College Tutors and clinical & specialty leads to the Director of Medical Education and via the Medical Education Quality Committee.

4. MEASUREMENTS/EVALUATIONS

4.1 GMC Enhanced Monitoring Status and Quality Visits

Enhanced monitoring was first applied to WHHFT in July 2015 because of medical educational concerns including:

- Quality of day-to-day supervision in medicine, particularly for geriatric medicine trainees
- Access to learning opportunities in medicine generally, particularly clinics for core medical trainees.

GMC monitoring, including review of previous GMC survey results, has moved around the acute medical departments over time, with all showing varying degrees of risk around supervision, feedback and access to educational opportunities.

The Trust have engaged with HEENW to undertake improvement in the delivery of education and training through interviews with trainees and educators, meetings with senior leaders, development of action plans, and the involvement of the GMC and School of Medicine.

The evidence of the 2021 Quality Review and 2021 GMC NTS showed promising improvements, such as a focus on supporting and developing the supervisory body and gave the GMC confidence that as a Trust we are able to identify, review and manage areas of improvement remaining fully engaged with our Junior Doctors workforce.

It was agreed the Trust, HEENW and the GMC would agree an exit plan and steps for the removal of the Enhanced Monitoring status. These steps were as follows.

1. Completion of Action plan update following the Quality Visit
2. GMCNTS results 2022
3. Internal Monitoring Measures – Developed with Alistair Thomson HEE Associate Dean. Current proposed options to support this include

- Attendance and Med Ed Quality Committee
- Attendance at JDF and other trainee feedback/engagement forums
- Bi-monthly update meetings with Executive Medical Director and Medical Education Manager

- Internal feedback collection – Oct 2022

5. TRAJECTORIES/OBJECTIVES AGREED

Removal of GMC Enhanced Monitoring status

6. MONITORING/REPORTING ROUTES

Medical Education action plans and trainee-related issues will be monitored:

- Within specialty / faculty areas
- Through the Medical Education Quality Committee – bimonthly
- Via GMC Enhanced Monitoring Submissions - periodic
- Reports to be submitted to Executive Team and HEE

7. TIMELINES

- Finalise GMC Survey Result Action Plans – mid September 2022
- GMC Enhanced Monitoring Internal review – October/November 2022 tbc
- Where appropriate, action plans to be developed by clinical / specialty / faculty leads / Royal College Tutors – mid October
- Progress / Action Plan updates will be reported to Medical Education Quality Committee via High Level Briefing papers for programme / specialty areas

8. ASSURANCE COMMITTEE

Medical Education Quality Committee which reports into Operational People Committee.

9. RECOMMENDATIONS

Board are asked to note the contents of the report. Assurance can be provided in that areas of concern that have been identified and action plans are being developed, monitored and actioned in line with the usual escalation processes with tighter oversight from Medical Education Quality Committee.

Appendix 1 – 2021 General Medical Council National Training Survey Results

Key

Each cell contains the mean score and a colour which indicates if the score is an outlier:

- Red: a red outlier is a score in the bottom quartile of the benchmark group, and the confidence interval does not overlap with that of the benchmark mean.
- Pink: a score in the bottom quartile, but the confidence interval overlaps with that of the benchmark mean.
- White: a score in between the top and bottom quartiles of the benchmark group.
- Light green: a score in the top quartile, but the confidence interval overlaps with that of the benchmark mean.
- Dark green: a green outlier is a score in the top quartile of the benchmark group, and the confidence interval does not overlap with that of the benchmark mean.
- Grey: fewer than three results (n<3). We only report results which have three or more responses.
- Yellow: no results (n=0).

*NB 2020 the GMC NTS was designed to capture feedback specifically regarding the COVID Pandemic. There are therefore no comparable scores for 2020.

Post specialty by trust/board single year - 2022

Post Specialty	Overall Satisfaction	Clinical Supervision	Clinical Supervision out of hours	Reporting systems	Work Load	Teamwork	Handover	Supportive environment	Induction	Adequate Experience	Educational Governance	Educational Supervision	Feedback	Local Teaching	Regional Teaching	Study Leave	Rota Design	Facilities
Acute Internal Medicine	63.33	81.25	79.51	57.00	31.95	72.22	68.75	66.67	75.00	64.58	61.11	72.92	34.72	53.67	59.17	40.11	31.25	54.00
Anaesthetics	93.33	95.83	96.88	82.00	62.50	68.06	67.19	93.33	98.33	95.83	87.50	98.96	97.92	92.50	70.84	93.40	88.54	
Cardiology	66.25	83.75	75.00	56.67	37.50	79.17		68.75	71.25	62.50	66.67	85.94					28.13	
Clinical radiology	94.29	97.86	87.92	89.00	74.40	84.73		95.71	97.14	89.29	80.95	98.21	80.83	89.05	73.81	73.61		
Emergency Medicine	63.50	75.14	70.37	67.22	24.38	66.67	48.33	59.50	81.25	68.75	72.50	78.13	75.93	75.33	71.67	59.58	42.50	53.21
Endocrinology and diabetes mellitus	63.33	86.67	82.29	56.00	25.00	70.83	62.50	63.33	67.50	64.58	55.56	75.00	66.67	41.33	40.83	32.50	18.75	41.46
Gastroenterology	61.00	80.00	74.17	68.25	23.75	61.67	72.92	51.00	59.00	60.00	43.33	76.25	66.67	50.56	44.44	29.17	17.08	
General (internal) medicine	60.00	80.00			34.72	75.00	72.92	70.00	61.67	58.33	69.44	85.42		28.33	54.17	36.11	47.92	
General surgery	73.44	87.19	87.89	66.33	43.88	68.23	64.06	66.56	76.88	71.88	67.71	84.38	64.88	67.59	66.20	80.68	45.00	54.17
Geriatric medicine	63.33	89.44	84.72	62.36	41.67	71.30	70.54	72.22	73.89	66.67	63.89	81.25	72.62	39.52	60.72	52.38	36.81	51.43
Intensive care medicine	96.25	100.00	96.88	91.67	81.25	89.58	81.25	95.00	98.75	96.88	87.50	90.63	90.28			93.75	95.31	
Obstetrics and gynaecology	70.29	85.94	85.29	70.00	47.79	73.53	66.67	68.53	80.51	69.85	71.08	81.62	72.12	56.35	63.54	66.05	44.12	66.25
Paediatrics	75.00	94.38	95.14	72.50	50.83	71.67	65.63	77.00	74.50	78.75	71.67	75.63	55.83	45.00	47.22	65.28	52.08	58.33
Respiratory Medicine	70.00	85.36	79.46	62.86	30.36	66.67	75.00	67.14	68.57	67.86	61.91	79.46	59.03	59.72	56.95	64.17	25.00	53.25
Trauma and orthopaedic surgery	82.50	92.50	81.25	74.69	51.56	81.25	56.25	86.25	83.75	81.25	75.00	95.31	87.50	83.89	83.34	88.54	59.38	

The results demonstrate the following trends compared to 2021 results:

Improvements since 2021 observed in: Acute Medicine, Cardiology, Geriatric Medicine, Obstetrics & Gynaecology and Paediatrics

Areas of Outstanding (positive outlier) observed in: Clinical Radiology, Anaesthetics and ICU

Deterioration since 2021 observed in: Gastroenterology, Diabetes and Endocrinology and General Internal Medicine

No/little Change since 2021 or no comparable data: Emergency Medicine (still remaining negative outlier), General Surgery, Trauma and Orthopaedics, and Respiratory Medicine

Action Plans required for improvement: Emergency Medicine, Gastroenterology, Diabetes and Endocrinology and General Internal Medicine. Update on current action plan requested from Acute Medicine

Specialty to note results – no formal action plan required: Cardiology, Radiology, General Surgery, Geriatric Medicine, Obstetrics & Gynaecology, Paediatrics, Respiratory Medicine, Trauma and Orthopaedics and ICU

Year by Year Comparisons by Specialty

1.1 Acute Internal Medicine

Post Specialty	Indicator	2018	2019	2021	2022
Acute Internal Medicine	Overall Satisfaction	51.67	61.78	67.14	63.33
Acute Internal Medicine	Clinical Supervision	70	76.25	75	81.25
Acute Internal Medicine	Clinical Supervision out of hours	76.39	84.12	73.21	79.51
Acute Internal Medicine	Reporting systems	65.56	71.67	60	57
Acute Internal Medicine	Work Load	31.94	47.22	36.61	31.95
Acute Internal Medicine	Teamwork	65.74	62.96	61.91	72.22
Acute Internal Medicine	Handover	57.5	61.25	67.71	68.75
Acute Internal Medicine	Supportive environment	50	57.22	54.29	66.67
Acute Internal Medicine	Induction	73.33	55	73.93	75
Acute Internal Medicine	Adequate Experience	62.78	68.33	58.93	64.58
Acute Internal Medicine	Curriculum Coverage	59.26	71.3	63.69	
Acute Internal Medicine	Educational Governance	59.26	66.67	69.05	61.11
Acute Internal Medicine	Educational Supervision	74.31	74.31	68.75	72.92
Acute Internal Medicine	Feedback	56.67	54.17	73.33	34.72
Acute Internal Medicine	Local Teaching	62.33	54.67	41.95	53.67
Acute Internal Medicine	Regional Teaching	80.67	69	46.53	59.17
Acute Internal Medicine	Study Leave	48.44	62.5	49.17	40.11
Acute Internal Medicine	Rota Design	29.17	47.92	45.54	31.25
Acute Internal Medicine	Facilities			42.5	54

	2021	2022	Trend

Reds	1	0	↑
Pinks	9	4	↑

Summary: There have been significant improvements in the volume of pink indicators in comparison to 2021 and 2019 and no further red indicators. Improvements noted in clinical supervision, teamwork and supportive environment which has taken them out of the lower quartile for the first time since 2018.

Action: Royal Colleague Tutor for Medicine and Clinical Lead for Acute Medicine to note results and continue to drive improvements accordingly. Action Plan shared from last years results and Quality Visits to be updated with any remaining focus areas to be monitored by the specialty and the Medical Education Quality Committee

1.2 Anaesthetics

Post Specialty	Indicator	2018	2019	2021	2022
Anaesthetics	Overall Satisfaction	85.11	88.91	76.67	93.33
Anaesthetics	Clinical Supervision	95.56	98.18	93.33	95.83
Anaesthetics	Clinical Supervision out of hours	96.53	94.89	90.97	96.88
Anaesthetics	Reporting systems	73.13	72.84	69.22	82
Anaesthetics	Work Load	57.64	60.23	63.89	62.5
Anaesthetics	Teamwork	73.15	72.73	66.67	68.06
Anaesthetics	Handover	63.99	62.08	46.09	67.19
Anaesthetics	Supportive environment	84.44	76.82	66.67	93.33
Anaesthetics	Induction	85	90.91	86.11	98.33
Anaesthetics	Adequate Experience	84.72	83.64	84.72	95.83
Anaesthetics	Curriculum Coverage	86.11	82.58	83.33	
Anaesthetics	Educational Governance	88.89	87.88	75.93	87.5
Anaesthetics	Educational Supervision	97.92	84.66	89.58	98.96
Anaesthetics	Feedback	91.67	92.86	72.03	97.92
Anaesthetics	Local Teaching	75.92	83.33	69.63	92.5
Anaesthetics	Regional Teaching	80.28	68.79	63.42	70.84
Anaesthetics	Study Leave	90.05	78.03	67.97	93.4
Anaesthetics	Rota Design	65.97	81.25	68.75	88.54

	2021	2022	Trend
Reds	1	0	↑
Pinks	2	0	↑

Summary: There has been significant improvement in a number of areas with the Speciality scoring in the top quartile of the benchmark group for 7 areas. Well done to all involved in showcasing some of the excellent educational opportunities Warrington Anaesthetics team has to offer.

Action: Royal Colleague Tutor for Anaesthetics to note results and continue to drive improvements accordingly.

1.3 Cardiology

Post Specialty	Indicator	2018	2019	2021	2022
Cardiology	Overall Satisfaction	51.4	74.2	72	66.25
Cardiology	Clinical Supervision	65	89	92	83.75
Cardiology	Clinical Supervision out of hours	68.75	85	80	75
Cardiology	Reporting systems	43	68	51	56.67
Cardiology	Work Load	31.25	40	32.5	37.5
Cardiology	Teamwork	53.33	68.33	56.67	79.17
Cardiology	Handover	18.75	68.75	64.58	
Cardiology	Supportive environment	50	65	54	68.75
Cardiology	Induction	56	61	80	71.25
Cardiology	Adequate Experience	45	64.5	60	62.5
Cardiology	Curriculum Coverage	50	63.33	66.67	
Cardiology	Educational Governance	51.67	45	68.33	66.67
Cardiology	Educational Supervision	63.75	75	90	85.94
Cardiology	Feedback	39.58	50		
Cardiology	Local Teaching	35	8.89	76.11	
Cardiology	Regional Teaching	62.78	67.22	66.67	
Cardiology	Study Leave	47.22	56.94	60.42	
Cardiology	Rota Design	17.5	33.75	46.25	28.13
Cardiology	Facilities			55	

	2021	2022	Trend
Reds	4	0	↑
Pinks	2	2	↑

Summary: There is a continued improving trend in Cardiology with a full reduction in all red areas. Well done to the team for all the hard work and we are pleased to see this has been recognised.

Action: Royal Colleague Tutor for Medicine and Clinical Lead for Cardiology to note results and continue to drive improvements accordingly. Action plan from 2021 results to be updated to allow us to close in Med Ed Quality Committee.

1.4 Clinical Radiology

Post Specialty	Indicator	2018	2019	2021	2022
Clinical radiology	Overall Satisfaction	91.14	86.86	79.38	94.29
Clinical radiology	Clinical Supervision	97.14	93.39	94.84	97.86
Clinical radiology	Clinical Supervision out of hours	88.89	96.25	84.38	87.92
Clinical radiology	Reporting systems	79.17	86	67.75	89
Clinical radiology	Work Load	59.82	63.69	71.36	74.4
Clinical radiology	Teamwork	83.34	87.5	69.05	84.73
Clinical radiology	Supportive environment	82.86	87.86	79.38	95.71
Clinical radiology	Induction	91.43	94.29	87.19	97.14
Clinical radiology	Adequate Experience	90.36	85.36	76.56	89.29
Clinical radiology	Curriculum Coverage	83.93	84.52	78.13	
Clinical radiology	Educational Governance	83.33	83.33	77.08	80.95
Clinical radiology	Educational Supervision	92.86	91.07	81.25	98.21
Clinical radiology	Feedback	91.67	88.89	73.96	80.83
Clinical radiology	Local Teaching	88.57	70.24	66.67	89.05
Clinical radiology	Regional Teaching	61.17	52.33	69.79	73.81
Clinical radiology	Study Leave	76.19	76.49	76.78	73.61
Clinical radiology	Facilities			68.75	

	2021	2022	Trend
Reds	0	0	↑
Pinks	3	0	↑

Summary: There has been significant improvement in a number of areas with the Speciality scoring in the top quartile of the benchmark group for a 4 areas. Well done to all involved in show casing some of the excellent educational opportunities Warrington Clinical Radiology has to offer.

Action: Royal Colleague Tutor to note results and continue to drive improvements accordingly.

1.5 Emergency Medicine

Post Specialty	Indicator	2018	2019	2021	2022
Emergency Medicine	Overall Satisfaction	71.92	73.46	67.81	63.5
Emergency Medicine	Clinical Supervision	85.52	92.21	89.06	75.14
Emergency Medicine	Clinical Supervision out of hours	82.29	86.81	88.67	70.37
Emergency Medicine	Reporting systems	77.5	71.06	63.85	67.22
Emergency Medicine	Work Load	34.62	27.88	35.55	24.38
Emergency Medicine	Teamwork	75.64	66.67	69.27	66.67
Emergency Medicine	Handover	68.58	53.96	57.68	48.33
Emergency Medicine	Supportive environment	68.85	71.15	64.69	59.5
Emergency Medicine	Induction	79.62	80.38	76.25	81.25
Emergency Medicine	Adequate Experience	78.65	79.23	71.88	68.75
Emergency Medicine	Curriculum Coverage	70.51	71.15	72.4	
Emergency Medicine	Educational Governance	74.36	68.59	61.98	72.5
Emergency Medicine	Educational Supervision	83.17	80.77	76.17	78.13
Emergency Medicine	Feedback	69.32	60.26	41.67	75.93
Emergency Medicine	Local Teaching	65.95	57.86	43.83	75.33
Emergency Medicine	Regional Teaching	75.95	74.88	62.5	71.67
Emergency Medicine	Study Leave	58.85	49.65	63.67	59.58
Emergency Medicine	Rota Design	49.52	47.6	56.25	42.5
Emergency Medicine	Facilities			66.48	53.21

	2021	2022	Trend
Reds	3	4	↓
Pinks	3	2	↑

Summary: There is deterioration in 11 indicators and improvements in 7. Overall, there are less pink indicators compared to 2021 and only 1 more red indicator.

Action: We recognise the unprecedented pressures experienced in the ED at the moment and we are committed to supporting the department and its trainees. We are also aware of the extensive improvement work and constant review already ongoing and thank you for keeping us updated on improvement plans and how they are evolving. Action plan from 2021 results and Quality Visit shared with Clinical Lead for Emergency Medicine to update the areas outstanding (particular focus on Supervision and handover). Action plan to be monitored by the specialty and the Medical Education Quality Committee

1.6 Diabetes and Endocrinology

Post Specialty	Indicator	2018	2019	2021	2022
Endocrinology and diabetes mellitus	Overall Satisfaction	50.67	63	77.5	63.33
Endocrinology and diabetes mellitus	Clinical Supervision	78.33	71.67	91.67	86.67
Endocrinology and diabetes mellitus	Clinical Supervision out of hours	85.42	75	86.81	82.29
Endocrinology and diabetes mellitus	Reporting systems	53.33		71.67	56
Endocrinology and diabetes mellitus	Work Load	33.33	25	34.38	25
Endocrinology and diabetes mellitus	Teamwork	61.11	77.78	65.28	70.83
Endocrinology and diabetes mellitus	Handover	47.92	75	65.28	62.5
Endocrinology and diabetes mellitus	Supportive environment	60	65	66.67	63.33
Endocrinology and diabetes mellitus	Induction	55	55	67.08	67.5
Endocrinology and diabetes mellitus	Adequate Experience	51.67	77.5	75	64.58
Endocrinology and diabetes mellitus	Curriculum Coverage	55.55	86.11	80.56	
Endocrinology and diabetes mellitus	Educational Governance	41.67	75	76.39	55.56
Endocrinology and diabetes mellitus	Educational Supervision	50	93.75	77.08	75
Endocrinology and diabetes mellitus	Feedback	48.61	58.33	84.72	66.67
Endocrinology and diabetes mellitus	Local Teaching	49.44	52.78	58.34	41.33
Endocrinology and diabetes mellitus	Regional Teaching	48.61	56.11	58.33	40.83
Endocrinology and diabetes mellitus	Study Leave	43.06		51.39	32.5
Endocrinology and diabetes mellitus	Rota Design	33.33	39.58	50	18.75
Endocrinology and diabetes mellitus	Facilities			62	41.46

	2021	2022	Trend
Reds	0	4	↓
Pinks	0	4	↓

Summary: There has been a deterioration in 17 of the areas including an increase of areas in the bottom quartile with 4 red indicators and 4 pink. Please review all areas in particular areas where the Trust is marked as an outlier (red/pink)

Action: Royal College Tutor for medicine / clinical lead for Endocrinology and Diabetes to develop an action plan for improvement to monitored by the specialty and the Medical Education Quality Committee

1.7 Gastroenterology

Post Specialty	Indicator	2018	2019	2021	2022
Gastroenterology	Overall Satisfaction	59.2	61	80	61
Gastroenterology	Clinical Supervision	82	82.5	87.68	80
Gastroenterology	Clinical Supervision out of hours	81.25	73.44	89.88	74.17
Gastroenterology	Reporting systems	62	67.5	69.17	68.25
Gastroenterology	Work Load	32.5	34.38	32.14	23.75
Gastroenterology	Teamwork	61.67	52.09	67.86	61.67
Gastroenterology	Handover	43.75		70.31	72.92
Gastroenterology	Supportive environment	54	52.5	68.57	51
Gastroenterology	Induction	48	62.5	83.57	59
Gastroenterology	Adequate Experience	59.5	73.75	76.79	60
Gastroenterology	Curriculum Coverage	63.33	75	77.38	
Gastroenterology	Educational Governance	58.33	72.92	75	43.33
Gastroenterology	Educational Supervision	78.75	73.96	87.5	76.25
Gastroenterology	Feedback	61.46	38.89	62.5	66.67
Gastroenterology	Local Teaching	61.11		65.55	50.56
Gastroenterology	Regional Teaching	56.67		66.67	44.44
Gastroenterology	Study Leave	57.64		48.44	29.17
Gastroenterology	Rota Design	38.75	48.44	53.57	17.08
Gastroenterology	Facilities			73.75	

	2021	2022	Trend
Reds	0	5	↓
Pinks	0	6	↓

Summary: There has been a deterioration in 15 areas and an improvement in 2. There are also 11 red or pink areas which is significant in particular compared to the previous results.

Action: Royal College Tutor for medicine / clinical lead for gastroenterology to develop an action plan for improvement to monitored by the specialty and the Medical Education Quality Committee

1.8 General Internal Medicine

Post Specialty	Indicator	2018	2019	2021	2022
General (internal) medicine	Overall Satisfaction	65.4	63.38	78	60
General (internal) medicine	Clinical Supervision	77	76.88	93.5	80
General (internal) medicine	Clinical Supervision out of hours	82.81	89.06	92.5	
General (internal) medicine	Reporting systems	62	66.88	76	
General (internal) medicine	Work Load	40	46.88	45	34.72
General (internal) medicine	Teamwork	70	65.63	76.67	75
General (internal) medicine	Handover	47.5	73.44	72.5	72.92
General (internal) medicine	Supportive environment	63	56.88	66	70
General (internal) medicine	Induction	68	67.19	68	61.67
General (internal) medicine	Adequate Experience	68.5	61.56	75	58.33
General (internal) medicine	Curriculum Coverage	63.33	56.25	71.67	
General (internal) medicine	Educational Governance	63.33	66.67	71.67	69.44
General (internal) medicine	Educational Supervision	81.25	77.34	72.5	85.42
General (internal) medicine	Feedback		42.71		
General (internal) medicine	Local Teaching	65	58.96	40.33	28.33
General (internal) medicine	Regional Teaching	57.17	56.87	55	54.17
General (internal) medicine	Study Leave	50	54.69	72.92	36.11
General (internal) medicine	Rota Design	40	38.28	59.9	47.92
General (internal) medicine	Facilities			66.67	

	2021	2022	Trend
Reds	0	0	↔
Pinks	2	5	↓

Summary: There has been a deterioration in 11 of the 18 areas including an increase 5 pink indicators in the lower quartile. Please review all areas in particular areas where the Trust is marked as an outlier (pink)

Action: Royal College Tutor for medicine / clinical lead for General Internal Medicine to develop an action plan for improvement to monitored by the specialty and the Medical Education Quality Committee

1.9 General Surgery

Post Specialty	Indicator	2018	2019	2021	2022
General surgery	Overall Satisfaction	80.39	82.14	71.36	73.44
General surgery	Clinical Supervision	87.5	86.82	81.08	87.19
General surgery	Clinical Supervision out of hours	85.81	86.93	82.44	87.89
General surgery	Reporting systems	76.14	73.33	69.88	66.33
General surgery	Work Load	44.02	56.25	45.74	43.88
General surgery	Teamwork	69.38	67.05	63.26	68.23
General surgery	Handover	68.94	68.13	61.63	64.06
General surgery	Supportive environment	74.57	67.95	64.09	66.56
General surgery	Induction	86.96	80.74	72.1	76.88
General surgery	Adequate Experience	84.67	82.39	73.86	71.88
General surgery	Curriculum Coverage	80.8	76.9	71.59	
General surgery	Educational Governance	71.74	73.86	71.97	67.71
General surgery	Educational Supervision	87.77	85.51	83.81	84.38
General surgery	Feedback	75	61.98	58.09	64.88
General surgery	Local Teaching	85.63	79.29	71.04	67.59
General surgery	Regional Teaching	92.08	89.05	77.09	66.2
General surgery	Study Leave	77.46	72.29	59.38	80.68
General surgery	Rota Design	64.95	67.33	41.96	45
General surgery	Facilities			57.57	54.17

	2021	2022	Trend
Reds	1	0	↑
Pinks	0	0	↑

Summary: The results remain stable with slight improvement in a 11 areas and slight deterioration in 7. There are no red or pink indicators and scoring is consistent and balanced.

Action: Royal College Tutor for surgery to note results and action accordingly

1.10 Geriatric Medicine

Post Specialty	Indicator	2018	2019	2021	2022
Geriatric medicine	Overall Satisfaction	53.11	58.73	72.5	63.33
Geriatric medicine	Clinical Supervision	76.25	69.43	83.5	89.44
Geriatric medicine	Clinical Supervision out of hours	63.02	77.08	76.88	84.72
Geriatric medicine	Reporting systems	54.44	60.91	62	62.36
Geriatric medicine	Work Load	39.58	37.5	39.38	41.67
Geriatric medicine	Teamwork	62.04	66.67	68.33	71.3
Geriatric medicine	Handover	46.88	60.42	72.5	70.54
Geriatric medicine	Supportive environment	44.44	55.91	71.5	72.22
Geriatric medicine	Induction	65.28	60.91	73.5	73.89
Geriatric medicine	Adequate Experience	57.5	60.45	72.5	66.67
Geriatric medicine	Curriculum Coverage	49.07	62.88	71.67	
Geriatric medicine	Educational Governance	50	68.18	73.33	63.89
Geriatric medicine	Educational Supervision	69.44	76.14	83.75	81.25
Geriatric medicine	Feedback	54.17	46.43	76.04	72.62
Geriatric medicine	Local Teaching	60.42	61.39	41	39.52
Geriatric medicine	Regional Teaching	65	63.61	56.67	60.72
Geriatric medicine	Study Leave	45.83	62.85	62.08	52.38
Geriatric medicine	Rota Design	18.75	34.09	50.63	36.81
Geriatric medicine	Facilities			72.08	51.43

	2021	2022	Trend
Reds	1	0	↑
Pinks	1	2	↓

Summary: Significant and ongoing improvement can be observed in particular in comparison to the 2018/2019 results. There are no red indicators and only 2 pink.

Action: Royal College Tutor for medicine / Clinical Lead for geriatrics to note results and action accordingly. No formal Trust action plan required at this stage.

1.11 Intensive Care Medicine

Post Specialty	Indicator	2018	2019	2021	2022
Intensive care medicine	Overall Satisfaction			68.33	96.25
Intensive care medicine	Clinical Supervision			93.33	100
Intensive care medicine	Clinical Supervision out of hours			91.67	96.88
Intensive care medicine	Reporting systems				91.67
Intensive care medicine	Work Load			75.69	81.25
Intensive care medicine	Teamwork			58.33	89.58
Intensive care medicine	Handover			45.83	81.25
Intensive care medicine	Supportive environment			71.67	95
Intensive care medicine	Induction			88.33	98.75
Intensive care medicine	Adequate Experience			87.5	96.88
Intensive care medicine	Curriculum Coverage			80.55	
Intensive care medicine	Educational Governance			69.45	87.5
Intensive care medicine	Educational Supervision			83.33	90.63
Intensive care medicine	Feedback				90.28
Intensive care medicine	Local Teaching				
Intensive care medicine	Regional Teaching				
Intensive care medicine	Study Leave			70.83	93.75
Intensive care medicine	Rota Design			72.92	95.31
Intensive care medicine	Facilities				

	2021	2022	Trend
Reds	2	0	↑
Pinks	1	0	↑

Summary: Significant improvements can be seen across all indicators and in particular the increase of 9 areas in the top quartile. Well done to all involved it is clear how much hard work has gone into enhancing the educational opportunities in our ICU department.

Action: Royal College Tutor for medicine / Clinical Lead for Critical care to note results and action accordingly.

1.12 Obstetrics and Gynaecology

Post Specialty	Indicator	2018	2019	2021	2022
Obstetrics and gynaecology	Overall Satisfaction	77.67	75.81	51.79	70.29
Obstetrics and gynaecology	Clinical Supervision	92.71	86.41	81.52	85.94
Obstetrics and gynaecology	Clinical Supervision out of hours	90.34	85.16	78.13	85.29
Obstetrics and gynaecology	Reporting systems	76.25	70	68.75	70
Obstetrics and gynaecology	Work Load	53.65	54.69	52.68	47.79
Obstetrics and gynaecology	Teamwork	75	70.83	67.86	73.53
Obstetrics and gynaecology	Handover	65.97	68.19	52.98	66.67
Obstetrics and gynaecology	Supportive environment	73.33	70.94	58.57	68.53
Obstetrics and gynaecology	Induction	79.58	77.81	73.21	80.51
Obstetrics and gynaecology	Adequate Experience	84.17	75.94	55.36	69.85
Obstetrics and gynaecology	Curriculum Coverage	83.33	73.7	56.55	
Obstetrics and gynaecology	Educational Governance	75.7	66.67	61.31	71.08
Obstetrics and gynaecology	Educational Supervision	75	79.3	76.79	81.62
Obstetrics and gynaecology	Feedback	91.67	59.94	73.33	72.12
Obstetrics and gynaecology	Local Teaching	51.95	64.22	29.49	56.35
Obstetrics and gynaecology	Regional Teaching	75.83	64.39	53.21	63.54
Obstetrics and gynaecology	Study Leave	83.71	75.69	59.67	66.05
Obstetrics and gynaecology	Rota Design	57.47	46.88	35.71	44.12
Obstetrics and gynaecology	Facilities			61.25	66.25

	2021	2022	Trend
Reds	6	0	↑
Pinks	1	0	↑

Summary: Significant improvements can be observed in O&G compared to 2021. The specialty should continue to strive towards excellence by working to further improve and to achieve scores in the upper quartiles (greens).

Action: Royal College Tutor for Obstetrics & Gynaecology to note results and continue to drive improvements accordingly. Action plan from 2021 results to be updated to allow us to close in Med Ed Quality Committee.

1.13 Paediatrics

Post Specialty	Indicator	2018	2019	2021	2022
Paediatrics	Overall Satisfaction	77.5	73.19	77	75
Paediatrics	Clinical Supervision	93.75	91.06	91.25	94.38
Paediatrics	Clinical Supervision out of hours	95.7	90.73	89.58	95.14
Paediatrics	Reporting systems	76.52	67.43	73.16	72.5
Paediatrics	Work Load	40.1	43.65	46.25	50.83
Paediatrics	Teamwork	82.55	69.25	64.91	71.67
Paediatrics	Handover	74.41	63.19	72.45	65.63
Paediatrics	Supportive environment	72.81	66.67	64.75	77
Paediatrics	Induction	70.31	74.76	77.94	74.5
Paediatrics	Adequate Experience	81.88	72.86	71.25	78.75
Paediatrics	Curriculum Coverage	77.6	67.06	73.25	
Paediatrics	Educational Governance	71.35	63.49	71.25	71.67
Paediatrics	Educational Supervision	77.73	77.08	73.75	75.63
Paediatrics	Feedback	69.58	50.32	49.31	55.83
Paediatrics	Local Teaching	47.22	55.09	69.74	45
Paediatrics	Regional Teaching	65.53	66.13	48.68	47.22
Paediatrics	Study Leave	59.82	54.63	56.69	65.28
Paediatrics	Rota Design	50.13	57.08	61.62	52.08
Paediatrics	Facilities			50.27	58.33

	2021	2022	Trend
Reds	3	1	↑
Pinks	2	1	↑

Summary: There is significant improvement from 2021 with the number of red/pink indictors reducing by over half and overall numbers improving in 11 out of the 18 areas.

Action: Royal College Tutor / Clinical Lead for Paediatrics note results and continue to drive improvements accordingly. Action plan from 2021 results to be updated to allow us to close in Med Ed Quality Committee.

1.14 Respiratory Medicine

Post Specialty	Indicator	2018	2019	2021	2022
Respiratory Medicine	Overall Satisfaction	63	64	80	70
Respiratory Medicine	Clinical Supervision	74.29	76.25	84.17	85.36
Respiratory Medicine	Clinical Supervision out of hours	69.64	73.44	79.86	79.46
Respiratory Medicine	Reporting systems	64.17	70	71	62.86
Respiratory Medicine	Work Load	32.14	34.38	33.33	30.36
Respiratory Medicine	Teamwork	63.1	60.42	68.06	66.67
Respiratory Medicine	Handover	53.13		70.83	75
Respiratory Medicine	Supportive environment	59.29	65	67.5	67.14
Respiratory Medicine	Induction	60.71	67.5	82.08	68.57
Respiratory Medicine	Adequate Experience	68.21	74.38	83.33	67.86
Respiratory Medicine	Curriculum Coverage	64.29	70.83	81.95	
Respiratory Medicine	Educational Governance	60.72	70.83	79.17	61.91
Respiratory Medicine	Educational Supervision	84.82	82.81	72.92	79.46
Respiratory Medicine	Feedback	69.64	63.54	60.42	59.03
Respiratory Medicine	Local Teaching	58.34		66.66	59.72
Respiratory Medicine	Regional Teaching	72.92		59.72	56.95
Respiratory Medicine	Study Leave	66.15		68.06	64.17
Respiratory Medicine	Rota Design	30.36	32.81	41.67	25
Respiratory Medicine	Facilities				53.25

	2021	2022	Trend
Reds	0	1	↓
Pinks	2	1	↑

Summary: Significant and ongoing improvement can be observed in particular in comparison to the 2018/2019 results. There is only 1 red indicator in rota design, which as medicine has been on an escalated rota we would expect across most of the specialities and 1 pink in team work. Consistent results and improvements maintained

Action: Royal College Tutor for medicine to note results and action accordingly. No formal Trust action plan required.

1.15 Trauma and Orthopaedics

Post Specialty	Indicator	2018	2019	2021	2022
Trauma and orthopaedic surgery	Overall Satisfaction	69.3	67.27	70	82.5
Trauma and orthopaedic surgery	Clinical Supervision	79.5	85.68	78.33	92.5
Trauma and orthopaedic surgery	Clinical Supervision out of hours	71.09	76.7	65.28	81.25
Trauma and orthopaedic surgery	Reporting systems	74.38	70	68.75	74.69
Trauma and orthopaedic surgery	Work Load	53.54	38.45	31.02	51.56
Trauma and orthopaedic surgery	Teamwork	71.67	70.46	65.63	81.25
Trauma and orthopaedic surgery	Handover	61.98	60.16	72.5	56.25
Trauma and orthopaedic surgery	Supportive environment	67.5	63.18	71.11	86.25
Trauma and orthopaedic surgery	Induction	76.5	78.64	76.11	83.75
Trauma and orthopaedic surgery	Adequate Experience	72.75	73.41	68.06	81.25
Trauma and orthopaedic surgery	Curriculum Coverage	82.5	72.73	71.3	
Trauma and orthopaedic surgery	Educational Governance	72.5	69.7	68.52	75
Trauma and orthopaedic surgery	Educational Supervision	79.38	79.55	83.33	95.31
Trauma and orthopaedic surgery	Feedback	61.98	73.75	72.92	87.5
Trauma and orthopaedic surgery	Local Teaching	78.33	59	60	83.89
Trauma and orthopaedic surgery	Regional Teaching	86	92.33	72.22	83.34
Trauma and orthopaedic surgery	Study Leave	55.65	59.52	71.25	88.54
Trauma and orthopaedic surgery	Rota Design	65.83	57.64	52.78	59.38
Trauma and orthopaedic surgery	Facilities			66.67	

	2021	2022	Trend
Reds	2	0	↑
Pinks	1	0	↑

Summary: Significant improvements can be observed with a full reduction of negative outliers and 4 categories where the speciality is highlighted as a positive outlier. Slight difference can be noted in the varying trainee groups however Speciality Lead and Medical Education are aware of the Foundation Doctor improvement areas.

Action: Specialty Tutor for T&O to note results and action accordingly. Ongoing monitoring of the action plan for Foundation Doctors and feedback to Medical Education Quality Committee and Junior Doctors forum.

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/22/11/154**	
SUBJECT:	**Medical Appraisal and GMC Revalidation Annual Report: September 2022**	
DATE OF MEETING:		
AUTHOR(S):	Janice Fazackerley – Associate Medical Director Hilary Furniss – Deputy Associate Medical Director Andrea Stazicker – Revalidation Lead Paula Harris – Medical Workforce Development Administrator Kate Davidson – Medical Education Operational Manager	
EXECUTIVE DIRECTOR SPONSOR:	Paul Fitzsimmons Executive Medical Director	
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	SO2 We will.. Be the best place to work with a diverse and engaged workforce that is fit for now and the future	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 Anne Robinson. 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:	The Trust Board is asked 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.			
	Date of meeting	21/9/22		
	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: September 2022**	**AGENDA REF:**	**BM/22/11/154**

1. BACKGROUND/CONTEXT

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 Anne Robinson.
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.

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

We will shortly change our online platform for appraisal, and at the same time incorporate the MAG 2022 model into our processes and documentation.

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

A WHH Appraisal Preparation crib-sheet is provided and updated annually to outline requirements, particularly on focussing the appraisal, quality not quantity, and presenting evidence at the meeting rather than uploading.

The Trust Governance Dept provides information on serious incidents, complaints and claims and this is uploaded to appraisal folders for reflection.

An Independent Sector Checklist or Letter of Good Standing is expected for all work external to WHH.

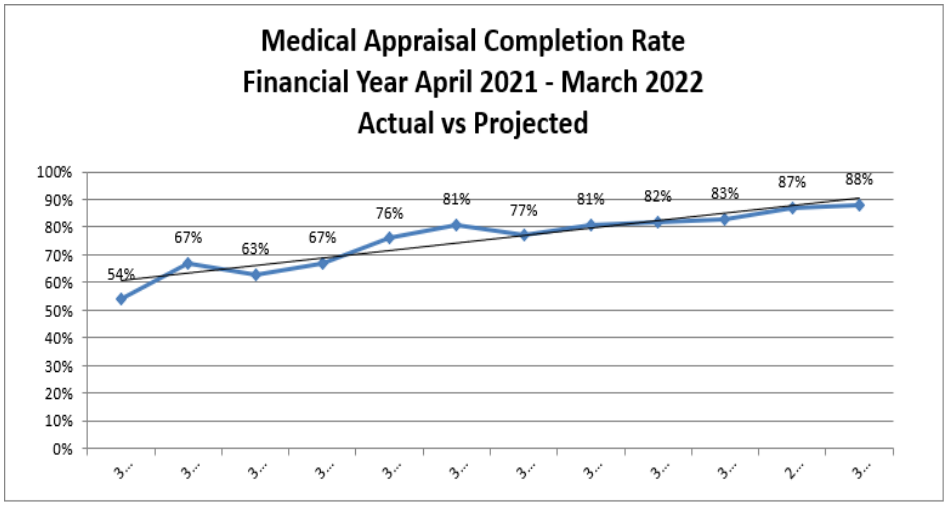
All doctors are programmed to have an appraisal covering the full scope of their work. The focus is very much on support for the doctor to complete their appraisal in a timely fashion. If however the doctor continues to have an overdue appraisal they will receive 3 non-engagement letters in keeping with Trust policy. The doctor will be contacted by the Associate Medical Director to seek mitigating factors and offer relevant support. The RO and Executive Medical Director will also be involved in support for the doctor. There is monitoring of this group of doctors by the Trust Triangulation Group. In addition, the R/O and Executive Medical Director meet with the GMC liaison officer on a quarterly basis and discuss doctors who may be having issues/ recommended for deferral. Reporting of non-engaging doctors to the GMC would be done as a last resort.

The Medical Appraisal policy is reviewed annually, ratified, and displayed on the Trust extranet - 1/7/22

The Trust maintains around 70 trained appraisers. The majority appraise 4 doctors, and a few appraise more.

Total number of doctors with a prescribed connection as of 31 March 2022	**298**
Total number of appraisals undertaken between 1 April 2021 and 31 March 2022	**272**
Total number of appraisals not undertaken between 1 April 2021 and 31 March 2022	**26**
Total number of agreed exceptions	**0**

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.



An annual training course for new appraisers, run by MIAD was held in November 2021. This is funded from the Medical Education budget with no financial impact on doctors Study Leave allowance

Appraiser forums are held bi-annually, the most recent date being 12/5/22

The Appraisal and Revalidation group are all available either by phone or email, as points of contact for advice and support.

b. Recommendations to the GMC

Recommendations to the GMC:	
Total number of positive recommendations submitted between 1 April 2021 and 31 March 2022	44
Total number of recommendations for deferral submitted between 1 April 2021 and 31 March 2022	6
Total number of recommendations for non-engagement submitted between 1 April 2021 and 31 March 2022	0
Total number of recommendations submitted after due date between 1 April 2021 and 31 March 2022	0

Doctors who are due for revalidation are identified via GMC Connect from the list of those for whom this Trust is the Designated Body. Supporting evidence is collated for each doctor and presented at the next Revalidation Decision Making Panel. Panels are held as needed and review 8-15 doctors per session. The panel consists of the Responsible Officer, Associate Medical Director Appraisal and Revalidation, Revalidation Lead and a Non-Executive Director. Doctors are considered for revalidation in time for any shortfalls to be addressed whenever possible. Most recommendations have been submitted to the GMC either ahead of time or on the actual submission date.

c. 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. Cases of concern are discussed at the monthly Medical Triangulation Meeting. This is attended by the Executive Medical Director, R/O, AMD for appraisal and revalidation, Head of HR and deputy director of governance.

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

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

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

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

2.4 Employment Checks

The system for ensuring pre-employment checks including qualifications and professional registrations are undertaken for fixed term/permanent doctors is completed via the Trust employment services team. In order that professional/clinical staff can fulfil their role, the vast majority are required to be registered with their regulatory body before they can practice. This is a contractual requirement, and it is an explicit term in the contract of employment.

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

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

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

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

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

3. ACTIONS REQUIRED/RESPONSIBLE OFFICER

a. General review of actions since last Board report

2021-2022 has seen a return to more usual functioning of the Appraisal & Revalidation Group following the worst phases of the pandemic.

Personnel changes: The RO and Executive Medical Director posts are now separated which allows some flexibility, and increased input to RO issues The appointment of a deputy AMD to ensure a seamless transfer of responsibility over approximately one year has been achieved by sharing the AMD remuneration. This allows the future AMD to orientate in the role and oversee the procurement and introduction of the new on-line platform.
The Medical Education Manager is now settled in post and has been re-interviewed and appointed to a higher level of responsibility. This has had a stabilising influence on our work. A mix of office and homeworking has developed which has some advantages in delivering the work. The appointment of further administrative support in Medical Education has been a huge help in in servicing meetings and supporting office functions.

Appraisal & Revalidation Group: Regular meetings of our group, chaired by the RO, and supported by the new administrative staff have resumed, initially monthly and now bi-monthly. This has allowed us to review our terms of reference, develop an annual workplan, and to review all our policies and SOPs which had continued unchanged during the pandemic. New policies around information transfer and acceptance of doctors to our Designated Body have been developed.
We have continued our regular bi-annual fora for appraisers and were able to resume new appraiser training and refresher training. All of these have run as on-line events up until now, which has some advantages for time and travel but is noted to be impersonal. We hope to return to in-person meetings during autumn 2022

Appraisal Process: The procurement process for the new on-line platform has begun, with SARD having been selected. The migration of data process will undoubtedly require considerable time together with the introduction of the new system into the Trust and planning of any new processes.
The introduction and acceptance of QA scoring of appraisals has seen some benefit in improving the standard of appraisal and the documented summaries. The average scores have risen over the year and allow us to assure the Board that an acceptable standard is

achieved. Having collected scores over 2 years allows us to identify highly performing appraisers who can accept challenges, and also those needing support, who are offered further help and advice.

3.2 Actions Still Outstanding

1. Discussions between the Medical Education Manager and members of the Human Resource Department are continuing around Medical Staffing issues. We aim to offer each doctor appropriate management of their appraisal and revalidation situation, and to do this effectively we must:
   1.1.1. Refine information flows between the Medical Education and HR departments, and develop productive links with staff involved in the employment process
   1.1.2. Ensure awareness of new starters and better identify the exact assignment of each doctor,
   1.1.3. Maintain accurate databases of doctors for appraisal and avoid last minute additions with subsequent deferral of revalidation.

2. As detailed above, the procurement/ introduction process for the new on-line platform SARD is ongoing and will be complete as our existing CRMS system is 'sunsetted' in January 2023.

4. MEASUREMENTS/EVALUATIONS

Last year we were proud to have maintained business as usual, but also to have developed using some of the positives from pandemic working.

This year, using our enhanced staffing we are better able to review processes and move forward to the new on-line platform, and consideration of further reviews and improvements.

5. TRAJECTORIES/OBJECTIVES AGREED

- Procurement process and implementing the smooth running of the new on-line platform. SARD.
- Continue to drive forward improvements and review of our processes evaluating the past 12 months and completing actions as noted

6. MONITORING/REPORTING ROUTES

- The appraisal activity quarterly reports are sent electronically to the NHS Regional Revalidation Team

- Bi-Annual Report to OPC - March 2023

- 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)

7. TIMELINES

Annual Work Plan for Appraisal & Revalidation Group 2022

Subject	Lead	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
Annual Board Report & Statement of Compliance - Submission	All												
Quarterly Report to Operational People Committee	KD, JF, & AR												
Revalidations: recent panels, & next panel Non-engagement reports/numbers/trends	AS												
Appraisals: numbers of doctors & appraisers, Overdue appraisals Numbers/Trends	PH												
Appraiser Forum Planning	JF/HF & PH												
Workplan for next year	AW												
Budget & contract reports	JF/HF (KD)												
Quality Assurance of appraisal	JF												
POLICY REVIEWS													
Terms of Reference	KD												
Medical Appraisal	JF/HF												
Revalidation	AS												
360 feedback	PH												
Starter/Leaver policies	AS												

8. ASSURANCE COMMITTEE

Appraisal and Revalidation group which feeds into OPC

9. RECOMMENDATIONS

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

PDF
COMPLETE_2021-20
22 Annual Submissi

2021-2022 Annual Submission to NHS England North West:

Appraisal and Revalidation and Medical Governance

Name of organisation:		
	Name	Contact information
Responsible Officer	**Dr Anne Robinson**	**Anne.robinson9@nhs.net**
Medical Director	**Dr Paul Fitzsimmons**	**paul.fitzsimmons1@nhs.net**
Medical Appraisal Lead	**Dr Janice Fazackerley**	**janice.fazackerley@nhs.net**
Appraisal & Revalidation Manager	**Ms Kate Davidson**	**kate.davidson4@nhs.net**
Additional Useful Contacts	**Ms Andrea Stazicker** **Ms Paula Harris**	**andrea.stazicker@nhs.net** **paula.harris6@nhs.net**

Contents

Introduction:

The Annual Organisational Audit has been stood down again for the 2021/22 year. A refreshed approach is planned for 2022/23. It still remains a requirement for each Designated Body to provide assurance to their Board about the governance arrangements in place in relation to appraisal, revalidation and managing concerns. In addition, NHS England North West use information previously provided in the AOA to inform a plan for quality visits to Designated Bodies. These visits are now starting to be planned in again moving forwards.

Amendments have been made to Board Report template (Annex D) with the intention of making completion of the submission straightforward whilst retaining the goals of the previous report:

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

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

c) act as evidence for CQC inspections.

This template for an Annual Submission to NHS England North West should be used as evidence for the Board (or equivalent management team) of compliance with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013) or appended to your own board report where a local template exists.

This completed document is required to be submitted to NHS England North West by the end of September 2022 and should be sent to england.nw.hlro@nhs.net

Annual Submission to NHS England North West

Section 1 – General:

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

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

Yes

2021/2022 update: Dr Anne Robinson, Deputy Medical Director has been appointed Responsible Officer (RO) for the Trust replacing Medical Director Alex Crowe in November 2021.

RO Training completed in September 2021

RO attends the North West Higher Level Responsible Officers Network (NWHLRO) update on a quarterly basis supported by AMD and Revalidation Lead.

Action for next year: Dr Robinson to continue as RO supported by relevant CPD/attendance at quarterly NHS England NWHLRO meetings

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

Yes

2021/2022 update including description of Appraisal & Revalidation support:

The Responsible Officer is supported by:

a. An Associate Medical Director (AMD), Dr Janice Fazackerley, resourced 2 PAs

b. A Revalidation Lead, Andrea Stazicker – 80% WTE

c. A Medical Workforce Development Administrator, Paula Harris 1 WTE

d. Medical Education Manager, Kate Davidson, who manages the Revalidation Lead and Medical Workforce Development Administrator in addition to duties in Medical Education.

As per our actions from last year we have now also appointed

- Deputy Associate Medical Director 1PA – Dr Hilary Furniss to ensure a seamless handover of AMD duties, and oversee introduction of new on-line platform for appraisal
- Additional Band 3 clerical support to facilitate cross-cover and support and avert single points of failure in the working practices

The Trust currently provides on-line platforms for the management of all doctors' annual appraisals. (CRMS / System C) A 360-degree feedback is provided in every 5 year cycle (Premier IT) to support the necessary colleague and patient feedback for revalidation

Due to the sunsetting of CRMS we are currently going through the review process to support procurement of a new more efficient system which encompasses all requirements including appraisal and 360 feedback in a user-friendly way.

The Trust's appraisers are remunerated 0.125PAs per 4 appraisees or 0.25 for more than 4. The Trust supports appraisers with initial training, refresher training and update forums

Action for next year:

1. Continue procurement process for new online appraisal system –[SARD] Deadline Jan 2023, with seamless transition between the two systems.

2 Dr Fazackerley to retire and Dr Furniss to take over the full AMD role, remunerated 3 PAs.

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

2021/2022 update:

Connections to, and removals from, the Designated Body are managed by the Revalidation Lead.

Lists of connected doctors and revalidation dates are shared and stored in electronic format in a secure area of the Trust server, which is accessible to ARG members, and updated monthly.

The Appraisal and Revalidation group have reviewed and developed policies relating to medical staffing as per actions

- annual review of Revalidation Policy and Medical Appraisal Policy complete

- SOP for Medical Workforce New Starter for Medical Appraisal and Revalidation Purposes -review complete

Action for next year:

Development of an SOP with HR input

-to facilitate improved information sharing between the two departments

-to support correct and prompt recognition and assignment of doctors, in particular locum doctors.

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

List of relevant policies and date of last review:

Medical Appraisal - 1/7/2022

Appraisal & Revalidation Group (ARG) Terms of Reference (ToR)– 1/2/22

Revalidation Policy – 1/4/22

Information Requests to WHH Responsible Officer SOP – 1/4/22

360 Feedback SOP – 3/3/22

Medical Workforce New Starter for Medical Appraisal and Revalidation Purposes – 1/7/22

2021/2022 update: ARG are completing a full policy review as part of their annual workplan documented in the ToR. Once approved, updated policies are displayed on the Trust Extranet.

Action for next year:

-Annual review of policies in line with ARG workplan ongoing

4. A peer review has been undertaken of this organisation's appraisal and revalidation processes.

2021/2022 update:

The RO and AMD have links to the NWHLRO network. They attend NWHLRO forums supported by the Revalidation Lead to keep up-to-date and discuss topical issues, comparing regional practises, and ensuring standard practices are observed.

National changes to appraisal and revalidation from the GMC and NHSE are communicated electronically to the RO and disseminated to the ARG Team.

All changes to WHH policies & processes in 2020-2021 were discussed and approved by Paul Twomey, then Medical Director, NHS England and NHS Improvement (North East and Yorkshire)

Action for next year:

Complete introduction of new on-line platform and consider a peer review in 2024

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

2021/2022 update:

The Trust employs locum and short term placement doctors to fill operational gaps in rotas. This can present some challenges in maintaining oversight of their appraisal and revalidation needs. Some of the doctors are unaware of the requirements for revalidation but since last year, we have continued to make progress in identifying and contacting these doctors earlier and planning their appraisals ahead. This has resulted in a more effective system.

The Appraisal & Revalidation Group receive monthly updates of new starters, leavers, doctors on periods of prolonged leave. A 'change of assignment' category was added in 2021, which aims to identify more accurately the exact capacity in which doctors are employed.

Many trainees take years out of training and work variable hours in the Trust in a variety of named posts, (including 'Trust Grade', 'Trust Bank Doctor', 'LAS', 'Clinical Fellow', 'FY3, FY4 etc') and locum in all of these grades. They take these posts in pursuit of increased flexibility, freedom from the structure of a training programme, no exams and less rigid and long hours.

The Trust also employs oral surgeons who have work in dental practices, or Trusts, but are supported with study leave allowance, and learning opportunities. They are not subject to GMC revalidation, but the Trust supports their appraisal, mandatory training and CPD to maintain their recognition by the General Dental Council. Governance information is received and reviewed from their other employers

Action for next year:

1.Work closely with HR/Bank and Recruitment department to refine information flows between our department and better identify the exact assignment of each doctor

2. Explore other methods of information capture to provide additional safety nets.

3. Maintain accurate databases of doctors for appraisal

6. Where a Service Level Agreement for External Responsible Officer Services is in place

Describe arrangements for Responsible Officer to report to the Board:

RO – Appraised by designated appraiser for the NWHLRO Network with the regional Higher Level Responsible Officer as RO

The formal appointment of an alternative RO for the Chief Executive & Executive Medical Director has been approved by the Higher Level Responsible Officer (Dr Michael Gregory, Regional Medical Director) in order to remove the potential for a conflict of interest in the form of an inverse reporting relationship with the Warrington and Halton RO. The alternative RO (RO at Liverpool University Hospitals) has agreed to undertake the role and

has assigned an appropriate Liverpool University Hospitals appraiser to each. The doctors designated body remains Warrington and Halton Teaching Hospitals with appraisal documentation hosted on the WHH on-line platform, with secure access granted to the appraisers and alternative RO.

Date of last RO report to the Board: September 2021

Action for next year:

Continue existing arrangements

Section 2a – Effective Appraisal

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

2021/2022 update:

We will shortly change our online platform for appraisal, and at the same time incorporate the MAG 2022 model into our processes and documentation.

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

A WHH Appraisal Preparation crib-sheet is provided and updated annually to outline requirements, particularly on focussing the appraisal, quality not quantity, and presenting evidence at the meeting rather than uploading.

The Trust Governance Dept provides information on serious incidents, complaints and claims and this is uploaded to appraisal folders for reflection.

An Independent Sector Checklist or Letter of Good Standing is expected for all work external to WHH.

Action for next year:

Procurement and migration onto new appraisal platform which incorporates the MAG 2022 model

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

2021/2022 update:

All doctors are programmed to have an appraisal covering the full scope of their work. The focus is very much on support for the doctor to complete their appraisal in a timely fashion. If however the doctor continues to have an overdue appraisal they will receive 3 non-engagement letters in keeping with Trust policy. The doctor will be contacted by the Associate Medical Director to seek mitigating factors and offer relevant support. The RO and Executive Medical Director will also be involved in support for the doctor. There is monitoring of this group of doctors by the Trust Triangulation Group. In addition, the R/O and Executive Medical Director meet with the GMC liaison officer on a quarterly basis and discuss doctors who may be having issues/ recommended for deferral. Reporting of non-engaging doctors to the GMC would be done as a last resort.

Action for next year:

1.Continue to review current processes and evaluate success

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

List of relevant policies and date of last review, 2021/2022 update:

The Medical Appraisal policy is reviewed annually, ratified and displayed on the Trust extranet.

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

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

Action for next year:

1.Continue Annual Review

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

2021/2022 update:

The Trust maintains around 70 trained appraisers. The majority appraise 4 doctors, and a few appraise more.

An annual training course for new appraisers, run by MIAD was held in November 2021. This is funded from the Medical Education budget with no financial impact on doctors Study Leave allowance

Appraiser forums are held bi-annually, the most recent date being 12/5/22

The Appraisal and Revalidation group are all available either by phone or email, as points of contact for advice and support.

Action for next year:

Continue annual courses for new appraisers and biannual forums

10. Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers[1] or equivalent).

2021/2022 update:

Medical appraisers in the Trust have been offered 2 virtual appraiser forums, to be updated on developments and to exchange views.

An Appraiser refresher course was offered, run by MIAD. This offered e-learning refresher programmes to cover up to date knowledge and a half-day of presentations and scenarios with discussion. Feedback was very good.

All appraisers were provided with the amalgamated feedback scores and comments from their appraisees following their appraisal meetings. These are collated in the on-line platform and sent to appraisers by email.

During 2020 and 2021, the AMD began making a quality assurance score on appraisal summaries. For the first time, in autumn 2021 appraisers were informed of PROGRESS scores on their appraisal summaries, alongside the Trust range of scores and mean score for comparison. Discussion was offered to any appraisers requesting further feedback, and to those who persistently scored below average. During the year an improvement in summaries and in

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

scores has been noted, with a rise in the Trust's overall average score from 15-16 out of a maximum of 20.

Action for next year:

1.Continue annual refresher programme and forums, hopefully returning to face-to-face meetings.

2. Monitor attendance to ensure that all appraisers have received at least one update during the year

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

2021/2022 update:

The ARG team have continued to track appraisal completion and collate completion data. Overdue appraisals are reported to CBU Clinical Directors or Clinical Leads, and Business Managers, to encourage timely completion.

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

Appraiser performance QA reports and scores are shared with them, as detailed in 10. above, for reflection and discussion, and to drive improvement.

Action for next year:

Continue reporting and QA processes, which will be modified by the new on-line platform

Section 2b – Appraisal Data

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

Total number of doctors with a prescribed connection as of 31 March 2022	**298**
Total number of appraisals undertaken between 1 April 2021 and 31 March 2022	**272**
Total number of appraisals not undertaken between 1 April 2021 and 31 March 2022	**26**
Total number of agreed exceptions	**0**

Section 3 – Revalidation Recommendations to the GMC

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

Recommendations to the GMC:	
Total number of positive recommendations submitted between 1 April 2021 and 31 March 2022	44
Total number of recommendations for deferral submitted between 1 April 2021 and 31 March 2022	6
Total number of recommendations for non-engagement submitted between 1 April 2021 and 31 March 2022	0
Total number of recommendations submitted after due date between 1 April 2021 and 31 March 2022	0

2.

2021/2022 update:

Doctors who are due for revalidation are identified via GMC Connect from the list of those for whom this Trust is the Designated Body. Supporting evidence is collated for each doctor and presented at the next Revalidation Decision Making Panel. Panels are held as needed and review 8-15 doctors per session. The panel consists of the Responsible Officer, Associate Medical Director Appraisal and Revalidation, Revalidation Lead and a Non-Executive Director. Doctors are considered for revalidation in time for any shortfalls to be addressed whenever possible. Most recommendations have been submitted to the GMC either ahead of time or on the actual submission date.

Action for next year:

Continue existing process for revalidation

3. 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.

List of relevant policies and date of last review, 2021/2022 update:

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 the additional information or documentation required, where it is evident that they cannot be given a positive recommendation for revalidation, because they do not meet the criteria, the AMD will discuss possible outcomes, including deferral, with the doctor and offer ongoing support.

Once a revalidation decision has been made by the panel, this is submitted to the GMC via GMC Connect. Each doctor is e-mailed to inform them of the decision. Those who do not receive a positive recommendation are given details of what remains outstanding and what they need to do. If the shortfall in evidence is likely to be rectified before the submission deadline, then the decision can be held back internally and reviewed by the Responsible Officer nearer to the submission deadline. Non-engagers are normally dealt with via the appraisal policy rather than through the revalidation process.

Action for next year:

Continue existing processes incorporating changes in on-line platform

Section 4 – Medical governance

1. This organisation creates an environment which delivers effective clinical governance for doctors. This includes reporting and collation of, for example, complaints, safeguarding concerns and incidents to identify necessity for appropriate intervention at the earliest opportunity.

List of relevant policies and date of last review, 2021/2022 update:

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. Cases of concern are discussed at the monthly Medical Triangulation Meeting. This is attended by the Executive Medical Director, R/O, AMD for appraisal and revalidation, Head of HR and deputy director of governance.

Action for next year:

Continue current process

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

2021/2022 update:

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

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

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

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

Action for next year:

Continue current process

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

List of relevant policies and date of last review, 2021/2022 update:

The Maintaining High Professional Standards Procedures for Medical & Dental Staff covers this process. It was updated in 2019 and has been further reviewed in 2022 to include the terms of reference for the triangulation meetings.

When a concern arises the first consideration is whether the alleged matter is of general misconduct rather than professional misconduct. If the former is considered to be the case, as determined by the Medical Director, the matter will be dealt with under the Trust's Disciplinary procedure. However, should professional concerns emerge during any investigation the case will transfer back to the Maintaining High Professional Standards procedures. At his discretion the Medical Director may convene a Decision-Making Group prior to reaching a conclusion in relation deciding under which procedure to continue the matter.

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

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

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

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

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

When serious concerns are raised about a practitioner, the Trust will consider whether it is necessary to place temporary restrictions on their practice. If the case manager considers a practitioner to be a serious potential danger to patients or staff, that practitioner is referred to the GMC/GDC,

The R/O and medical director hold regular quarterly update meetings with NHS resolution and the ELA from the GMC

Action for next year:

Continue process

4. The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors.[2]

Outline arrangements and frequency for reporting to the Board, 2021/2022 update:

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

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

• Regular triangulation meetings attended by the Medical Director, RO, senior representatives of Human Resources, and the AMD for Appraisal and Revalidation. No decisions about case management are made at these meetings. They are used to discuss progress on investigations and open or emerging cases or issues. No notes of these meetings are kept but the tracker (referred to below) is updated with the current position.

• A tracker in the form of an excel spread sheet which gives brief details of 'live' matters being considered and their current status. This is used to keep track of progress and for reporting at Revalidation Decision Making panels. Access to the tracker is on a restricted basis.

• Regular progress reports on all Employee Relations cases [anonymous basis], are made to the Operational and Strategic People Committees. These committees are held bi-monthly, and the regular reports are presented at each meeting.

Action for next year:

Continue existing processes

5. There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to your organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation.[3]

2021/2022 update:

As per our action last year a robust SOP relating to information transfer has now been developed.: Information Requests for WHH Responsible Officer SOP – 1/4/22

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

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

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

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

Action for next year:

Implement policy

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

2021/2022 update:

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

Case managers and case investigators involved in these procedures are appropriately experienced or have received appropriate training which may be delivered by an external provider or arranged in-house. All nominated case investigators and case managers as a minimum must maintain compliance with mandatory EDI training.

Case investigator training was provided by NHS resolution for a group of Consultants and SAS doctors from WHHNHSFT and RLBUH in July 2022.

Action for next year:

Continue process

Section 5 – Employment Checks

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

List of relevant policies and date of last review, 2021/2022 update:

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

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

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

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

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

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

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

Action for next year:

To continue to review policy annually and work in line with requirements documented.

Section 6 – Summary of comments, and overall conclusion

Please use the Comments Box to detail any additional information that you wish to highlight (the following provides a guide to information that you may wish to include):

- **New Actions: Implement new Appraisal and Revalidation platform into Trust**

Overall conclusion:

General review of actions since last Board report

2021-2022 has seen a return to more usual functioning of the Appraisal & Revalidation Group following the worst phases of the pandemic.

Personnel changes: The RO and Executive Medical Director posts are now separated which allows some flexibility, and increased input to RO issues The appointment of a deputy AMD to ensure a seamless transfer of responsibility over approximately one year has been achieved by sharing the AMD remuneration. This allows the future AMD to orientate in the role and oversee the procurement and introduction of the new on-line platform.

The Medical Education Manager is now settled in post and has been re-interviewed and appointed to a higher level of responsibility. This has had a stabilising influence on our work. A mix of office and homeworking has developed which has some advantages in delivering the work. The appointment of further administrative support in Medical Education has been a huge help in in servicing meetings and supporting office functions.

Appraisal & Revalidation Group: Regular meetings of our group, chaired by the RO, and supported by the new administrative staff have resumed, initially monthly and now bi-monthly. This has allowed us to review our terms of reference, develop an annual workplan, and to review all our policies and SOPs which had continued unchanged during the pandemic. New policies around information transfer and acceptance of doctors to our Designated Body have been developed.

We have continued our regular bi-annual fora for appraisers and were able to resume new appraiser training and refresher training. All of these have run as on-line events up until now, which has some advantages for time and travel but is noted to be impersonal. We hope to return to in-person meetings during autumn 2022

Appraisal Process: The procurement process for the new on-line platform has begun, with SARD having been selected. The migration of data process will undoubtedly require considerable time together with the introduction of the new system into the Trust and planning of any new processes.

The introduction and acceptance of QA scoring of appraisals has seen some benefit in improving the standard of appraisal and the documented summaries. The average scores have risen over the year and allow us to assure the Board that an acceptable standard is achieved. Having collected scores over 2 years allows us to identify highly performing appraisers who can accept challenges, and also those needing support, who are offered further help and advice.

Actions Still Outstanding

1. Discussions between the Medical Education Manager and members of the Human Resource Department are continuing around Medical Staffing issues. We aim to offer each doctor appropriate management of their appraisal and revalidation situation, and to do this effectively we must:

i Refine information flows between the Medical Education and HR departments, and develop productive links with staff involved in the employment process

ii. Ensure awareness of new starters and better identify the exact assignment of each doctor,

iii. Maintain accurate databases of doctors for appraisal and avoid last minute additions with subsequent deferral of revalidation.

2. As detailed above, the procurement/ introduction process for the new on-line platform SARD is ongoing and will be complete as our existing CRMS system is ‘sunsetted’ in January 2023.

Reflections of impact of COVID 19 on delivering service to patients

WHH is currently dealing with Wave 6 of Covid-19 patients with patients occupying up to 3 wards worth of beds. However, there is less burden on Intensive Care in the later waves. COVID-19 continues to affect staff sickness absence

Attendances at the Emergency Dept are 11% higher than last year with a department designed for 150 per day now regularly seeing double that number. There are more acutely unwell patients presenting who take longer to diagnose and stabilise. Medically-optimised patients are occupying 3-4 wards and with fewer available beds there are longer waits for admission. All of the winter capacity remains open to accommodate the increase in patients. The Trust has invested in a major expansion of urgent and emergency care to create the same-day assessment and treatment centre. The Trust and Warrington Borough Council have worked on earlier discharge for long stay patients, together with the local community and mental healthcare partners.

Fewer doctors mention Covid in their appraisals this year, and it is now usually in the context of their own or their family's illness. The impact of colleague sickness necessitating last minute changes to rotas and work practice is a cause of frustration and weariness. The overriding message from appraisal is one of unrelenting clinical pressure as Covid recovery has progressed into pressures on beds from increasing social care and emergency admissions.

Current Issues

Our most pressing issue is completion of the procurement process and implementing the smooth running of the new on-line platform. SARD.

New Actions

Next year's actions will build on our current position in consolidating the progress made. The new on-line platform will generate new and different issues which will be dealt with as they arise.

Overall Conclusion

Last year we were proud to have maintained business as usual, but also to have developed using some of the positives from pandemic working.

This year, using our enhanced staffing we are better able to review processes and move forward to the new on-line platform, and consideration of further reviews and improvements.

Section 7 – Statement of Compliance:

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

Signed on behalf of the designated body

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

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

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

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

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

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/22/11/155**
SUBJECT:	**Infection Prevention and Control Board Assurance Framework Compliance Report**
DATE OF MEETING:	30th November 2022
AUTHOR(S):	Lesley McKay, Associate Chief Nurse, Infection Prevention + Control
EXECUTIVE DIRECTOR SPONSOR:	Kimberley Salmon-Jamieson, Chief Nurse + Deputy Chief Executive
LINK TO STRATEGIC OBJECTIVE:	SO1 We will.. Always put our patients first delivering safe and effective care and an excellent patient experience. SO2 We will.. Be the best place to work with a diverse 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):	**#1215** If the Trust does not have sufficient capacity (theatres, outpatients, diagnostics) because of the ongoing COVID-19 pandemic then there may be delayed appointments and treatments, and the trust may not be able to deliver planned elective procedures causing possible clinical harm and failure to achieve constitutional standards. **#1273** If we continue to experience system-wide Covid-19 pressures, then we may be unable to provide timely patient discharge and experience potential reduced capacity to admit patients safely. **#115** Failure to provide minimal staffing levels in some wards and departments. Caused by vacancy position, current sickness levels and absence due to COVID 19. Resulting in depleted staffing levels, potentially impacting the ability to provide basic patient care and treatment. **#1275** If we do not prevent nosocomial Covid-19 infection, then we may cause harm to our patients, staff and visitors, which can result in extending length of inpatient stay, staff absence, additional treatment costs and potential litigation. **#1134** If we see an increase in absence relating to COIVD-19, then we may experience resource challenges and an increase within the temporary staffing domain. **#125** If the hospital estate is not sufficiently maintained then there may be an increase in capital and backlog costs, a reduction in compliance and possible patient safety concerns
EXECUTIVE SUMMARY	This paper includes: • a compliance assessment against version 1.8 of the Board Assurance Framework for Covid-19 • evidence of high level of compliance 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

<table>
<tr><td></td><td colspan="4">Activities) Regulations 2014 as demonstrated by areas rated green in appendix 1
• an action plan appendix 2 to mitigate gaps in assurance highlighted from the compliance assessment

Gaps in assurance include: -
• compliance with health technical memorandum (HTM) standards in relation to ventilation in areas that could potentially be used for care of patients with respiratory infections e.g., theatre recovery. A capital bid is being submitted to upgrade the ventilation system to meet HTM standards
• Currently asymptomatic Covid-19 testing on admission, day 3 and day 5 is paused. There was an increase in Covid-19 outbreaks in September and, in the absence of prior Covid-19 inpatient testing, some patients are testing positive on the day of planned discharge to care facilities resulting in extending length of inpatient stay. Review of testing has commenced with a view to implementing local adaptation of national guidance to support timely patient discharge
• The FFP3 fit testing programme continues to ensure staff have access to ‘adequate and suitable’ respiratory protective equipment. Within the Board Assurance Framework there is a requirement to ensure records are centrally held and regularly reviewed by the Board and updates are received via the Quality Assurance Committee, Infection Control Sub-Committee High Level Briefing Paper

The Trust Board is asked to note the paper.</td></tr>
<tr><td>PURPOSE: (please select as appropriate)</td><td>Information</td><td>Approval</td><td>To note
✓</td><td>Decision</td></tr>
<tr><td>RECOMMENDATIONS:</td><td colspan="4">The Board is asked to receive the report</td></tr>
<tr><td>PREVIOUSLY CONSIDERED BY:</td><td colspan="2">Committee</td><td colspan="2">Quality Assurance Committee</td></tr>
<tr><td></td><td colspan="2">Agenda Ref.</td><td colspan="2">QAC/22/11/290</td></tr>
<tr><td></td><td colspan="2">Date of meeting</td><td colspan="2">1 November 2022</td></tr>
<tr><td></td><td colspan="2">Summary of Outcome</td><td colspan="2">Submit to Board</td></tr>
<tr><td>FREEDOM OF INFORMATION STATUS (FOIA):</td><td colspan="4">Release in Full</td></tr>
<tr><td>FOIA EXEMPTIONS APPLIED: (if relevant)</td><td colspan="4">None</td></tr>
</table>

REPORT TO BOARD OF DIRECTORS

SUBJECT	IPC Board Assurance Framework Covid-19	AGENDA REF:	BM/22/11/155

1. BACKGROUND/CONTEXT

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

This assessment has been refined to reflect requirements specified in the Infection Prevention and Control for seasonal respiratory infections in health and care settings (including SARS-CoV-2) for winter 2021/22.

The framework is used to assure the Trust Board of Directors, by assessing the measures taken in line with current guidance and identifies areas where further action is required.

Legislative requirements relating to Covid-19 include: -

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

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

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

This assessment has been made against version 1.8 of the Infection Prevention and Control Board Assurance Framework published on 24th December 2021.

2. KEY ELEMENTS

Please see Appendix 1 for compliance assessment.

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

3) ACTIONS REQUIRED/RESPONSIBLE OFFICER

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

- Monitor the action plan to address gaps in assurance until completion

4) IMPACT ON QPS?

- **Q**: Visiting restrictions may have had a negative impact on patient experience. Several communication mechanisms have been implemented. Visiting restrictions have been lifted and returned to pre-pandemic visiting times

- **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. Staff absence due to infection or vulnerability 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
- Learning fromCovid-19 Action Plan
- Nosocomial case monitoring and outbreak detection and reporting

6) TRAJECTORIES/OBJECTIVES AGREED

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

7) MONITORING/REPORTING ROUTES

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

8) TIMELINES

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

9) ASSURANCE COMMITTEE

- Infection Control Sub-Committee

10) RECOMMENDATIONS

The Board is asked to receive the report.

APPENDIX 1 Infection Prevention and Control Board Assurance Framework Compliance Assessment 10 2022

1. Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks their environment and any other users may pose to them.				**RAG**
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure that:				
A respiratory season/winter plan is in place: - that includes point of care testing (POCT) methods for seasonal respiratory viruses to support patient triage/ placement and safe management according to local needs, prevalence, and care services - to enable appropriate segregation of cases depending on the pathogen - plan for and manage increasing case numbers where they occur - a multidisciplinary team approach is adopted with hospital leadership, estates & facilities, IPC Teams, and clinical staff to assess and plan for creation of adequate isolation rooms/units as part of the Trusts winter plan	Triage tool in ED: Molecular Point of Care Testing for Covid-19. Seasonal respiratory testing SOP (including Influenza A/B; RSV and Covid-19) for patients attending ED with respiratory symptoms ED triage and placement according to respiratory/ non-respiratory presentation. Liaison with Patient Flow on Covid status to ensure appropriate isolation or cohorting Covid capacity escalation plan discussed and agreed at Tactical Group meetings Additional side room capacity created with pods inserted in - ED x1 - ICU x5 - B18 x4 Additional side rooms created on Wards - A2 - A3 - A6 - A9 - C21	Demand for side rooms exceeds capacity	Liaison with Patient Flow Team throughout each day to optimise side room use, based on transmission risks	

APPENDIX 1 Infection Prevention and Control Board Assurance Framework Compliance Assessment 10 2022

1. Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks their environment and any other users may pose to them.				**RAG**
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure that:				
	Lateral Flow Device testing introduced for pre-admission elective procedures Lateral Flow Device testing implemented for day 3 and day 5 of admission Admission, Day 3, Day 5 testing paused from 1st September 2022 Trust SOP updated	Some patients may require assistance with testing and reporting results pre-admission Text message alerts to IPCNs is not in place	Day of admission testing support where required for elective procedures Liaison with Patient Flow Team about positive results	
Health and care settings continue to apply COVID-19 secure workplace requirements as far as practicable, and that any workplace risk(s) are mitigated for everyone.	Completed risk assessments			
Organisational /employers risk assessments in the context of managing seasonal respiratory infectious agents are: - based on the measures as prioritised in the hierarchy of controls, including evaluation of the ventilation in the area, operational capacity, and prevalence of infection/new variants of concern in the local area - applied in order and include elimination; substitution, engineering, administration and PPE/RPE - communicated to staff	Risk assessments in place for all locations in the Trust Signage on room doors	Risk assessment formatting does not use hierarchies of control Communication of control measures	Revision to risk assessment in progress (draft submitted to IPC Silver Cell 31/01/2022) to provide risk mitigation measures in the order of elimination, substitution, engineering, administrative controls, and Personal Protective Equipment (including Respiratory Protective Equipment) Single page guidance given to all staff at CSTM building	

APPENDIX 1 Infection Prevention and Control Board Assurance Framework Compliance Assessment 10 2022

1. Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks their environment and any other users may pose to them.				**RAG**
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure that:				
Safe systems of working; including managing the risk associated with infectious agents through the completion of risk assessments have been approved through local governance procedures, for example Integrated Care Systems	All risk assessments are approved via a robust Governance procedure at Tactical meetings			
If the organisation has adopted practices that differ from those recommended/stated in the national guidance a risk assessment has been completed and it has been approved through local governance procedures, for example Integrated Care Systems.	Nil derogation from national guidance			
Risk assessments are carried out in all areas by a competent person with the skills, knowledge, and experience to be able to recognise the hazards associated with respiratory infectious agents.	All completed risk assessments are reviewed by the Head of Safety and Risk			
If an unacceptable risk of transmission remains following the risk assessment, the extended use of Respiratory Protective Equipment (RPE) for patient care in specific situations should be considered.	Risk assessments include RPE and other key items of PPE including eye protection			
Ensure that patients are not transferred unnecessarily between care areas unless, there is a change in their infectious status, clinical need, or availability of services	Patients are allocated to wards based on speciality requirements	Learning from nosocomial Covid cases identified concerns about patient transfers	Operational and Patient Flow teams work cohesively to minimise patient transfers as far as reasonably practicable	
The Trust Chief Executive, the Medical Director or the Chief Nurse has oversight of daily sitrep in relation to COVID-19, other	- Chief Nurse/DIPC signs off data submissions - Sign off process in place for daily nosocomial SitRep			

APPENDIX 1 Infection Prevention and Control Board Assurance Framework Compliance Assessment 10 2022

1. Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks their environment and any other users may pose to them.				**RAG**
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure that:				
seasonal respiratory infections, and hospital onset cases	- Daily data validation process for new admissions and inpatient Covid-19 tests prior to forwarding for sign off - BI reports are emailed daily to the Executive Team - RSV dashboards discussed at the IPC/Paediatric Surge planning meetings			
There are check and challenge opportunities by the executive/senior leadership teams of IPC practice in both clinical and non-clinical areas	- Matron and IPC Walkarounds - Senior nursing team checks that action cards are being completed - Executive Team walkabouts - Ward Accreditation with IPC reviewer membership - Challenge occurs at the following meetings: - Tactical - Silver IPC Cell - Quality Assurance Committee - Infection Control Sub-Committee - Senior Executive Oversight Group - Covid NED Group - Increased Microbiology support/ briefings delivered to medical cabinet - Surface wipes and alcohol-based hand rubs are provided for all non-clinical areas			
Resources are in place to implement and measure adherence to good IPC practice.	PPE supply is monitored at tactical Group meetings			

APPENDIX 1 Infection Prevention and Control Board Assurance Framework Compliance Assessment 10 2022

1. Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks their environment and any other users may pose to them.				**RAG**
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure that:				
This must include all care areas and all staff (permanent, agency and external contractors)	PPE audit programme in place Health and Safety Team audit programme Signage is displayed on donning and doffing as an aide memoire for staff.			
The application of IPC practices within this guidance is monitored, e.g.: - hand hygiene - PPE donning and doffing training - cleaning and decontamination	Weekly hand hygiene audits Covid-19 PPE audits (for aerosol and non-aerosol generating procedures) are in place for all clinical areas	Centralised information on PPE training Level 2 clinical IPC training 81% at the end of September 2022.	UK HSA training videos are included in annual mandatory training programmes. Trajectories set by CBU, 2 taught sessions per week, eLearning option, additional sessions provided	
The IPC Board Assurance Framework is reviewed, and evidence of assessments are made available and discussed at Trust board.	Bimonthly review or sooner if updated Board meeting agenda Board meeting minutes			
The Trust Board has oversight of ongoing outbreaks and action plans.	- Information on outbreaks included in daily executive summary and discussed at the daily Senior Executive Oversight Group Meeting - Learning from Outbreaks included in Nosocomial Board Paper 01 2021 - Nosocomial learning action plan in place reviewed at Silver IPC cell meetings			

APPENDIX 1 Infection Prevention and Control Board Assurance Framework Compliance Assessment 10 2022

1. Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks their environment and any other users may pose to them.				**RAG**
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure that:				
	- Covid-19 RCA findings fed back to CBUs with drill down to individual ward learning September 2021 - Outbreak email circulation - Email showing locations where Covid-19 exposure has inadvertently occurred, and bays monitored for further cases			
The Trust is not reliant on a particular mask type and ensure that a range of predominantly UK Make FFP3 masks are available to users as required.	Fit Testing programme in place and working to ensure all staff are successfully Fit tested against 2 types of mask, using Qualitative and Quantitative testing methods			

2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections				**RAG**
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure that:				
The Trust has a plan in place for the implementation of the National Standards of Healthcare Cleanliness and this plan is monitored at board level. B0271-national-standards-of-healthcare-cleanliness-2021.pdf (england.nhs.uk)	Task and Finish Group established with Action Plan in place for implementation. Progress will be included in IPC quarterly reports to QAC / Trust Board			

2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure that:				
	The Commitment to cleanliness charter has been approved, signed, and is displayed in all areas			
The organisation has systems and processes in place to identify and communicate changes in the functionality of areas/rooms	Communications team are involved in changes and ensure information is cascaded and signage displayed			
Cleaning standards and frequencies are monitored in clinical and non-clinical areas with actions in place to resolve issues in maintaining a clean environment.	Robust audit programme with timely feedback for corrective action as per the national cleanliness standards	Roles and responsibilities for cleaning Displaying star ratings and rectification if audit score is 3 star or less from a 5-star rating	Cleaning responsibilities framework in development as part of the implementation of the revised national cleanliness standards	
Increased frequency of cleaning should be incorporated into the environmental decontamination schedules for patient isolation rooms and cohort areas	Additional cleaning of outbreak areas including frequently touched surfaces			
Where patients with respiratory infections are cared for, cleaning and decontamination are carried out with neutral detergent or a combined solution followed by a chlorine-based disinfectant, in the form of a solution at a minimum strength of 1,000ppm available chlorine as per national guidance.	Chlorine based cleaning products are in use as required. Return to use of detergents in May 2022 Hydrogen peroxide Vapour is used following terminal cleaning by a Task Team trained in use of the equipment			
If an alternative disinfectant is used, the local infection prevention and control team (IPCT) are consulted on this to ensure that this is effective against enveloped viruses.	- Alternative disinfectant used in CT scanning room.	Specialist cleaning plan in place in the CT scanning room	- CT Manufacturer provided alternative decontamination guidance - Consultant Microbiologists and IPCNs included in discussions on alternative	

2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure that:				
			products to ensure effective against coronaviruses	
Manufacturers' guidance and recommended product 'contact time' is followed for all cleaning/disinfectant solutions/products.	Information on contact time is included in the decontamination policy			
A minimum of twice daily cleaning of: - patient isolation rooms - cohort areas - donning & doffing areas - 'Frequently touched' surfaces e.g., door/toilet handles, patient call bells, over bed tables and bed rails - where there may be higher environmental contamination rates, including toilets/commodes particularly if patients have diarrhoea	- Twice daily cleaning in place - Ring the bell it's time for Clinell campaign - Domestic staff record when they have cleaned areas - Enhanced cleaning – all areas, including non-clinical, supplied with desk wipes - Increased cleaning frequency in all public areas including toilets, communal spaces, lifts - Cleaning of workstations is included in the Environmental Action Plan - Domestic staff time cleaning activity when areas are vacant - Increased cleaning included in ICU Bioquell pod SOP - Review of guidance to reduce cleaning in low-risk elective procedure areas and return to use of detergents			

2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure that:				
	UKHSA review into IPC guidance - GOV.UK (www.gov.uk)			
A terminal/deep clean of inpatient rooms is carried out: - following resolutions of symptoms and removal of precautions - when vacated following discharge or transfer (this includes removal and disposal/or laundering of all curtains and bed screens)	- Terminal cleaning and decontamination polices in place including guidance on environmental disinfectant required to decontaminate the environment. Decontamination included in the Covid-19 policy - All policies are used in conjunction with any updates provided by COVID-19 national guidance - Terminal Cleaning Guidelines 2018 - Decontamination Policy 2019 - 4 additional HPV machines purchased and in use - CEO meeting and Chief Nurse/Deputy CEO and ADIPC meeting with domestic staff - Associate Director of Estates is a member of Silver IPC cell - Terminal cleaning standards sign off checklist			

2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure that:				
- following an AGP if room vacated (clearance of infectious particles after an AGP is dependent on the ventilation and air change within the room)	- Ventilation Group and Ventilation Policy	Ventilation and air changes per hour in all areas is not unknown	Discussion on down time following areas where AGPs are performed based on air changes/hour where known and time extended in areas where mechanical ventilation is not available	
Reusable non-invasive care equipment is decontaminated: - between each use - after blood and/or body fluid contamination - at regular predefined intervals as part of an equipment cleaning protocol before inspection, servicing, or repair equipment.	- Included in Decontamination Policy which incorporates single use and single patient use guidance - Cleaning monitoring audits - Decontamination audits - Policy and certification process to confirm cleaning prior to service inspection or repair - Dynamic mattresses are cleaned off site by contractual arrangements - Green I am clean indicator tape for items cleaned/ decontaminated at ward level			
Compliance with regular cleaning regimes is monitored including that of reusable patient care equipment	Robust audit programme with timely feedback for corrective action as per the national cleanliness standards			
As part of the Hierarchy of controls assessment: ventilation systems, particularly in, patient care areas (natural or mechanical) meet national recommendations for	Theatre ventilation audits	Trust-wide audit and Action plan required	Requirement for Estate overview discussed at Ventilation Group and action plan to be developed to address non-compliant areas	

2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure that:				
minimum air changes refer to country specific guidance.				
The assessment is carried out in conjunction with organisational estates teams and or specialist advice from ventilation group and or the organisations, authorised engineer	The Trust is supported by an Appointed Authorising Engineer/Ventilation. Guidance sought on all capital projects with sign off of plan			
A systematic review of ventilation and risk assessment is undertaken to support location of patient care areas for respiratory pathways		Trust-wide audit and Action plan required	Requirement for Estate overview discussed at Ventilation Group and action plan to be developed to address non-compliant areas Capital bid required for upgrades	
Where possible air is diluted by natural ventilation by opening windows and doors where appropriate	'Give fresh air to show you care' campaign	As above	As above	
Where a clinical space has very low air changes and it is not possible to increase dilution effectively, alternative technologies are considered with Estates/ventilation group.	Trial of alternative technology completed Products will be reviewed by the Ventilation Group to ensure fitness for purpose			
When considering screens/partitions in reception/ waiting areas, consult with estates/facilities teams, to ensure that air flow is not affected, and cleaning schedules are in place.	Discussion on air flow takes place between IPC Team and Estates Team			

3. Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
Arrangements for antimicrobial stewardship are maintained - previous antimicrobial history is considered - the use of antimicrobials is managed and monitored to reduce inappropriate prescribing to ensure patients with infections are treated promptly with correct antibiotic.	- Consultant Medical Microbiology daily Ward Round in Critical Care - Ward based Pharmacist support - Prescribing advice available by telephone (in and out of hours 24/7) - Pharmacist prescribing support on all inpatient wards - Infection Control Doctor presentations to Medical Cabinet - Formulary reviewed as evidence/ guidelines are updated - Antibiotic prescribing guidelines for COVID suspected patients have been published - Antimicrobial Management Steering Group Meetings - Quarterly - C difficile outliers ward rounds - Quarterly Point Prevalence audits with concerns discussed at Medical Cabinet and Infection Control Sub-Committee – Process reviewed, and point prevalence audits reduced to biannual with more focussed audits in areas where improvement is required	Point prevalence Audit scores in the region of 87%. Some wards have lower than 90% compliance for more than 1 quarter	Business case approved to strengthen stewardship resources. Escalation of decrease in prescribing compliance to PSCE sub-committee Change approach to auditing to provide more meaningful data Changes to first line treatment for CDI included in the SIGHT mnemonic promotional video	

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:				
	- Antimicrobial Stewardship is included in the IPC Strategy 2022 - 2023			
Mandatory reporting requirements are adhered to, and boards continue to maintain oversight	- Mandatory reporting of HCAIs has continued to be completed timely - Data on HCAIs is included on the Quality Assurance Committee and Trust Board and Infection Control Sub-Committee Dashboards - DIPC reports HCAI data at Trust Board - Information on Data Capture System - Distribution of HCAI surveillance data weekly - Annual UKHSA HCAI reports and monthly dashboards			
Risk assessments and mitigations are in place to avoid unintended consequences from other pathogens.	- Infection control risk assessments completed on admission and updated in light of microbiology results - Electronic patient record alerting system - IPC Policies/guidelines - IPC on call service			

4. Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion.				**RAG**
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
Visits from patient's relatives and/or carers (formal/informal) should be encouraged and supported whilst maintaining the safety and wellbeing of patients, staff, and visitors	Risk assessment in place Compassionate visiting supported Visiting restrictions lifted and returned to pre-pandemic visiting times 1st June 2022			
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 close family and friends visiting may be admitted: - Patients in critical care - Vulnerable young adults		• 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/ iPad • Visiting restrictions lifted and returned to pre-pandemic visiting times 1st June 2022	

4. Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion.				**RAG**
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
	- 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 - Visiting permitted with booked and timed slot on Christmas Day and Boxing Day with control measures in place on symptom checks and where possible Lateral Flow Device Test (with negative result) - Visiting guidance updated to meet current national guidance – 2 visitors per patient, timed slots, for 1 hour - Visiting restrictions lifted and returned to pre-pandemic			

4. Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion.				**RAG**
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
	visiting times following Guidance on 1st June 2022			
Restrictive visiting may be considered appropriate during outbreaks within inpatient areas This is an organisational decision following a risk assessment.	- Guidance on visiting in place - Maternity specific Guidance on birthing partner - Appointment scheduling system implemented to ensure social distancing isn't breached, particularly where there are concerns regarding ventilation/ low air change/hour - Visited restricted during outbreaks			
There is clearly displayed, written information available to prompt patients' visitors and staff to comply with handwashing, wearing of facemask/face covering and distancing.	Signage across the Trust including at entrances and in public toilets: - Face masks - Hand washing - Social distancing suspended signage from ceilings on all corridors and at entrances/exits - PPE/ mask stations located at entrances/exits alongside alcohol-based hand gels - Facemasks no longer required, and guidance implemented from 13th June 2022		Every action counts campaign signage – roll out plan in place Leaflets on face mask wearing provided January 2022	
If visitors are attending a care area with infectious patients, they should be made	PPE provided at all Trust entrances and entrances to wards			

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:				
aware of any infection risks and offered appropriate PPE. This would routinely be an FRSM	Ward staff assist visitors with PPE where required			
Visitors with respiratory symptoms should not be permitted to enter a care area. However, if the visit is considered essential for compassionate (end of life) or other care reasons (e.g., parent/child) a risk assessment may be undertaken, and mitigations put in place to support visiting wherever possible.	Visitor Risk assessment Sign-in sheet symptom checker Visiting restrictions lifted and returned to pre-pandemic visiting times following Guidance on 1st June 2022			
Visitors are not present during AGPs on infectious patients unless they are considered essential following a risk assessment e.g., carer/parent/guardian.	FFP3 Fit testing for visitors to ICU			
Implementation of the Supporting excellence in infection prevention and control behaviours Implementation Toolkit has been adopted C1116- supporting-excellence-in-ipc-behaviours-imp-toolkit.pdf (england.nhs.uk)	Campaign posters received and roll- out plan devised	Images of WHH staff selected for campaign use Wellbeing support area established	Roll out completed January 2022	

5. Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people				**RAG**
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
Signage is displayed prior to and on entry to all health and care settings instructing	Signage displayed at all main entrances			

5. Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people				**RAG**
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
patients with respiratory symptoms to inform receiving reception staff, immediately on their arrival.				
Infection status of the patient is communicated to the receiving organization, department or transferring services, when a possible or confirmed seasonal respiratory infection needs to be transferred.	- SBAR transfer form in place - Covid-19 Alert added to Lorenzo for all patients with a positive SARS-CoV-2 swab - Covid-19 status included on SBAR form - Covid-19 has been added to e-discharge summary template - Pre-admission information provided to patients being admitted electively - Policy for patients being discharged to care homes	Review of guidance published 17/01/22 Stepdown of infection control precautions and discharging COVID-19 patients and asymptomatic SARS-CoV-2 infected patients - GOV.UK (www.gov.uk) Limited number of side rooms	Liaison with Patient Flow Team throughout each day to optimise side room use, based on transmission risks	
Staff are aware of agreed template for screening questions to ask.	ED triage tool Senior staff in ED Triage Covid screening sign in sheet			
Screening for COVID-19 is undertaken prior to attendance wherever possible to enable early recognition and to clinically assess patients prior to any patient attending a healthcare environment	Visitor risk assessment Review of guidance to perform testing on admission in low-risk elective procedure areas UKHSA review into IPC guidance - GOV.UK (www.gov.uk)		UKHSA Guidance agreed for site specific and lower risk procedures including Halton Ward B4 and Endoscopy Pre-admission testing for low-risk elective procedures using Lateral Flow device testing introduced 13TH June 2022	
Front door areas have appropriate triaging arrangements in place to cohort patients with possible or confirmed COVID-19/ other	Triage tool and molecular Point of Care testing is in use in ED and Maternity.	Out of hours Cover for results from 10pm until am where POC test was	To be discussed	

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:				
respiratory infection symptoms and segregation of cases to minimise the risk of cross-infection as per national guidance.	ED Triage tool included a question on travel history Positive results are sent by text message to Infection Prevention and Control (IPC) Nurses, who review and put IPC advice in place. PCR testing is also undertaken on admission Respiratory/non-respiratory pathway SOP Infection Risk Assessment in EPR Symptom screening checklist Virtual Ward Pathways	negative, but PCR result is positive Laboratory reverted back from 24/7 to business-as-usual hours		
Triage is undertaken by clinical staff who are trained and competent in the clinical case definition and patient is allocated appropriate pathway as soon as possible.	Senior staff triage in ED			
There is evidence of compliance with routine patient testing protocols in line with trust approved hierarchies of control risk assessment and approved	Compliance reviewed during outbreaks and at nosocomial RCA review meetings BI reporting systems shows swabs due to be taken daily. Daily oversight by senior nursing team to support compliance with admission, day 3 and day 5 testing Weekly testing stepped down 04/2022	Audit of compliance required	Process for reporting of Lateral Flow Device testing numbers to be confirmed Pause on asymptomatic admission, day 3 and day 5 testing	

5. Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people				**RAG**
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
Patients with suspected or confirmed respiratory infection are provided with a surgical facemask (Type II or Type IIR) to be worn in multi-bedded bays and communal areas if this can be tolerated	Patient information leaflet circulated in January 01/2022 promoting use of face masks for in patients Facemasks for patients stepped down on 13 June 2022	Some patients exempt from face mask use and some patients decline National restrictions on face mask use lifted on 27/01/22 for public spaces	Communication circulated on 27/01/22 that use of Face masks in healthcare settings remains in place Clear curtains between inpatient beds	
Patients with respiratory symptoms are assessed in a segregated area, ideally a single room, and away from other patients pending their test result	ED segregation of respiratory non-respiratory areas			
Patients with excessive cough and sputum production are prioritised for placement in single rooms whilst awaiting testing	Prioritisation for side rooms is based on suspected/known diagnosis	Demand for side rooms exceeds capacity	Liaison with Patient Flow Team throughout each day to optimise side room use, based on transmission risks	
Patients at risk of severe outcomes of respiratory infection receive protective IPC measures depending on their medical condition and treatment whilst receiving healthcare e.g., priority for single room isolation and risk for their families and carers accompanying them for treatments/procedures must be considered	Isolation Policy Isolation of immunocompromised patient s policy Side room optimisation with IPC and Patient Flow using side room isolation tool			
Where treatment is not urgent consider delaying this until resolution of symptoms providing this does not impact negatively on patient outcomes	Virtual Ward Pathways		Consultant decision to proceed if urgent	

5. Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people				**RAG**
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
Face masks/coverings are worn by staff and patients in all health and care facilities.	Universal masking policy in place SOP for face mask refusal	Some patients exempt and some refusals to wear masks	SOP to guide staff on actions to take for refusal Poster campaign to encourage use of masks	
Where infectious respiratory patients are cared for physical distancing remains at 2 metres distance.	- Inpatient bed spacing assessment - Perspex screens in place at reception areas - Facemasks for patients stepped down on 13 June 2022 - Facemasks for standard and contact precautions stepped down on 13 June 2022	Some bed spaces are closer than 2 metres	- Use of clear curtains between bed spaces - Timing of visits to toilet facilities - Use of face masks where tolerated	
Patients, visitors, and staff can maintain 1 metre or greater social & physical distancing in all patient care areas; ideally segregation should be with separate spaces, but there is potential to use screens, e.g., to protect reception staff.	Effective systems in place to support prevention of HCAI including: - training, policies, and audit plan: - - Hand hygiene audits weekly - PPE (readily available) audits of AGP and non-AGP weekly - Environmental audits according to risk category - High impact intervention audits - Supplies monitoring of PPE levels - Social distancing check included on the daily Clinical Area Action Card - Spot checks on break rooms			

5. Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people				**RAG**
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
	- Signage and refresh campaign aligned to national campaign - Infection Prevention and Control Team visibility on wards			
Patients that test negative but display or go on to develop symptoms of COVID-19 are segregated and promptly re-tested and contacts traced promptly.	Testing advice is included on the Antibiotic Formulary for patients with hospital onset Pneumonia Patients are isolated or cohorted promptly	Contact tracing is challenging as there isn't an electronic Patient tracking system	Contact tracing is carried out as far as reasonably practicable. Letters are given to contacts advising them of the Covid contact and includes advice on isolation requirements Publication approval reference: C1630 – isolation of Covid-19 contacts no longer required if asymptomatic. Bays are monitored for 7 days following exposure to detect any new onset cases – stepped down from 1st September 2022.	
Isolation, testing and instigation of contact tracing is achieved for all patients with new-onset symptoms, until proven negative.	Testing advice is included in the Antibiotic Formulary for patients with hospital onset Pneumonia Testing protocol in place on admission, day 3, day 5 and weekly thereafter Outbreak reporting in place aligned to NHSE/I HOCI SOP using IIMARCH reporting template Major Outbreak Policy	Contact tracing is challenging as there isn't an electronic Patient tracking system Demand for side rooms exceeds capacity	Liaison with Patient Flow Team throughout each day to optimise side room use, based on transmission risks	

5. Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
Patients that attend for routine appointments who display symptoms of COVID-19 are managed appropriately.	- Information provided prior to attending Outpatient Departments and further symptom screening in place on arrival - Virtual appointments where practicable - Temperature checking and symptom screening in place in OPD/ Vaccination centre			

6. Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
Appropriate infection prevention education is provided for staff, patients, and visitors.	IPC Mandatory training programme Signage for visitors and support provided by staff on duty	Level 2 clinical IPC training 81% at the end of September 2022.	Trajectories set by CBU, 2 taught sessions per week, eLearning option	
Training in IPC measures is provided to all staff, including: - the correct use of PPE including an initial face fit test/and fit check each time when wearing a filtering face piece (FFP3) respirator and	Fit Testing programme			

6. Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
- the correct technique for putting on and removing (donning/doffing) PPE safely.	UK HSA training videos shown during mandatory training sessions Aide memoire posters on donning and doffing are displayed in all clinical areas Hand hygiene technique is displayed on all soap dispensers PPE/swabbing Champions (58), training and cascaded roving training on donning and doffing of PPE Training for Helping Hands staff IPC Team out of hours advice IPCN and Consultant Microbiologist Departmental visits to provide support			
All staff providing patient care and working within the clinical environment are trained in the selection and use of PPE appropriate for the clinical situation and on how to safely put it on and remove it;	Mandatory IPC Training package			
Adherence to national guidance on the use of PPE is regularly audited with actions in place to mitigate any identified risk	PPE audits in place Concerns identified are addressed at the time of audit			

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:				
	Increased auditing schedule during outbreaks Standard PPE Audit tool developed and being piloted October 22			
Gloves are worn when exposure to blood and/or other body fluids, nonintact skin or mucous membranes is anticipated or in line with SICPs and TBPs.	Standard precautions and PPE guidelines			
The use of hand air dryers should be avoided in all clinical areas. Hands should be dried with soft, absorbent, disposable paper towels from a dispenser which is located close to the sink but beyond the risk of splash contamination as per national guidance	- Hand air dryers not in place in clinical areas - Access to hand hygiene facilities (stock of liquid soap, hand gel and paper towels is included in the auditing template) - Removal of hand driers in public toilets (none in clinical areas) has taken place as part of the environmental action plan - Hand towel dispensers have been installed and waste collection schedule put in place			
Staff maintaining physical and social distancing of 1 metre or greater wherever possible in the workplace	Guidance on social distancing re-enforced Risk assessment templates updated to reflect the removal of			

6. Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
	the requirement for social distancing June 2022			
Staff understand the requirements for uniform laundering where this is not provided for onsite	Guidance included in Uniform Policy and Covid-19 PPE booklet. Scrub suit provided for use in place of uniforms which are laundered by the Trust			
All staff understand the symptoms of COVID-19 and take appropriate action if they or a member of their household display any of the symptoms (even if experiencing mild symptoms) in line with national guidance.	SOP in place for testing staff and or household members HR process in place for reporting to Line Manager and Occupational Health In-house testing is promoted for timey availability of results SOP in place for Lateral Flow Testing prior to return to work in line with revised guidance COVID-19: management of staff and exposed patients or residents in health and social care settings - GOV.UK (www.gov.uk)	Staffing absence due to Covid-19 Some staff use external testing resulting in delay in result turn around time	Staffing meetings held throughout each day to ensure safety in inpatient areas Absence monitoring at Tactical Group meetings In-house testing is promoting – including for household members	
To monitor compliance and reporting for asymptomatic staff testing	LAMP testing compliance data monitored at Tactical Group meetings LAMP testing removed and returned to twice weekly Lateral Flow Device testing	Uptake low approximately 450 staff Uptake of testing unknown	Uptake encouraged at trust wide Team brief, DIPC promotional video Use of asymptomatic testing promoted to encourage uptake	

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:				
	Stepdown of asymptomatic staff testing September 22			
There is a rapid and continued response to ongoing surveillance of rates of infection transmission within the local population and for hospital/organisation onset cases (staff and patients/individuals)	Consultant Microbiologist presentations at Tactical Group meetings. Local prevalence data included in Tactical Group agendas BI reports with UpToDate position Datix reporting of hospital onset case, Outbreak reporting as per the NHSE/I HOCI SOP Regional benchmarking using the Cheshire and Merseyside Nosocomial pack UKHSA CCDC attends Infection Control Sub-Committee Silver Infection Control Cell meetings chaired by the DIPC All Covid-19 positive results are communicated by text alert to the IPCNs. Patient records are flagged, and IPC advice documented			
Positive cases identified after admission who fit the criteria for investigation should trigger a case investigation. Two or more positive cases linked in time and place trigger an outbreak investigation and are reported.	IPC Team monitor incidence and report outbreaks via the web-based reporting system in line with the NHSE/I northwest HOCI SOP			

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:				
	Datix reports are completed for all hospital onset cases and where an Outbreak is declared. RCA investigations are completed and reviewed to identify learning and harm. Where concerns are identified regarding harm, referral is made to the Governance Team for further review. PowerPoint feedback reports on learning from incidents shared with each CBU for 2020/2021			

7. Provide or secure adequate isolation facilities				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
That clear advice is provided, and monitoring is carried out of inpatients compliance with wearing face masks (particularly when moving around the ward or healthcare facility) providing it can be tolerated and is not detrimental to their (physical or mental) care needs.	Patient information leaflet circulated in January 01/2022 promoting use of face masks for in patients Signage on display advising use of face masks Facemasks no longer required for patients, and guidance implemented from 13th June 2022	Some patients exempt from face mask use and some patients decline National restrictions on face mask use lifted on 27/01/22 for public spaces	Communication circulated on 27/01/22 that use of Face masks in healthcare settings remains in place Clear curtains between inpatient beds Communication from CEO 13/06/2022	
Separation in space and/or time is maintained between patients with and	Symptom screening on arrival at clinics			

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:				
without suspected respiratory infection by appointment or clinic scheduling to reduce waiting times in reception areas and avoid mixing of infectious and non-infectious patients.	Pre-attendance advice not to attend if symptomatic.			
Patients who are known or suspected to be positive with a respiratory pathogen including COVID-19 where their treatment cannot be deferred, their care is provided from services able to operate in a way which minimise the risk of spread of the virus to other patients/individuals.	Appointment scheduling to avoid cross over of Covid/non-Covid patients			
Patients are appropriately placed i.e., infectious patients in isolation or cohorts.	Monitoring of Covid testing for patient placement Isolation Policy Isolation of Immunosuppressed Patients Guidelines Side room audit tool Additional side room capacity created with pods inserted in - ED x1 - ICU x5 - B18 x4 Additional side rooms created on Wards - A2 - A3 - A6	Demand for side rooms exceeds capacity	Liaison with Patient Flow Team throughout each day to optimise side room use, based on transmission risks	

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:				
	- A9 - C21			
Ongoing regular assessments of physical distancing and bed spacing, considering potential increases in staff to patient ratios and equipment needs (dependent on clinical care requirements).	Environmental action plan Clear curtains Clear curtains removed August/September 2022			
Standard infection control precautions (SIPCs) are used at point of care for patients who have been screened, triaged, and tested and have a negative result	SOP for respiratory/non-respiratory pathways and PPE requirements Standard IPC precautions Guidelines IPC audit programme in place IPC Mandatory training programme Facemasks no longer required, and guidance implemented from 13th June 2022			
The principles of SICPs and TBPs continued to be applied when caring for the deceased	Care of deceased patients' guidelines revised October 2022			

8. Secure adequate access to laboratory support as appropriate				**RAG**
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
Testing is undertaken by competent and trained individuals.	Training on swabbing technique provided verbally and by video			

8. Secure adequate access to laboratory support as appropriate				**RAG**
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
	Competency assessment tool launched Training provided on use of point of care molecular testing equipment UKAS accredited laboratory with Quality Control checks in place			
Patient testing for all respiratory viruses testing is undertaken promptly and in line with national guidance	Swabbing SOP in place covering day of admission, day 3, day 5, weekly thereafter if previous results negative, symptomatic, pre-admission elective and discharge screening. Weekly testing stepped down in May 2022 Quadplex testing (Influenza A/B RSV – in addition to Covid-19) for patients presenting with respiratory symptoms Legionella and Pneumococcal antigen testing	- RCAs identified some routine samples are being missed -	- Daily senior nurse oversight to ensure compliance - Electronic systems support identification of patients who have not been screened as per routine testing protocol - Additional control measures put in place to ensure compliance including reminders via daily safety brief, emails to senior staff, electronic monitoring system	
Staff testing protocols are in place	Staff testing SOPs Asymptomatic / Symptomatic – including for household members Asymptomatic LAMP testing in place for staff LAMP testing removed 31/03/22 and returned to twice weekly Lateral Flow Device testing	Low uptake of staff LAMP testing	Uptake encouraged at trust wide Team brief, DIPC promotional video Use of asymptomatic testing promoted to encourage uptake	

8. Secure adequate access to laboratory support as appropriate				**RAG**
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
		Uptake of testing Lateral Flow Device testing unknown	Asymptomatic staff testing stopped in September 2022	
There is regular monitoring and reporting of the testing turnaround times, with focus on the time taken from the patient to time result is available	Monitoring at Silver IPC	Reporting frequency	Request made for regular reporting.	
There is regular monitoring and reporting that identified cases have been tested and reported in line with the testing protocols (correctly recorded data)	- LION BIS used to monitor testing in line with guidance and follow-up of omitted tests on admission/ day 3 /day 5/ weekly from day 5 - Documentation of IPC advice on receipt of positive results - RCA requests for cases ≥ day 8 of admission, with monitoring system in progress - Daily data validation process for Sit Rep sign-off and external reporting - IPC Team Spreadsheet with RCA follow up of all cases ≥ day 8 of admission - Turn around times are monitored at Silver Cell IPC meetings			
Screening for other potential infections takes place	Other routine admission screening (CPE, MRSA, VRE) in place			
That all emergency patients are tested for COVID-19 and other respiratory infections as appropriate on admission.	All patients being admitted to the Trust have Covid admission tests taken in ED using point of care			

8. Secure adequate access to laboratory support as appropriate				**RAG**
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
	(Abbot ID Now) testing and PCR swab Point of Care Testing supports ED and inpatient placement			
That those inpatients who go on to develop symptoms of respiratory infection/COVID-19 after admission are retested at the point symptoms arise.	Covid is considered as a differential diagnosis for inpatients developing respiratory symptoms	A small number of RCA investigation findings identified missed testing opportunities	Discussion took place at Medical Cabinet to advise timely testing for Covid when inpatients develop Hospital acquired pneumonia Guidance added to the Trust Antibiotic Formulary to test for Covid-19 in any patients who develop HAP	
That all emergency admissions who test negative on admission are retested for COVID-19 on day 3 of admission, and again between 5-7 days post admission.	Daily monitoring system in place to achieve full screening compliance for admission, day 3 and day 5 swabs Weekly screening implemented Lateral Flow Device testing implemented in June 2022 for day 3 and day 5 inpatient testing Asymptomatic Lateral Flow Device testing protocol paused September 2022 as per national guidance	RCAs are identifying a very small number of routine samples are being missed	- Daily senior nurse oversight to ensure compliance - Electronic systems support identification of patients who have not been screened as per routine testing protocol - Additional control measures put in place to ensure compliance including reminders via daily safety brief, emails to senior staff, electronic monitoring system - PowerPoint presentation on RCA learning fed back to CBUs with drill down of learning at individual ward level	
That sites with high nosocomial rates should consider testing COVID-19 negative patients daily.	- Community prevalence increasing >1400 per 100k/7-day rate January 2022 - Reduced nosocomial case numbers			

8. Secure adequate access to laboratory support as appropriate				**RAG**
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
	- 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 tested for COVID-19, 48 hours prior to discharge (unless they have tested positive within the previous 90 days), and result is communicated to receiving organisation prior to discharge.	Discharge screening in place with results shared accordingly prior to patient discharge Discharge to care home SOP in place including process to check results prior to discharge Additional of Lateral Flow Device testing prior to discharge to Care Homes if prior covid positive test within <90 days. PCR testing for negative patients remains in place			
Those patients being discharged to a care facility within their 14-day isolation period are discharged to a designated care setting, where they should complete their remaining isolation as per national guidance	Named community facility for care of patients who require continued isolation for Covid-19			
There is an assessment of the need for a negative PCR and 3 days self-isolation before certain elective procedures on selected low risk patients who are fully vaccinated, asymptomatic, and not a contact of case	SOP revised to reflect pre-admission Lateral Flow device testing.			

8. Secure adequate access to laboratory support as appropriate				**RAG**
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
suspected/confirmed case of COVID-19 within the last 10 days. Instead, these patients can take a lateral flow test (LFT) on the day of the procedure as per national guidance.				

9. Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections				**RAG**
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
The application of IPC practices is monitored and that resources are in place to implement and measure adherence to good IPC practice. This must include all care areas and all staff (permanent, agency and external contractors).	IPC Audit Programmes - Hand hygiene - PPE - High Impact Intervention Audits - Ward audit programme Escalation in auditing schedule where concerns are identified and during outbreaks			
Staff are supported in adhering to all IPC policies, including those for other alert organisms.	- PPE Champions in place supported by training - Clinical advice for management of patients with suspected infections continued - IPC on call service to provide advice 7 days per week			

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:				
	- PPE donning and doffing included in Induction and Mandatory training sessions - IPC Team visit areas to discuss concerns raised in relation to national guidance - Alert organisms are flagged on Lorenzo - IPCNs review patients with Alert organisms and provide advice to clinical teams - Discussion with Patient Flow Team on side room prioritisation - Pseudomonas surveillance in place in ICU, NNU - Prioritisation of side rooms for infections transmitted by the respiratory route and returning travellers from abroad - Isolation and CPE screening for patients admitted by inter-hospital transfer - Signage is displayed on donning and doffing as an aide memoire for staff - Covid-19 PPE booklet			
Safe spaces for staff break areas/changing facilities are provided.	Break rooms are Covid secure risk assessed. Spot checks on social distancing are carried out			

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:				
	Removal of the requirement for social distancing June 2022			
Robust policies and procedures are in place for the identification of and management of outbreaks of infection. This includes the documented recording of an outbreak.	- Daily surveillance in place of ≥ day 8 cases and location tested to promptly identifying clusters and initiate outbreak investigation accordingly - Occupational Health and Wellbeing Team monitor for clusters of staff cases - Outbreak meeting agendas, minutes, and action plans - Outbreak reporting reference numbers from NHSE/I via web-based reporting system - Emails to UKHSA; CCG; CQC, WHH Communications Team - Daily HOCI reporting template completed by Ward Managers and submitted to IPC/ Matron for review and action - Datix reporting			
All clinical waste and linen/laundry related to confirmed or suspected COVID19 cases is handled, stored, and managed in accordance with current national guidance.	- Guidance included in Covid-19 Policy. Early guidance adhered to when initial classification of a			

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:				
	HCID. Waste was quarantined and disposed of by incineration - Guidance included in the Coronavirus Policy - Used linen is processed as infected via red alginate stitched bag stream - Linen Policy - Waste segregation, handling, and disposal guidelines - Waste is disposed of via orange waste stream as per updated national guidance - Waste segregation included in mandatory training - All waste bins have colour coded lids and signage to denote waste category			
PPE stock is appropriately stored and accessible to staff who require it.	- Stock control in place - In and out of hours access protocol in place - Specialist PPE equipment office with access available 7 days/week - National distribution to maintain stock levels			

10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection				**RAG**
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
Staff seek advice when required from their IPCT/occupational health department/GP or employer as per their local policy.	SOP for staff and household member Covid-19 testing			
Bank, agency, and locum staff follow the same deployment advice as permanent staff.	Bank, agency, and locum staff follow the same deployment advice as permanent staff			
Staff who are fully vaccinated against COVID-19 and are a close contact of a case of COVID-19 are enabled to return to work without the need to self-isolate (see Staff isolation: approach following updated government guidance)	SOP in-place to allow return to work in line with NHSE/I guidance			
Staff understand and are adequately trained in safe systems of working, including donning, and doffing of PPE.	Included in mandatory IPC training. Level 2 compliance eat the end of September 22 = 81%	Some CBUs with less than 85% training compliance	IPCN offer to provide additional training sessions. 2 taught sessions per week and eLearning option	
A fit testing programme is in place for those who may need to wear respiratory protection.	Fit Testing programme is in place.			
Where there has been a breach in infection control procedures staff are reviewed by occupational health. Who will: lead on the implementation of systems to monitor for illness and absence. Infection prevention and control board assurance framework - facilitate access of staff to antiviral treatment where necessary and implement a vaccination programme for the healthcare workforce	Outbreak meeting discussions on exposed staff Datix reports on workplace exposure incidents	Review of updated guidance published 17/01/22 COVID-19: management of staff and exposed patients or residents in health and social care settings - GOV.UK (www.gov.uk)		

10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
- lead on the implementation of systems to monitor staff illness, absence and vaccination against seasonal influenza and COVID-19 - encourage staff vaccine uptake.				
Staff who have had and recovered from or have received vaccination for a specific respiratory pathogen continue to follow the infection control precautions, including PPE, as outlined in national guidance.	Covid-19 SOP Staff seasonal influenza vaccination programme commenced in September 2022			
A risk assessment is carried out for health and social care staff including pregnant and specific ethnic minority groups who may be at high risk of complications from respiratory infections such as influenza and severe illness from COVID-19. A discussion is had with employees who are in the at-risk groups, including those who are pregnant and specific ethnic minority groups. that advice is available to all health and social care staff, including specific advice to those at risk from complications	- An integrated self-risk assessment tool has been produced for all staff to identify if they are 'at-risk'. - Following identification (through the tool or the personal information held on individuals), and a subsequent detailed risk assessment is completed for all staff who are within an 'at-risk' group, compliance Sep-21 at 94% and is reported daily - Chief People Officer and Chief Executive Officer and Chairman attended the BAME Staff Network Group in June 2020 to receive feedback			

10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection				**RAG**
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
Bank, agency, and locum staff who fall into these categories should follow the same deployment advice as permanent staff. A risk assessment is required for health and social care staff at high risk of complications, including pregnant staff.	- Individual letters have been sent to BAME members of staff, outlining support available - Named midwife contact within Maternity Department provides advice for pregnant staff - All staff who are considered clinically extremely vulnerable are supported by robust workforce support and the Trust are in the process of having one to one discussion to agree support and adjustments - All staff working at home have been provided with a 'working from home pack', including access to mental health support - Enhanced Occupational Health Service to 7 days per week with additional staffing both administration and clinical. Service resumed to 5 day working - 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			

10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection				**RAG**
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
	- Access to face-to-face counselling - Wellbeing Wednesday emails			
Vaccination and testing policies are in place as advised by occupational health/public health.	Health Clearance Policy			
Staff required to wear FFP3 reusable respirators undergo training that is compliant with HSE guidance, and a record of this training is maintained and held centrally/ESR records	- Fit testing programme, including quantitative and qualitative testing, in place - Qualitative Fit testing SOP - Quantitative Fit testing SOP - Records are added to a central database - Powered Hoods are offered as an alternative where it has not been possible to fit close fitting face masks Only EN 149:2001 compliant masks are accepted as fit for use for Aerosol Generating procedures			
Staff who carry out fit test training are trained and competent to do so.	Programme of Fit Testing in place which is only carried out by trained Fit testers An accredited Fit2Fit company or the Department of Health virtual training provided staff training			
All staff required to wear an FFP3 respirator have been fit tested for the model being	- Programme of Fit Testing in place			

10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
used and this should be repeated each time a different model is used.	- Compliance with Fit testing is monitored. Paper submitted to QAC in February 2021 - Programme of Fit Testing continues with an ambition to ensure staff are Fit Tested against 2 types of FFP3 respirators. Data on 08/10/2021 - Total Number on Database: 3848 - Total Number passed on at least 1 current supported mask: 2422 - Total Number passed on at least 2 current supported masks: 554			
All staff required to wear an FFP3 respirator should be fit tested to use at least two different masks	- Programme of Fit testing in progress	- Some staff tested against only 1 mask	- Continuous Availability of Fit Testing to achieve the requirement to be fit tested against 2 masks	
A record of the fit test and result is given to and kept by the trainee and centrally within the organisation.	- Database with Fit testing details including those staff requiring specialist respiratory equipment which is updated as additional fit testing is completed	- Data not held on ESR	- Action in place to review use of ESR for recording Fit Testing records - Trust-wide data held on a spreadsheet	
Those who fail a fit test, there is a record given to and held by employee and centrally within the organisation of repeated testing on alternative respirators and hoods.	- Spreadsheet with Fit testing details included	- Data not held on ESR	- Action in place to review use of ESR for recording Fit Testing records	

10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection				**RAG**
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
That where fit testing fails, suitable alternative equipment is provided. Reusable respirators can be used by individuals if they comply with HSE recommendations and should be decontaminated and maintained according to the manufacturer's instructions.	- Alternative respiratory protection is offered i.e., powered hood - Staff are redeployed to green pathway areas or amber areas where aerosol generating procedures are not performed - Provision of specialist PPE equipment is recorded including advice on decontamination of re-usable PPE			
Members of staff who fail to be adequately fit tested a discussion should be had, regarding re deployment opportunities and options commensurate with the staff members skills and experience and in line with nationally agreed algorithm.	- Alternative respiratory protection is offered i.e., powered hood - Staff are redeployed to green pathway areas or amber areas where aerosol generating procedures are not performed - Provision of specialist PPE equipment is recorded including advice on decontamination of re-usable PPE	-	-	
A documented record of this discussion should be available for the staff member and held centrally within the organisation, as part of employment record including Occupational health.	- Provision of specialist PPE equipment is recorded	- Documented evidence of discussion and central holding of this record	- Process under review to capture this data	

10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection				**RAG**
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
Boards have a system in place that demonstrates how, regarding fit testing, the organisation maintains staff safety and provides safe care across all care settings. This system should include a centrally held record of results which is regularly reviewed by the board.	- Spreadsheet with Fit testing details included - Compliance with Fit testing is monitored. Paper submitted to QAC - Email updates provided weekly by the Fit Testing Team Coordinator	- Data not held on ESR	- Action in place to review use of ESR for recording Fit Testing records - Information on Fit testing figures is reported at Tactical meetings and included at Senior Executive Oversight Group Meetings - Report to QAC 02/2021	
Consistency in staff allocation should be maintained, reducing movement of staff and the crossover of care pathways between planned/elective care pathways and 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			
Health and care settings are COVID-19 secure workplaces as far as practical, that is,	- Risk assessment in place to reduce risk			

10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection				**RAG**
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
that any workplace risk(s) are mitigated maximally for everyone.	- Agile working policy includes home working - Staying Covid-19 secure signage listing mitigation in place			
Staff absence and well-being are monitored and staff who are self-isolating are supported and able to access testing	- Managers have been supported to record absence in 'real time'. Daily and weekly absence reporting is in place - Data reported at Tactical meetings - Staff self-Isolation SOP in place from 08/2021 to enable staff to return to work, if they meet a risk assessed criteria from non-household Covid-19 contact - HR advisors support wellbeing meetings for long-term absence - Return to work advice includes requirement for 2 negative Lateral Flow Device tests from day 6 and day 7			
Staff who test positive have adequate information and support to aid their recovery and return to work	- A COVID-19 Occupatinal Health advice line has been created, to provide a range of advice and guidance to the workforce - The OH Service has also developed the co-ordination and advice service for staff testing (for symptomatic staff)	- Test and Trace Service hours of operation	- Notifications from Test and Trace are received in the Control Room and forwarded to the Occupational Health and Infection Control Teams for action	

10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection				**RAG**
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
	- Enhanced Occupational Health Service to 7 days per week with additional staffing both administration and clinical. Service returned to 5 days - Occupational Health and Wellbeing advise staff of test results and provide further wellbeing support as and when required - Retesting is in place as appropriate and is set out in Staff Testing SOP - Occupational Health e-mail to staff and their manager with return-to-work guidance			

APPENDIX 2 Action Plan for IPC BAF 10 2022

Ref No	Action required	Target / review date	Date met	Supporting action	Lead	Supported by	Evidence/ Current position	RAG status
Criterion 1 Systems are in place to manage and monitor the prevention and control of infection								
Criterion 2 Provide and maintain a clean and appropriate environment								
1	A systematic review of ventilation and risk assessment is undertaken to support location of patient care areas for respiratory pathways	**Mar 23**		Requirement for discussion on audit findings at Ventilation Group and plan to agree actions	ADE	IPCT ICD	Site audits completed Action plan required to address areas of non-compliance Capital bids required	
Criterion 3 Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance								
Criterion 4 Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion.								
Criterion 5 Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people								
2	Audit of compliance with routine patient testing protocols in line with Trust approved hierarchies of control risk assessment and approved	**Mar 23**			IPCT	Informatics	BI report on testing provides information on tests outstanding for completion. Process for reporting of Lateral Flow Device testing compliance numbers to be confirmed Pause on asymptomatic admission, day 3 and day 5 testing	

APPENDIX 2 Action Plan for IPC BAF 10 2022

Ref No	Action required	Target / review date	Date met	Supporting action	Lead	Supported by	Evidence/ Current position	RAG status
Criterion 6 Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection								
Criterion 7 Provide or secure adequate isolation facilities								
Criterion 8 Secure adequate access to laboratory support as appropriate								
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								
3	All staff required to wear an FFP3 respirator should be fit tested to use at least two different masks	**Mar 23**		Continuous Fit Testing Programme	DCN		Figures reported to Trust Board	

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**
ICD	**Infection Control Doctor**
IPC Admin	**Infection Prevention and Control Administrator**
IPCT	**Infection Prevention and Control Team**

APPENDIX 2 Action Plan for IPC BAF 10 2022

Completed actions

Ref No	Action required	Target / review date	Date met	Supporting action	Lead	Supported by	Evidence/ Current position	RAG status
Criterion 1 Systems are in place to manage and monitor the prevention and control of infection								
1	Revise risk assessment templates to NHSE/I hierarchies of control template	Feb 22	Feb 22		HW	IPCT	Approved at Tactical meeting 04/02/22	
2	Role out of revised Risk Assessments	Apr 22	Apr 22		HW			
Criterion 2 Provide and maintain a clean and appropriate environment								
3	Trust wide audit of ventilation systems and gap analysis against national guidance	Mar 22	Apr 22	Discussed at Ventilation Group. Further meeting required to agree scope of assessment.	ADE		Audits conducted by the appointed Authorising Engineer Ventilation	
4	Strengthening of stewardship resources	Mar 22	Mar 22	Business case in progress to strengthen stewardship resources, Change approach to auditing to provide more meaningful data	CMM	LPAMS	Hot topic 21/02/22 at Trust wide Safety Brief Business case approved	
5	Implementation of the Supporting excellence in infection prevention and control behaviours	Feb 22	Feb 22	Roll out plan approval	ADIPC		Campaign materials rolled out Trust wide	
6	Improve compliance with LAMP testing	Mar 22	Mar 22	Revise introduction plan Communication strategy to improve uptake including CEO led team brief June 2021 Discussion on importance at Outbreak meetings	CPO	CBU Triumvirate Leads	LAMP testing ceased 31/03/22	

APPENDIX 2 Action Plan for IPC BAF 10 2022

Ref No	Action required	Target / review date	Date met	Supporting action	Lead	Supported by	Evidence/ Current position	RAG status
7	Consider daily testing of COVID-19 negative patients when there are high nosocomial rates should consider testing daily.	Feb 22	Feb 22	Increased testing in wards during outbreaks	CMM		Outbreak case detection	
8	Prompt tracing of Covid-19 contacts where this occurs	May 22	Apr 22	Publication approval reference: C1630 – isolation of Covid-19 contacts no longer required if asymptomatic	CMM/ ADIPC		Covid-19 exposed contact letter updated Completed as far as reasonably practicable	
9	Prioritisation patients with excessive cough and sputum production for placement in single rooms whilst awaiting testing.	**May 22**	N/A		PFT	IPCT	Patients are prioritised based on risk assessment by mode of infection transmission. Not actioned	
10	Revision to pre-admission PCR / Lateral Flow Device testing.	**May 22**	June 22		Planned Care Group Triumvirate	IPCT	Proposal to implement on the day Lateral Flow Device testing for day case surgery Halton ward B4 and both site Endoscopy Units.	

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/22/11/156**	
SUBJECT:	**Safeguarding Bi-Annual Report**	
DATE OF MEETING:	30th November 2022	
AUTHOR(S):	Layla Alani, Director of Governance & Quality, and Interim Deputy Chief Nurse	
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
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): ***(Please DELETE as appropriate)***	**#224** If there are capacity constraints in the Emergency Department, Local Authority, Private Provider and Primary Care capacity then the Trust may not meet the four hour emergency access standard and incur recordable 12 hour Decision to Admit (DTA) breaches, resulting in potential risks to the quality of care and safety to patient, staff health and wellbeing, Trust reputation, financial impact and below expected patient experience. **#1215** If the Trust does not have sufficient capacity (theatres, outpatients, diagnostics) because of the ongoing COVID-19 pandemic then there may be delayed appointments and treatments, and the trust may not be able to deliver planned elective procedures causing possible clinical harm and failure to achieve constitutional standards. **#1273** If we continue to experience system-wide Covid-19 pressures, then we may be unable to provide timely patient discharge and experience potential reduced capacity to admit patients safely. **#1275** If we do not prevent nosocomial Covid-19 infection, then we may cause harm to our patients, staff and visitors, which can result in extending length of inpatient stay, staff absence, additional treatment costs and potential litigation. **#134** If the Trust is not financially viable then there may be an impact on patient safety, operational performance, staff morale and potential enforcement/regulatory action taken. **#115** Failure to provide minimal staffing levels in some wards and departments. Caused by vacancy position, current sickness levels and absence due to COVID 19. Resulting in depleted staffing levels, potentially impacting the ability to provide basic patient care and treatment. **#1372** If the Trust is unable to procure a new Electronic Patient Record then then the Trust may have to continue with its current suboptimal EPR or return to paper systems triggering a reduction in operational productivity, reporting functionality and possible risk to patient safety.	
EXECUTIVE SUMMARY ***(KEY ISSUES):***	The Safeguarding Strategy (2019) identified 7 areas of priority – these have been achieved. The Safeguarding strategy is being reviewed. The number of ICE referrals for both adults and children remains high but has slightly decreased (section 4.1) with an increase in maternity data reported (47 – 59) referrals. This increase was expected due to a higher September birth rate. Adult domestic abuse referrals have reduced by 50%.	

	Training compliance is monitored monthly via the safeguarding Committee. This has remained challenging due to operational pressures, staffing and the time required for training attendance. CBUs have trajectories in place and a Safeguarding Task and Finish Group is scheduled to commence on the 31st October 2022, led by the Director of Governance and Deputy Chief People Officer Liberty Protection Safeguards will replace Deprivation of Liberty and will apply for 16+ rather than 18+. Mental Capacity Act training is in place. The final report with regard to implementation is awaited from the national team and the WHH service is being considered. This is anticipated to be a significant piece of work with requirements for additional resource. This is being explored.			
PURPOSE: ***(please select as appropriate)***	Information	Approval	To note X	Decision
RECOMMENDATION:	The Trust Board is asked to note the report for assurance purposes.			
PREVIOUSLY CONSIDERED BY:	**Committee**	Quality Assurance Committee		
	Agenda Ref.	QAC/22/11/284		
	Date of meeting	1ST November 2022		
	Summary of Outcome	The Quality Assurance Committee noted the report.		
FREEDOM OF INFORMATION STATUS (FOIA):	Partial FOIA Exempt			
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	Section 22 – information intended for future publication			

Warrington and Halton Teaching Hospitals

NHS Foundation Trust

Safeguarding Bi-Annual Report 2022-2023

Contents

1. Executive Summary

Safeguarding is a Care Quality Commission (CQC) standard and a duty at the centre of our daily business. The scope of safeguarding is wide reaching and incorporates all categories of abuse. This is the fourth bi-annual report regarding adult and children's safeguarding within Warrington and Halton Teaching Hospitals NHS Foundation Trust (WHH).

The Trust is committed to continually providing best practice standards in the delivery of a positive Safeguarding culture and considers this a fundamental component in providing a safe environment for staff, patients and the public.

The Trust's mission is to be 'outstanding for our patients, our communities and each other', with a vision that 'we will be a great place to receive healthcare, work and learn'. The embedding of safeguarding practices across the organisation are fundamental in achieving this.

2. Introduction

This report provides the Safeguarding Committee and Quality Assurance Committee with a progress update in relation to the safeguarding agenda and the trusts Safeguarding Strategy. A full analysis of data and activity will be provided in the annual report in 2023.

The Safeguarding of children, young people and adults at risk in the NHS, accountability and assurance framework (2019) sets out the safeguarding roles, duties and responsibilities of all NHS organisations and is integral to the safeguarding agenda, thus forming the basis of this report.

In recognition of the legislation as described in the Children Act 2014 and the Care Act 2014, WHH are supported by policies, Standard Operating Procedures, and risk assessments to ensure that all WHH staff are aware of how to discharge their safeguarding duties and responsibilities. The Children Act 2014 and the Care Act 2014 requires the Trust to provide and maintain:

- Safeguarding Children Policy
- Safeguarding Adult at Risk Policy
- Safeguarding Strategy
- Safeguarding Training and supervision
- Processes to support recognition and response to safeguarding situations
- Information resources to support in their decision making
- Subject matter experts that are available to support safeguarding practice

There are safeguarding reporting processes in place to provide assurance of compliance with proactive monitoring and triangulation through existing governance mechanisms.

3. Safeguarding Strategy

In 2019 the Safeguarding Strategy was launched outlining seven priorities as detailed in figure 1 below, these have been achieved. The new Safeguarding Strategy is under development with new priorities being considered.

Figure 1

<table>
<tr><th></th><th>Priorities</th><th>October 2022 – Final progress update</th></tr>
<tr><td>Domestic Abuse</td><td>1. To raise awareness to enable staff to identify domestic abuse and what their responsibilities are

2. To ensure the learning from the 2018 DHR is shared with regards to coercive and controlling behaviour

3. To support our Occupational Health and HR departments where domestic abuse victims/perpetrator involved staff</td><td>All actions for this objective have been completed and achieved. A base line audit to assess DA knowledge and practice was completed by the domestic abuse (DA) trainer prior to the role out of the DA training. This will now be re-evaluated to assess the effectiveness of the training. The 3-year training trajectory is on target with compliance detailed below:
<table>
<tr><th>Training – September 2022</th><th>Number of people to be trained</th><th>Number of people trained</th><th>Compliance</th></tr>
<tr><td>Domestic Abuse Level 1</td><td>4333</td><td>3052</td><td>70.44%</td></tr>
<tr><td>Domestic Abuse Level 2</td><td>2009</td><td>979</td><td>48.73%</td></tr>
</table></td></tr>
<tr><td>MCA DoLS (LPS)</td><td>1. To continue to train staff with regards to their responsibilities of their MCA practice

2. To plan and monitor training with regard to the new LPS process

3. To work towards roll out of LPS</td><td>All actions for this objective have been completed. Training compliance has reached and been maintained at expected levels. The final report remains outstanding from the national team with regard to the implementation of the LPS. The Warrington local implementation network are trialling the documentation to check the usability of these documents and will share their findings. MCA training is in place to support the implementation of LPS this will be supported by a practice development trainer who has been recruited into a 6-month post.
Training compliance up to September 2022:
<table>
<tr><th>Training – September 2022</th><th>Number of people to be trained</th><th>Number of people trained</th><th>Compliance</th></tr>
<tr><td>DoLS</td><td>2640</td><td>2291</td><td>86.78%</td></tr>
<tr><td>MCA</td><td>2707</td><td>2414</td><td>89.18%</td></tr>
</table></td></tr>
<tr><td>Child Sexual Exploitation</td><td>1. To raise awareness through masterclass training

2. To help staff to understand all elements of CSE including the criminal aspects of this abuse

3. To support staff in recognising and reporting this abuse HSAB priorities and actions to be added then circulate for comment before final sign off.</td><td>All actions regarding this objective have been achieved, training was well received, feedback from staff attending this was positive and there has been a positive effect on the CSE referrals received by the WHH safeguarding team, the table below describes this activity.
<table>
<tr><th></th><th>Apr</th><th>May</th><th>Jun</th><th>Jul</th><th>Aug</th><th>Sep</th><th>Oct</th><th>Nov</th><th>Dec</th><th>Jan</th><th>Feb</th><th>Mar</th></tr>
<tr><td>19/20</td><td>1</td><td>3</td><td>1</td><td>5</td><td>4</td><td>6</td><td>6</td><td>2</td><td>7</td><td>11</td><td>18</td><td>16</td></tr>
<tr><td>20/21</td><td>2</td><td>2</td><td>9</td><td>14</td><td>3</td><td>0</td><td>12</td><td>17</td><td>7</td><td>6</td><td>6</td><td>9</td></tr>
</table></td></tr>
</table>

<table>
<tr><td>Neglect</td><td>1. This element of Safeguarding includes neglect of adults at risk and children it also includes self-neglect

2. To raise awareness of above issues amongst Trust staff and to provide education to enable them to recognise and report neglect of all types

3. To raise awareness of the self-neglect assessment tool

4. To raise awareness of processes that support child neglect</td><td>All actions for this objective have been achieved. WHH supported the Warrington Safety Partnership with the development of a child neglect strategy which in being launched. WHH have contributed the development of a multi-agency adult neglect policy, assessment tool and training program. This is to be used by all partner agencies to assist professionals in caring for and supporting patients who are self-neglecting. A MARAM process and document has also been developed; this is a multi-agency risk assessment meeting that supports the management of patients who present with difficult to manage issues.</td></tr>
<tr><td>Learning Disabilities</td><td>1. To promote flagging of inpatients and outpatients by staff creating alerts in Lorenzo where required

2. To continue to support the learning disability improvements programme

3. Upon the appointment of the new Safeguarding Adults team member, to further support the learning disability agenda</td><td>All actions regarding this objective have been achieved, training for LD and Autism levels 1 and 2 has been developed in line with national standards and include the lessons learnt from the Oliver McGowan review. This training has been delivered over a three-year trajectory and is on target to be achieved. Compliance is detailed below. WHH continues to support the National Improvement Standards and flagging of patients with LD and Autism is in place. The LeDeR process has been embedded as part of MRG review processes and WHH continues to contribute to the local LeDeR process. The following tools have been developed to assist staff in their delivery of LD and Autism care:
Reasonable adjustment care plan and SOP
WHH passport for use when patients do not have their own or who have forgotten them
Communication aide
Use of Widget programs to support the development of documents
The LD/Autism policy has been re-written
Makaton Monday happens every Monday morning, staff are taught a new sign every week
<table>
<tr><th>Training – September 2022 (this data is indicative of the training commenced in February 2021)</th><th>Number of people to be trained</th><th>Number of people trained</th><th>Compliance</th></tr>
<tr><td>LD level one</td><td>1405</td><td>1001</td><td>71.25%</td></tr>
<tr><td>LD level two</td><td>2882</td><td>1604</td><td>55.66%</td></tr>
<tr><td>Autism level one</td><td>1376</td><td>1003</td><td>72.89%</td></tr>
<tr><td>Autism level two</td><td>2883</td><td>1591</td><td>55.19%</td></tr>
</table></td></tr>
<tr><td>Early Help</td><td>1. To raise awareness across the organisation of staff responsibility to offer early help to families in need in paediatric and adult settings

2. To ensure that staff in inpatient and outpatient areas are aware of this important support for families</td><td>All actions regarding this objective have been achieved. WHH safeguarding team are working closely with Warrington BC Early Help Team and the health link worker to further assist multi-agency partners with this element of their care delivery. Training has highlighted the think family approach, staff have been educated to be aware of the importance of recognising the needs of children where parents have physical or mental health challenges.</td></tr>
</table>

Modern Slavery/Trafficking	1. To provide training to raise awareness of modern slavery and human trafficking issues in relation to children and adults at risk 2. To raise awareness of county lines via training 3. To support staff in recognising and reporting modern slavery and trafficking 4. To work with our procurement teams to gain assurance that our business is conducted with businesses that observe the modern slavery act 2015	All actions regarding this objective have been achieved. The Safety Partnership/Safeguarding Adult Board and WHH devised and delivered a training program that educated staff in recognising and reporting modern slavery and human trafficking issues. It was identified that the finance dept have a person who visits foreign nationals in A/E and on the wards to address international cross charging of care received in the NHS, this person has received additional training to ensure they are aware of how to recognise and report slavery and trafficking, the person has successfully identified two cases pertaining to trafficking. An external trainer attended to deliver several sessions about trafficking, cuckooing and county lines. Procurement leads have provided assurance that WHH is only doing business with companies who hold the same values and who are signed up to the provision of a statutory anti-slavery statement

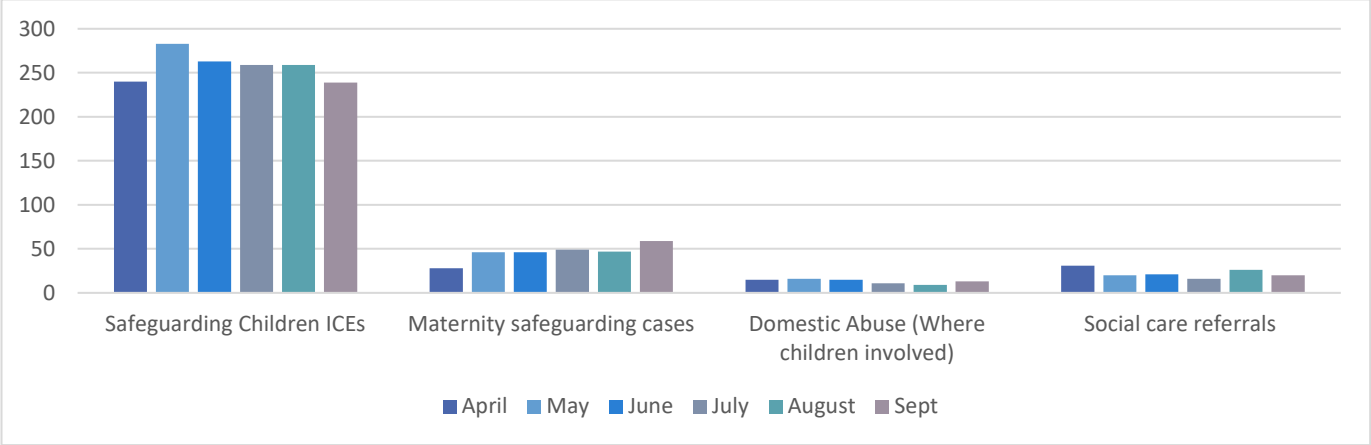
4. Safeguarding Activity

Whilst the annual report which is expected later in 2023 will provide a full analysis of the data, the below figure provides an overview of activity in Quarter 1 and Quarter 2 of 2022 / 2023.

Safeguarding notifications to the safeguarding teams are completed using the ICE electronic system. Each ICE notification is reviewed and actioned by a Specialist Safeguarding Nurse. The data collected from the ICE notifications, telephone calls, emails and face to face contacts have been captured and are reflected in this report.

4.1 Safeguarding Unborns, Children and Young People

The graph below (figure2) provides an overview of activity in quarter 1 & 2 and 2022/2023



Overall, activity across quarter 1 and quarter 2 remains consistent. ICE notifications have started to decrease however this was expected following a piece of work with specific departments to ensure that all ICE referrals are both complete and appropriate.

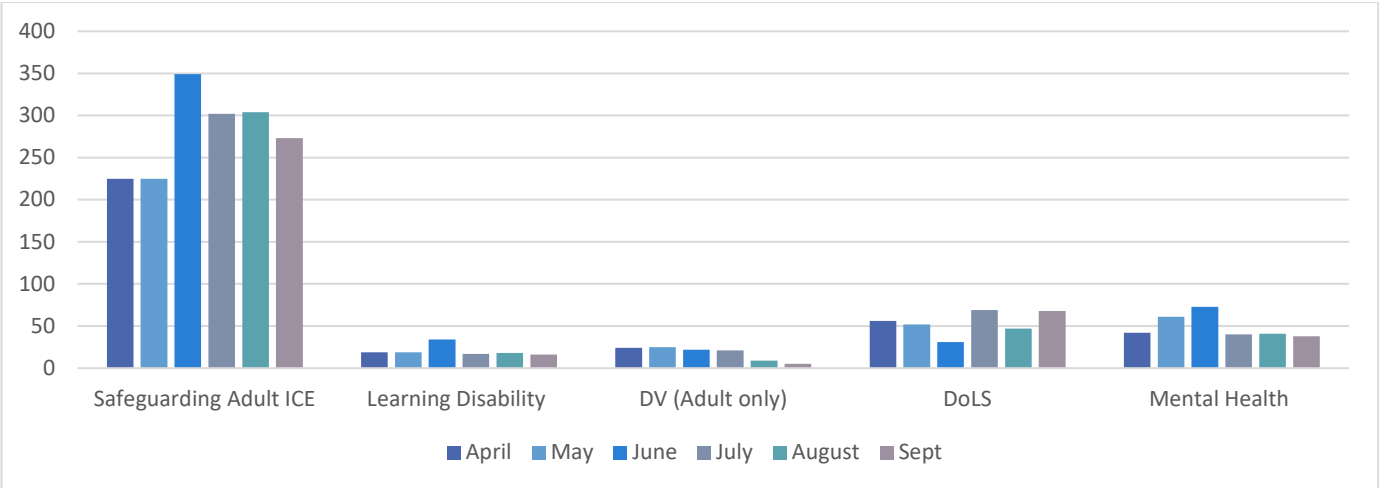
The maternity figures reflect women who are due to deliver that month with safeguarding concerns. September data noted an increase from 47 to 59 when compared to the previous month, however this was expected as national birth-rates generally peak in the month of September.

Domestic abuse referrals where there are children involved remain static with 10-15 referrals per month. This remains consistent with the previous year's data.

April and August noted a spike in referrals to children social care up to 31 cases which could be a result of the children being off school during the holidays. There were no clear trends in the reasons for referral and so this will continue to be monitored.

4.2 Safeguarding Adults at Risk

Figure 3



The graph above (figure 3) demonstrates the safeguarding adult activity in quarter 1 and quarter 2. There was a significant spike in ICEs in the month of June which was consistent with the activity across the trust. Since June the number of ICEs remain high at over 270 per month.

Domestic abuse referrals involving adults only have reduced significantly. In comparison to the previous year's data for August and September the referrals have reduced by 50% (28 down to 14 referrals). There is no clear explanation for this reduction, however the data will be monitored monthly via safeguarding committee to ensure trends are reviewed and scrutinised.

Learning Disability (LD) referrals, Mental health ICEs (MH)and DoLS activity remains consistent with no exceptions to report.

5. Safeguarding Training Compliance

Training compliance is monitored monthly via the safeguarding Committee. This has remained challenging due to operational pressures, staffing and the time required for training attendance. CBUs have trajectories in place and a Safeguarding Task and Finish Group is scheduled to commence on the 31st October 2022, led by the Director of Governance and Deputy Chief People Officer. The table below (figure 4) describes compliance up to 30/09/22. Domestic Abuse, Learning Disability and Autism training commenced in February 2021 with the current trajectories on target for 2024 (3-year training plan).

Figure 4

Training – September 2022	Number of people to be trained	Number of people trained	Compliance
DoLS	2640	2291	86.78%
MCA	2707	2414	89.18%
WRAP	1769	1647	93.10%
Prevent Basic Awareness	4333	3765	86.89%
Safeguarding Children Level 1	4333	3757	86.71%
Safeguarding Children Level 2	2601	1944	74.74%
Safeguarding Children Level 3	479	332	69.31%
LD level one	1405	1001	71.25%
LD level two	2882	1604	55.66%
Autism level one	1376	1003	72.89%
Autism level two	2883	1591	55.19%
Domestic Abuse Level 1	4333	3052	70.44%
Domestic Abuse Level 2	2009	979	48.73%
Adult safeguarding level 1 Face to face	4333	2571	59.34%
Adult safeguarding level 1 eLearning	4333	3435	79.28%
Adult safeguarding level 2 Face to face	2724	1610	59.10%
Adult safeguarding level 2 eLearning	2724	2060	75.62%
Adult safeguarding level 3 (this figure describes the face-to-face training data only)	1073	428	39.89%

6. Safeguarding Datix

The DATIX reporting and categorisation has recently changed therefore the Annual Report will be providing a full 12months overview of activity. It should be noted that there are significant trends and themes to report on.

7. Safeguarding Team Recruitment

Children and Young People Liaison Practitioner (Band 6)

The role of Children and Young People Liaison Practitioner has been developed jointly between Warrington and Halton Hospitals NHS Foundation Trust, Warrington Local Authority and Warrington Clinical commissioning group (now ICB). The new role was developed to support the offer to children and young people who attend the hospital/ and or are admitted due to complexities surrounding their mental health.

The post was successfully recruited too in July 2022 and the impact of this new role has already been noted across the services. A more detailed update will be provided within the Annual Report 2022/2023

Learning Disability and Autism Specialist Nurse (Band 7)

In May 2022 the trust recruited a Learning Disability and Autism Specialist Nurse to join the Safeguarding Adult Team.

Safeguarding Specialist Midwife (Band 7 – Temporary post)

The recruitment of a temporary additional safeguarding midwife in September 2022 was required to provide additional focussed safeguarding training and further develop the knowledge of the workforce across midwifery.

8. Progress Statement and Liberty Protection Safeguards

Whilst the new Safeguarding Strategy remains under development, the 2019-2022 Strategy remains in place. This report demonstrates the ongoing progress within training compliance across all levels. Activity continues to increase in complexity and number which will be explored further in the annual report 2022/2023.

In preparation for the implementation of Liberty protection Safeguards the WHH Safeguarding Service is being reviewed and plans are being developed for implementation recognising that the acute trust will become the legal Responsible Body. Requirements for the implementation of the LPS continue to require further clarification and the report is awaited from the national team. In the interim staff training with regard to the Mental Capacity Act continues which will be fundamental in the delivery of LPS. An MCA trainer has been recruited as a secondment.

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/22/11/157**
SUBJECT:	**Summary Report from Digital Strategy Group (DSG)**
DATE OF MEETING:	30th November 2022
AUTHOR(S):	Tom Poulter, Chief Information Officer
EXECUTIVE DIRECTOR SPONSOR:	Paul Fitzsimmons, Executive Medical Director
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	SO1 We will.. Always put our patients first delivering safe and effective care and an excellent patient experience. 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)***	**#1114** FAILURE TO provide essential and effective Digital Services CAUSED BY increasing demands upon resources (e.g. cyber defences), new technology skillsets (e.g. Cloud), unfit solutions (e.g. Maternity), end-of-life solutions (e.g. Telephony), poor performance (e.g. Lorenzo EPR)RESULTING in a potentially reduced quality of care, data quality, a potential failure to meet statutory obligations (e.g. Civil Contingency measures) and subsequent reputational damage. **#1372** If the Trust is unable to procure a new Electronic Patient Record then then the Trust may have to continue with its current suboptimal EPR or return to paper systems triggering a reduction in operational productivity, reporting functionality and possible risk to patient safety.
EXECUTIVE SUMMARY *(KEY ISSUES):*	The Digital Strategy Group (DSG) met on 10th October 2022. As per proposals approved by FSC earlier this year, the DSG has replaced the Digital Board with updated membership and new Terms of Reference. The DSG is focussed on development and delivery of a new Digital Strategy for WHH and the digital work programmes that are being planned and delivered at ICB regional and Place levels. Links to WHH strategy and transformation team activities have also been strengthened, with consistent RAG status reporting on any digital workstreams. This report provides a summary of updates received from the new DSG feeder groups, providing the following assurance status for key delivery areas: • **ICS Digital Update** Moderate Assurance • **Place Digital Updates (Warrington Together & One Halton)** Moderate Assurance • **Digital Strategy Refresh** Moderate Assurance • **Digital Diagnostic Business Cases** Moderate Assurance

<table>
<tr><td></td><td colspan="4">

- **Capital Scheme Overview**
  Moderate Assurance
- **Digital Transformation Group Highlight Report**
  Substantial Assurance
- **Digital Service Delivery Highlight Report**
  Moderate Assurance
- **Digital Analytics Update**
  Substantial Assurance
- **Digital Maternity Strategy**
  Moderate Assurance

All Digital work areas that have previously been reported to FSC with an internally assessed assurance rating are included within scope of the new Digital governance arrangements. The new Digital Care Delivery Group is due to commence in October 2022 when assurance reporting on clinical system optimisation and the expanded scope of Digital Clinical Safety processes will be provided to DSG, with escalation to FSC as appropriate.

Items to escalate to Trust Board include:

- Halton SAN
- Reprioritisation
- Lion outage
- Lorenzo outage
- PACS update

Minutes of the Digital Strategy Group meeting are attached as Appendix A to this report for reference.
</td></tr>
<tr><td>PURPOSE: (please select as appropriate)</td><td>Information *</td><td>Approval</td><td>To note</td><td>Decision</td></tr>
<tr><td>RECOMMENDATION:</td><td colspan="4">The Trust Board is asked ton ote the contents of the report, including assurance levels.</td></tr>
<tr><td>PREVIOUSLY CONSIDERED BY:</td><td colspan="2">Committee</td><td colspan="2">Finance + Sustainability Committee</td></tr>
<tr><td></td><td colspan="2">Agenda Ref.</td><td colspan="2">FSC/19/10/101</td></tr>
<tr><td></td><td colspan="2">Date of meeting</td><td colspan="2">26th October 2022</td></tr>
<tr><td></td><td colspan="2">Summary of Outcome</td><td colspan="2"></td></tr>
<tr><td>FREEDOM OF INFORMATION STATUS (FOIA):</td><td colspan="4">Partial FOIA Exempt</td></tr>
<tr><td>FOIA EXEMPTIONS APPLIED: (if relevant)</td><td colspan="4">Section 43 – prejudice to commercial interests</td></tr>
</table>

REPORT TO BOARD OF DIRECTORS

SUBJECT	Summary Report from Digital Strategy Group	**AGENDA REF:**	**BM/22/11/157**

1. BACKGROUND/CONTEXT

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

As per proposals approved by FSC, the Digital Strategy Group has now replaced the Digital Board, with newly configured feeder groups providing highlight reports and items for escalation as appropriate. The new arrangements are intended to :

- Enable more focus on a WHH Digital Strategy review and refresh process, ensuring comprehensive stakeholder engagement and alignment with ICS, place and trust corporate and clinical strategies
- Improve oversight of ICS regional and place level digital programmes that WHH are involved in
- Provide a clearer distinction between programmes and projects that are being delivered to advance digital transformation and service improvement and the "BAU" activities related to ongoing management and development of production systems (i.e. the "live" environment)
- Provide a clearer remit and responsibilities for the new Clinical group, with more decision-making authority on standardisation and optimisation of clinical content in existing systems and a wider scope of Digital Clinical Safety processes to be applied across all clinical systems
- Improve engagement and alignment with corporate strategy and transformation team projects, ensuring that digital workstreams on major projects being planned and delivered outside of digital are well-managed with consistent highlight reporting
- Improve engagement with CBU management with a more customer focussed approach to reporting digital activity and performance via new Service Level Agreements
- Develop vendor management processes to ensure that all business-critical systems have adequate arrangements in place for supplier performance management

Systems and processes for consistent and reliable highlight reporting are being put in place, in parallel with the new groups being established. A full set of the new Terms of Reference for DSG and its feeder groups will be included in the November 2022 update for Trust board.

2. KEY ELEMENTS

ICS Digital Update : Moderate Assurance

An overview of the strategy was presented which will be a key driver of WHH's Digital Strategy.
Work has taken place over the last few months to pull together information from various stakeholder groups, and the draft was presented to the ICB committee, comments are due by this Thursday and aims to be signed off in November.

Place Digital Updates (Warrington Together & One Halton) : Moderate Assurance

WGLL baseline assessments have been completed by all partners within the Place arrangements. This has enabled a combined digital maturity assessment to be conducted and has highlighted strengths and weaknesses within current digital strategies and work programmes. A key area highlighted for further attention is "Empower Citizens", which includes a range of patient-facing developments such as patient portals, Apps and digital channels such as Attend Anywhere. Key work programmes being delivered at Place level include:

Virtual Wards
Person Held Records
Shared Care Records
Collaboration tools for integrated teams

A digital day event is to be planned, supporting people to download NHS app to pave the way for further information and functionality to be added to the app, to provide digital readiness of the patient population. The content of the Strategy would be structured in accordance with the WGLL framework, this model is being used at Place level and ICB level, also to measure Digital Maturity. A new Digital Maturity Assessment is due to be launched soon, for which a baseline assessment has already taken place for each individual partner organisation and combined to give an overall Place view.

WHH Digital Strategy Refresh (Moderate Assurance)

The Strategy team have aligned the corporate strategy refresh timetable with our Digital Strategy, which will also need to align with the ICS strategy shown. The stakeholder information will be combined, a survey has been designed and will invite all staff to complete a questionnaire about their opinions

An approach has been verbally confirmed, a 6-year strategy for the Trust and enabling strategies would last for 3 years. The Board development session is being designed and is aimed for delivery in Q4 and a final strategy document will be ready for publishing in 2023.

Digital Diagnostic Business Cases (Moderate Assurance)

DDCP meeting took place last Friday, this covers the Diagnostics in the region, a significant amount of funding has been allocated to the region for schemes, clarification has been provided for these and business cases are to be drafted. We are awaiting the Templated to be issued by the ICS before drafts can be shared.

Capital Schemes Overview (Moderate Assurance)

The investment is required to modernise the IT estate. A significant amount of IT equipment has now reached end of life and funding has been secured to replace the oldest equipment year on year. There is a bid submitted for the Edge network and Wi-Fi network.

EPR system has already been moved to the Cloud, Lorenzo is hosted by Amazon Web Services. The direction of travel and the government policy directive is to use Cloud first where possible. It is proposed that we would buy cloud services with capital investment. Work is ongoing, with input from procurement and finance colleagues.

A £3mil proposal has been submitted, however the regional director for NHSE/I states that there is an underspend on Tech fund, indicating there may be money available to bid for in the near future

The DSG is asked to note the overview provided and the importance of securing funding for full network replacement 2023/2024, with regards to potential funding implications potential for cloud migration, the DSG is asked to support an overview/presentation to the Capital Planning Group. Digital Services DLT continue to work with Finance and Procurement colleagues on detailed review of future capital plans and any proposed change in approach.

Digital Transformation : Substantial Assurance

This Digital Transformation Delivery Group report provided a progress update on digital transformation projects that underpin the Digital Strategy aligning with WHH's Quality, People and Sustainability and What Good Looks Like Aims and Objectives.

Paperless Care

The reprioritisation of Patient and Ward Board Project to be replaced by Patient Flow and Bed Management (Right Patient, Right Bed, Frist Time) and the reprioritisation of Outpatients ePMA (Recovery of Unplanned Care Outpatient Activity).
ePMA Neonate Go Live 10th October
Trust-Wide Paper and Printing Task and Finish Group ToR being drafted first meeting to be arranged in October
As part of new governance arrangement Noting the first WHH Collaborative Working Group meeting (Strategy and Partnership, Quality Improvement, Transformation and Digital Services) took place on 4th October.

Digital Infrastructure

escalation of RED status SAN DR capital scheme to Capital Planning Group, advising of inability to deliver £200k spend on this scheme in 2022/23, but with contingency options available (a request to bring forward a portion of tech refresh 2023/24 scheme) and a requirement to still fund the scheme next year, but potentially as revenue not capital.
Digital Infrastructure Programme Board to be established, to ensure that robust project management arrangements are in place with detailed planning activity and routine highlight reporting to be implemented. This should include representatives from Finance, Estates, Procurement and Emergency Planning – with Clinical and Operational reps attending periodically as/when required.

Capital bids have been submitted for 2023/24 schemes. Whilst approval is pending some business-critical schemes are large, complex all proposed capital schemes for next year's programme should be subject to more detailed scoping and planning activity in the current financial year, ensuring that fully resourced and timetabled plans are ready for implementation without delay if/when funding is confirmed .

Place (Warrington Together & One Halton

ICS are assessing what platform for Share Care Records and Personal Held Records – a recommendation is planned to go the Transformation Board by end of October for formal Sign off

Acute Respiratory Infection (ARI) Virtual Ward soft launch for 19th October.

Digital Diagnostics

Digital Diagnostics Capability Programme for Radiology and Pathology (DDCP) business Case meetings have begun, with the Financial workshops. This work will lead to the completion of the LOA22Path and LOA22IMAGE funding request £276k

EPCMS

Option 4 - Partnership Procurement is the preferred option and St. Helens & Knowsley and Southport & Ormskirk have agreed in principle (subject to further exec agreement) to join ePR Procurement partnership with WHH.

The Financial case will be reviewed in line with the above preferred option

Review costs, potential for reduced costs e.g. shared deployment

Review benefits, potential for increased benefits e.g. patient pathways, staff mobility

External funding expected to be available for WHH

Digital Service Delivery: Moderate Assurance

This new Digital Service Delivery Group first meeting was held 7 October this report provides a progress update on service level activity (SLAs) performance reporting, cyber security, and vendor management that underpin the Digital Services business as usual (BAU) workstreams and delivery plans.

RCA:

The PACS anti-virus installed on node 1 on 6th October with all the features disabled. Workflow manager, portal and worklists ran on node 2 with McFee

with all elements active without issues. Further activity scheduled w/c 10 October to enable full protection and scanning

Digital Compliance:
ISDN Accreditation level 1 presented 21 September still require further evidence follow-up arranged 11th October
Information Governance (cyber savvy) training ratings concerning. Evaluating moving back to face to face delivery

Digital Analytics : Substantial Assurance

The team has completed a number of complex deliverables during the month of September, including:
Migration of Lorenzo from the old Integration Engine to the New Integration Engine completing the project of all systems now moved to the new infrastructure
ED&I Dashboard for the Emergency department
AKI (Acute Kidney Injury) dashboard – Phase 2

LION portal dashboards used on a daily basis – issues that this was unavailable, now working with third party to work on change control processes and stabilisation of the portal. Aim to relaunch portal in 2023/24

Digital Maternity Strategy (Moderate Assurance)

The strategy reflects the need for Women and babies to receive the highest standard of care…. Better births. Share data between professionals. Looked at WGLL framework.
MIAA are conducting a Critical Application Review on Badgernet – this was selected as the first of the systems, the report will be shared.

3. ACTIONS REQUIRED/RESPONSIBLE OFFICER

The following items are highlighted for escalation to the Board Committee, but for information only.

- Halton SAN Capital scheme in 2022/23 is “Red” requiring reprioritisation and a proposal to switch/defer schemes to CPG 14 October. Inability to deliver £200k spend on this scheme in 2022/23, but with contingency options

available (a request to bring forward a portion of tech refresh 2023/24 scheme) and a requirement to still fund the scheme next year, but potentially as revenue not capital.

- The reprioritisation of Patient and Ward Board Project to be replaced by Patient Flow and Bed Management (Right Patient, Right Bed, Frist Time) due to capacity and demand and the reprioritisation of Outpatients ePMA. Following mock CQC Inspection in Outpatients we were asked to review whether we could support Outpatient Prescribing for a pilot group of users. Further to this the Trust has been engaged with the ICB and are involved in the set up of Virtual Wards that will require elements of outpatient prescribing.

- An unplanned outage of the LiON portal (business intelligence reports) was caused by changes made by a third-party supplier. This impacted on operational services, but the incident was managed via Digital Analytics providing workarounds for access to critical information until the LiON portal was fully restored. A root cause analysis will be conducted in accordance with new SOPs.

- Dedalus system outage 16th September – received correspondence from UK director with RCA, details technical outage, however it has not detailed any lessons learned for incident management processes and customer service improvements. Further communications to be undertaken with Dedalus regarding this. The root cause of this event was a software defect in the process that manages the Active Directory (AD) DNS Forwarder configuration on the AWS domain controllers (DCs). Which corrupted the stored configuration when DNS forwarding was enabled and prevented it from being applied to newly provisioned DCs.

- PACS antivirus has now been resolved, fully installed on both nodes of PACS, still reactivating different elements on Primary Node, due for completion Monday 17th October.

4. RECOMMENDATIONS

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

The full set of Terms of Reference for the new Digital Strategy Group and its feeder groups is included in the Appendices and the Board Committee are

asked to approve them as the overarching governance and assurance reporting structure for the trust's Digital portfolio.

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/22/11/157**
SUBJECT:	**Summary Report from Digital Strategy Group (DSG)**
DATE OF MEETING:	30th November 2022
AUTHOR(S):	Tom Poulter, Chief Information Officer
EXECUTIVE DIRECTOR SPONSOR:	Paul Fitzsimmons, Executive Medical Director
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	SO1 We will.. Always put our patients first delivering safe and effective care and an excellent patient experience. 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)***	**#1114** FAILURE TO provide essential and effective Digital Services CAUSED BY increasing demands upon resources (e.g. cyber defences), new technology skillsets (e.g. Cloud), unfit solutions (e.g. Maternity), end-of-life solutions (e.g. Telephony), poor performance (e.g. Lorenzo EPR)RESULTING in a potentially reduced quality of care, data quality, a potential failure to meet statutory obligations (e.g. Civil Contingency measures) and subsequent reputational damage. **#1372** If the Trust is unable to procure a new Electronic Patient Record then then the Trust may have to continue with its current suboptimal EPR or return to paper systems triggering a reduction in productivity, reporting functionality and possible risk to patient safety..
EXECUTIVE SUMMARY ***(KEY ISSUES):***	The Digital Strategy Group (DSG) met on 14th November 2022. This report provides a summary of updates received from the new DSG feeder groups, providing the following assurance status for key delivery areas: • **WHH Digital Strategy Refresh** Moderate Assurance • **Digital Transformation Group Highlight Report** Substantial Assurance • **Digital Service Delivery Highlight Report** Moderate Assurance • **Digital Care Group Highlight Report** Moderate Assurance • **Digital Analytics Update** Moderate Assurance • **EPCMS Investment Case** Moderate Assurance The new Digital Care Delivery Group commenced in November 2022 and going forwards highlight reporting with assurance reporting on

	clinical system optimisation and the expanded scope of Digital Clinical Safety processes will be provided to DSG, with escalation to FSC as appropriate. **Items to escalate to FSC include:** • Nominations for membership of Paper/Print Reduction T&F Group • Maternity reporting issues resolved • NHS Digital Health Technology Audit • Frontline Digitisation Investment Agreement • Resolution of PACS Antivirus issues Minutes of the Digital Strategy Group meeting are attached as Appendix A to this report for reference.			
PURPOSE: ***(please select as appropriate)***	Information *	Approval	To note	Decision
RECOMMENDATION:	The Trust Board is asked ton ote the contents of the report, including assurance levels.			
PREVIOUSLY CONSIDERED BY:	**Committee**	Finance + Sustainability Committee		
	Agenda Ref.	**FSC/19/10/101**		
	Date of meeting	23rd Novmeber 2022		
	Summary of Outcome	The report was noted.		
FREEDOM OF INFORMATION STATUS (FOIA):	Partial FOIA Exempt			
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	Section 43 – prejudice to commercial interests			

REPORT TO BOARD OF DIRECTORS

SUBJECT	Summary Report from Digital Strategy Group	**AGENDA REF:**	**BM/22/11/157**

1. BACKGROUND/CONTEXT

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

As previously reported, systems and processes for consistent and reliable highlight reporting are being put in place, in parallel with the new Digital Strategy Group and its feeder groups being established.

A summary pack of the Terms of Reference for DSG and its feeder groups is included as Appendix B to this report**.**

2. KEY ELEMENTS

2.1 Governance/ToR packs for DSG and Feeder Groups

There are now four groups feeding into the Digital Strategy Group (DSG), which each provide a highlight report as a summary of the groups' monthly meetings (including escalations and recommendations):

- Digital Service Delivery Group
- Digital Transformation Delivery Group (formerly Digital Optimisation Group)
- EPCMS Project Group (formerly EPR Project Board)
- Digital Care Delivery Group

Membership of these groups is extended to subject experts and relevant stakeholders throughout the Trust, emphasising the involvement of Digital Services in all aspects of the operational delivery of care and also the wider Trust, Place and regional development programmes. The Trust's involvement in Place and Regional digital programmes is increasing and this will be routinely reported at the DSG.

2.2 WHH Digital Strategy : Moderate Assurance

Extraordinary meeting/workshop scheduled for 2nd December 2022. A Board Development session is being planned for Jan/Feb 2023 and subject to agreement it is intended for the new WHH Digital Strategy will go to Trust

Board for sign off March 2023, with implementation in new financial year. The scope of the structure will cover all of the feeder groups and align with the Trust Strategy refresh/ICS, with targeted stakeholder engagement.

DSG discussed proposals for a "Digital Week" to take place in late April 2023. This would involve a range of activities aimed at both staff and patients, to increase uptake of the NHS App, to promote awareness and uptake of healthcare Apps in the ORCHA library, to engage clinicians in evaluation of new end user device options and to generally promote awareness of and commitment to digital transformation programmes, projects and activities.

2.3 NHS Digital Health Technology Standards Audit

Developed by NHSX, the Digital Technology Assessment Criteria (DTAC) is a new advisory assessment criteria for the commissioning of digital health technologies. The standard gives staff, patients and citizens confidence that the digital health technologies that they use meet the NHS minimum baseline standards. The following link can be used to view a short video providing an overview https://youtu.be/JgH5R7pdzSI.

A new Digital Health Technology Standards Audit is now being conducted as mandatory national return, to baseline the current level of compliance with DTAC. The requirement for this Audit has generated some concerns due to the scale of data collection involved in a short timeframe, but also because the trust is likely to have significant gaps with regards to evidence of specific cyber security and clinical safety assessments having been conducted in relation to all technology solution vendors and products used by the trust.

The scope of DTAC also includes medical devices that are connected to software applications via interface messaging and a requirement for assurance that these systems confirm to all minimum technical and safety standards. This is partly due to the growing scale and complexity of the digital healthcare ecosystem and the fact that more and more medical equipment is being configured to flow clinical data directly into patient records. Due to this development area MIAA have proposed that some of the 2023/24 Audit days allocated for Digital are used for an internal audit of our current governance, management, processes and controls in this area.

Digital Services are therefore linking with the Medical Engineering Department to conduct a joint review of the medical equipment asset register and associated applications and will use this information to complete the DHTS

audit and to inform the terms of reference for the proposed Digital Medical Devices audit exercise next year.

2.4 Digital Transformation : Substantial Assurance

This Digital Transformation Delivery Group report provided a progress update on digital transformation projects that underpin the Digital Strategy aligning with WHH's Quality, People and Sustainability and What Good Looks Like Aims and Objectives.

Paperless Care

- Lack of nominating staff for the Trust-wide Paper/Print Task and Finish Group delaying start up thus impacting projected CIP plans. Decision to go ahead with meeting 22 November with received limited nominations.
- Final ePMA inpatient area Neonatal go live 10 October - removing recording prescriptions and medication on paper to digital
- Digital Nursing Documentation and new Nursing Clinical Charts Project Initiation Document approved by SRO, final go/no go meeting scheduled 25 November for 28 November go live.
- Clinical Data Capture to support ITU discharge pathways and OncoAlerts

Digital Infrastructure

- The setting up of new project group is in progress. All except Halton SAN Refresh on track for Q4. SAN Refresh escalated to Capital Planning Group to request support to FSC for approval to put the DR SAN £200K capital bid back into contingency and then request for a proportion of 2023/24 technical device refresh scheme of £200k to be brought forward.
- A business case detailing cloud DR SAN scope and costing to be developed in the current financial year.

Place (Warrington Together & One Halton

- The Virtual Ward for ARI (phase 1) went live 19th October. Plans for Phase 2 for referrals from Community are being progressed with go live in Q3.
- Work continues with ICS assessing what platform for Share Care Records and Personal Held Records still awaiting a recommendation to go the Transformation Board formal Sign off

Digital Diagnostics

- Working with finance colleagues to complete the business case for the Digital Diagnostics Capability Programme for Radiology and Pathology (DDCP)

new provision of a networked Picture Archiving Communication Software Solution end of November.

EPCMS

- In preparation for Option 4 - Partnership Procurement (agreed in principle with St. Helens & Knowsley and Southport & Ormskirk) the procurement proposal, partnership procurement options and programme governance have been drafted . The Frontline Digitisation investment is to be completed and returned to ICB by 18th November..

Digital Care Delivery Group

- The first meeting held 3 November. The group received a presentation on Clinical Transformation workstreams specifically on the 4 CQUINS for 2022/23 and assurances of digital progress.
- The Digital Midwife also gave presentation on the Maternity 4 key areas of work – MSDS CNST Scorecard performance, MIASS Critical Application Review, Phase 2 BadgerNet development and Smoking Cessation process update.
- The group was also made aware of two audits MIAA Clinical Safety Sign Off and DTAC which is looking at bringing together clinical safety process, cyber security and information governance. This is a large data gathering and analysis exercise a plan is being formed to complete and return the DTAC data within the next 3 weeks.

2.5 Digital Service Delivery: Moderate Assurance

This new Digital Service Delivery Group first meeting was held 7 November, this report provides a progress update on service level activity (SLAs) performance reporting, cyber security, and vendor management that underpin the Digital Services business as usual (BAU) workstreams and delivery plans.

RCA:

- Dedalus RCA has been received and discussed at Vendor Management meeting, no breach of contract for availability. Being tracked through EPG.

CAB Update:

- There were 22 change requests submitted since September; of these, 16 were completed, 4 are on hold, 2 are pending. A new change process is being worked on by the team and this aims to provide a digitised/automated solution to submit a Request for Change as well as producing a forward schedule of change calendar and SOP for users.

Cyber Security Update:

- SDN Accreditation: The ISDN Accreditation Team are recommending to the ISDN Accreditation Assurance Board that we have achieved level 1 accreditation; we will know if that has been approved on the 24th November.
- ORMIS: Dedalus confirm that a fix is under development and testing, it is expected to be in build 10.5 which should conclude development/testing in December and be rolled out after that.
- PACS has now been fully secured with antivirus software.

2.6 Digital Analytics : Moderate Assurance

The team has completed a number of complex deliverables during the month of October, including:

- PACU dashboard
- Implementation of Virtual Ward referrals to external agencies
- Cancer Somerset upgrade to test system
- Testing of BARs 111 Referral forms

2.7 EPCMS Investment Agreement: Moderate Assurance

There is an agreement in principle to partner on the EPCMS relaunch. Partnership framework is being worked on and confirmation of latest developments will be given. The updated OBC will go to Trust Board in early 2023 and a more detailed update will be provided at December's FSC meetings. The immediate focus now is on agreeing the Programme governance model for the Partnership procurement, including clarification of ICB role etc. Documents are being shared with colleagues in NHSE/I, and the initial investment agreement for 2022/23 funding allocation has been submitted.

3. ACTIONS REQUIRED/RESPONSIBLE OFFICER

The following items are highlighted for escalation to the Board Committee, but for information only.

Nominations for membership of Paper/Print Reduction T&F Group

The Task & Finish group to be established to drive forward the agreed paper/print reduction programme has not received sufficient nominations for reps from trust departments – this has been escalated as appropriate

Maternity reporting issues

the difficulties previously reported with regards to completeness and accuracy of records during transition to the new Badgernet EPR have been fully resolved

NHS Digital Health Technology Audit
As described in this report, a new national audit of DTAC compliance is being overseen by DSG

Frontline Digitisation Investment Agreement
The initial national funding allocation for 2022/23, for the trust's EPR replacement programme has been agreed

Resolution of PACS Antivirus issues
As reported verbally to the October meeting of FSC, the on-going risk related to PACS cyber security has now been fully addressed, with successful implementation of full Antivirus protection

4. RECOMMENDATIONS

The Trust Board is asked to note the contents of the report, including internally assessed assurance levels where appropriate.

The full set of Terms of Reference for the new Digital Strategy Group and its feeder groups is included in the Appendices and the Board Committee isasked to approve them as the overarching governance and assurance reporting structure for the trust's Digital portfolio.

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/22/11/158**	
SUBJECT:	**Learning from Experience, Q2 2022/23**	
DATE OF MEETING:	30th November 2022	
AUTHOR(S):	Layla Alani, Directof Governance and Quality Maresa Kelsall, Patient Safety Manager Josie Hancox, Head of Complaints, PALS & Legal Services	
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
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): (*Please DELETE as appropriate)*	**#224** If there are capacity constraints in the Emergency Department, Local Authority, Private Provider and Primary Care capacity then the Trust may not meet the four hour emergency access standard and incur recordable 12 hour Decision to Admit (DTA) breaches, resulting in potential risks to the quality of care and safety to patient, staff health and wellbeing, Trust reputation, financial impact and below expected patient experience. **#1215** If the Trust does not have sufficient capacity (theatres, outpatients, diagnostics) because of the ongoing COVID-19 pandemic then there may be delayed appointments and treatments, and the trust may not be able to deliver planned elective procedures causing possible clinical harm and failure to achieve constitutional standards. **#1273** If we continue to experience system-wide Covid-19 pressures, then we may be unable to provide timely patient discharge and experience potential reduced capacity to admit patients safely. **#1275** If we do not prevent nosocomial Covid-19 infection, then we may cause harm to our patients, staff and visitors, which can result in extending length of inpatient stay, staff absence, additional treatment costs and potential litigation. **#134** If the Trust is not financially viable then there may be an impact on patient safety, operational performance, staff morale and potential enforcement/regulatory action taken. **#1134** If we see an increase in absence relating to COIVD-19, then we may experience 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. **#115** Failure to provide minimal staffing levels in some wards and departments. Caused by vacancy position, current sickness levels and absence due to COVID 19. Resulting in depleted staffing levels, potentially impacting the ability to provide basic patient care and treatment. **#1372** If the Trust is unable to procure a new Electronic Patient Record then then the Trust may have to continue with its current suboptimal EPR or return to paper systems triggering a reduction in operational productivity, reporting functionality and possible risk to patient safety **#1579** If the North West Ambulance Service is unable to provide the expected response times for critical transfers due to demand then the	

	Trust may not be able to transfer patients with time critical urgent care needs to specialist units which may result in patient harm
EXECUTIVE SUMMARY ***(KEY ISSUES):***	The following report provides an overview of the Learning from Experience Report, Quarter 2, 2022/23. The information within the Learning from Experience report, is extracted from the Datix system and other Clinical Governance reports for Incidents, Complaints, Claims, Health & Safety and Clinical Audit related to Quarter 2, 2022/23. **Q2 Summary:** • 6% increase in incident reporting across the Trust in Q2 (3728 in Q1 vs 3940 in Q2). • The number of no harm incidents reported increased by 4% indicating that whilst incident reporting has increased the harm profile has remained static. • Urgent and Emergency care reported the highest number of incidents (1425), this was also the case in Quarter 1 (1496). This was an expected increase as a result of system pressures. Themes include delay to assessment and time to treatment. • Incidents relating to access, transfer and discharge, security and clinical care decreased by 26% in Q2, 1167 compared to 1480 in Q1. • 30% increase in complaints opened Trust-wide in Q2 (87 in Q2 versus 61 in Q1) • There has been an increase in the number of complaints received, specifically Women's and children's, ED and Digestive Diseases. A thematic review of complaints in digestive diseases, women's and children's and clinical support services is underway. **Clinical Claims Received** 23 clinical claims were received in Q2. This is a decrease from Q1, where 26 clinical claims were received. **Clinical Claims Closed** are detailed in section 2.3 on page 14

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

RECOMMENDATION:	The Trust Board is asked to noted the contents of the report.	
PREVIOUSLY CONSIDERED BY:	**Committee**	Quality Assurance Committee
	Agenda Ref.	QAC/22/11/286
	Date of meeting	1st November 2022

	Summary of Outcome	Noted for assurance.
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	Section 22 – information intended for future publication	

REPORT TO BOARD OF DIRECTORS

SUBJECT	Learning from Experience Q2 2022/23	AGENDA REF:	BM/22/11/158

1. BACKGROUND/CONTEXT

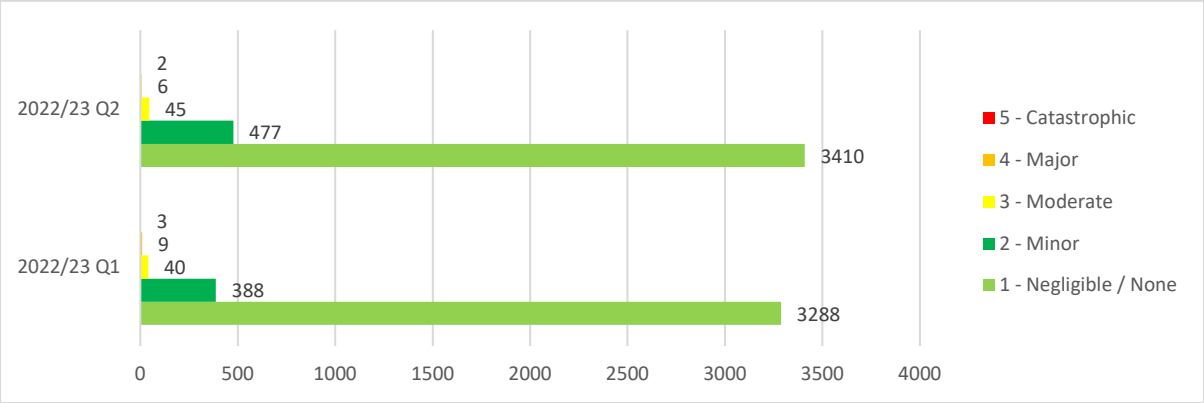
This report relates to the period 1st July to 30th September 2022 (2022/23 Q2). It contains a quantitative and qualitative data analysis (using information obtained from the Datix risk system) of incidents, complaints, claims, health & safety and clinical audit. The report includes a summary of themes, trends and key findings identified in Quarter 2 with specific recommendations to support learning across the organisation.

2. KEY ELEMENTS

2.1 Learning from Incidents

Reporting Position

There was a 6% increase in incident reporting across the Trust in Q2 (3728 in Q1 vs 3940 in Q2). The number of no harm incidents reported increased by 4% indicating that whilst incident reporting has increased the harm profile has remained static. The increase in incident reporting is reflective of continued increased attendances, patient acuity and operational pressures.

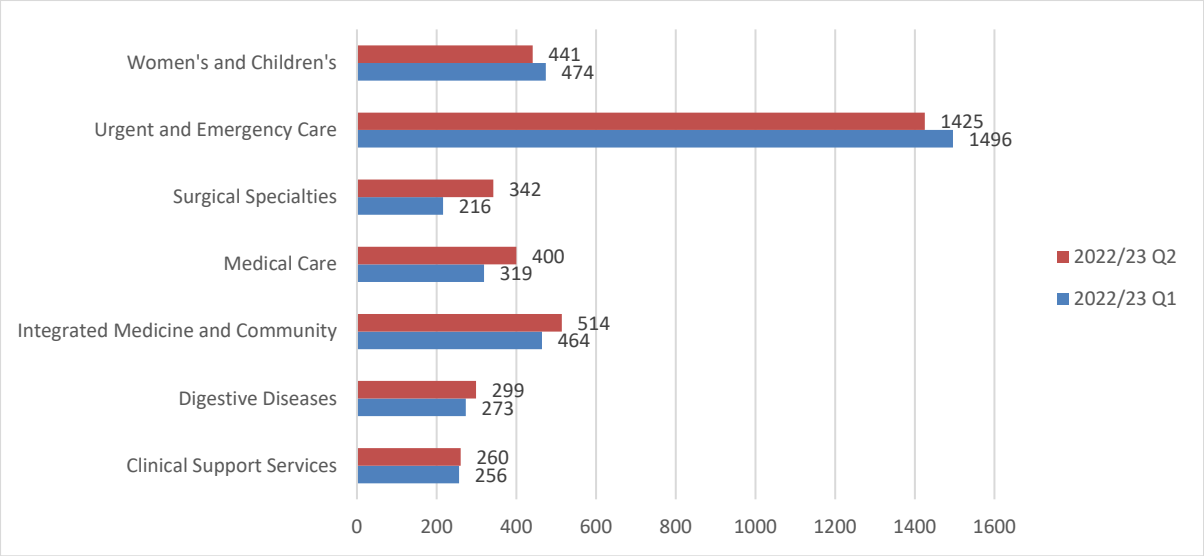


The above graph shows that 2 incidents were categorised as catastrophic in Q2 and 6 were categorised as major. 45 were categorised as moderate and the rest minor or negligible. Compared to Q1, 3 incidents were deemed catastrophic, 6 were deemed as major and 40 were deemed moderate. However, it is important to note that incidents should not be defined only by their grade and should be investigated on the learning that is identified as per the serious incident framework 2015.

Incidents reported per CBU

There was an increase in the number of incidents reported from the previous Quarter, demonstrating a positive reporting culture. A total of 3681 incidents were reported across the 6 CBUs and Clinical Support Services in Quarter 2, this has increased from 3498 when compared to Quarter 1. This demonstrates a positive reporting culture.

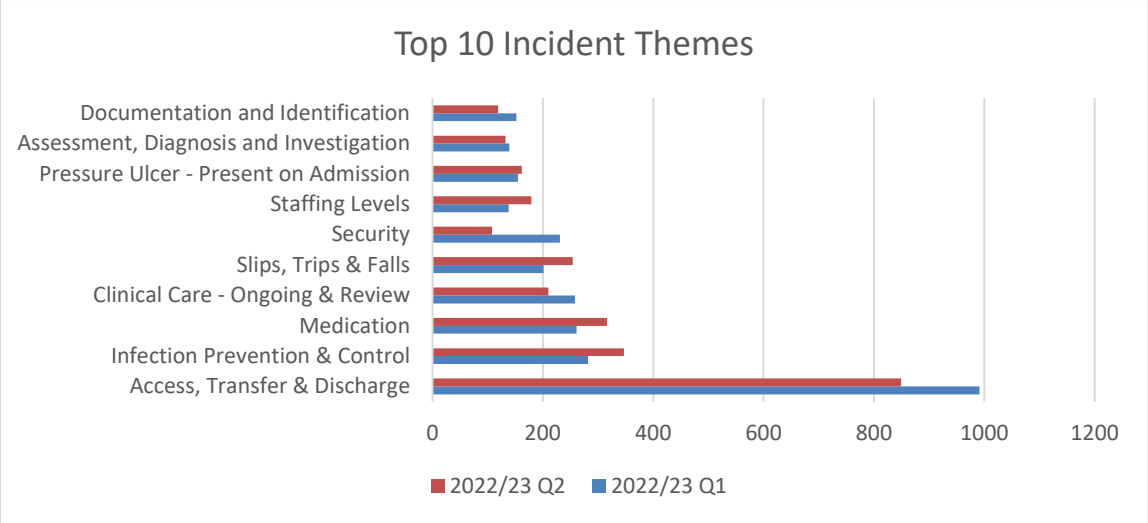
In Quarter 2, Urgent and Emergency care reported the highest number of incidents (1425), this was also the case in Quarter 1 (1496). This was an expected increase as a result of system pressures. Themes include delay to assessment and time to treatment reflecting the challenges of increased activity being experienced nationally. The harm profile however has not increased when compared to Q1. This demonstrates that the Urgent and Emergency Care CBU is promoting a culture of positive incident reporting with learning identified and actioned. Surgical Specialties has had a significant increase in incident reporting in Q2 (342) compared with Q1 (216) representing a 58% increase. Women's and Children's CBU has reported 441 incidents in Q2 compared to 474 in Q1. This remains within statistical control. In order to improve reporting culture further, the report to improve campaign continues to be shared on a weekly basis Trust wide with CBUs via the governance managers. The governance managers also offer a daily prompt to all CBUs when reviewing incidents. In addition, bespoke Datix training is offered by the senior administrator and Patient Safety Manager for Datix. This will continue over the next Quarter. A weekly drop in governance session has been established to support any additional training needs. Junior Doctor Datix training continues to be delivered on a monthly basis. A rolling agenda item has been added to the CBU Governance agenda to highlight the reduction in reporting to those areas noted.



Types of Incidents being reported

The number of incidents reported relating to antisocial / abusive / violent Behaviour has been reviewed with subcategories created on the system to support focused reporting. Incident reporting in relation to this category will be referenced within the Q3 report. Infection Prevention & Control, increases in Hospital Onset Covid and medication increased in Q2 by 42% (776) compared to (543) in Q1. Incidents relating to access, transfer and discharge, security and clinical care decreased by 26% in Q2, 1167 compared to 1480 in Q1.

As per the below graph, incidents relating to access, transfer and discharge in Q2 continue to be the most reported at 849 and 99% of these incidents were minor or negligible harm. This was mirrored in Q1. Discharge, access and transfer has been significantly affected by the number of patients who do not fit the criteria to reside. This data is now being captured.



Incident Themes

In Quarter 2, there has been an increase in the **number** of Infection Prevention & Control incidents reported (23%) with no increase in harm noted. The governance team have been feeding back to CBU's through governance meetings aspects of clinical care which include 12 hour breaches (709), delays in treatment (81) and delay in assessment (66).

There has been a continued increase in the number of medication incidents reported (21%) with no increase in harm noted. This is monitored through the medicines governance meeting with measures in place including medicine reconciliation. This work is ongoing. Infection Prevention & Control continue to foster a culture of continued vigilance across the organisation and incident report where further review may be required. In order to support this on-going piece of work, the Quality Improvement Team have developed a Gram-Negative Bloodstream Infections (GNBSI) collaborative. The aim of this collaborative is to reduce healthcare associated GNBSI by 5% by March 2022 and will focus on hot spot areas as noted within the Datix system. Reduction of GNBSI has been identified as a 2021/22 Trust quality priority. A change package outlining evidence-based interventions has been developed in Quarter 1 (revised due to operational pressures), for all wards to implement and is ongoing at present.

Subcategory	DD	IMC	SS	UEC	WACH	Grand Total
Alcohol / Substance Misuse	0	1	0	0	0	**1**
Diagnosis - Missed	0	0	0	1	1	**2**
Medical Device-Related Unstageable PU - Hospital Acquired	0	1	0	0	0	**1**
Missed Fracture	0	1	0	0	0	**1**
Reportable Ward / Unit Closure	0	0	0	0	2	**2**
Safeguarding Adult - Concern (Internal)	0	0	1	0	0	**1**
Test / Results - Results Not Reviewed / Acted On	1	0	0	0	0	**1**
Treatment - Delay	0	1	0	0	0	**1**
Treatment - Inappropriate / Incorrect	0	0	0	1	0	**1**
Complication of Procedure	1	0	0	0	0	**1**
Delay in Treatment	0	0	0	1	0	**1**
Unanticipated Admission > 37 weeks - respiratory distress / grunting	0	0	0	0	1	**1**
Unexpected Death	1	1	0	0	0	**2**
Grand Total	**3**	**5**	**1**	**3**	**4**	**16**

Serious and Concise Incidents closed within Quarter 2

There were 16 Serious Incidents closed within Quarter 2. The reporting areas for SI's are:

Area	Number	Findings
Birth Suite @WARRIN	2	1. Maternity Divert 2. Maternity Divert
ED Majors @WARRIN	3	1. Delay in treatment 2. Diagnosis – Missed 3. Treatment – Inappropriate/Incorrect
Gynaecology Outpatients @WARRIN	1	1. Diagnosis – Missed
Neonatal Unit (NNU) @WARRIN	1	1. Unanticipated Admission > 37 weeks - respiratory distress / grunting
Outpatient Department @HALTON	1	1. Test / Results - Results Not Reviewed / Acted On
Ward A4 @WARRIN	1	1. Safeguarding Adult - Concern (Internal)
Ward A8 @WARRIN	2	1. Missed Fracture 2. Unexpected Death
Ward A9 @WARRIN	2	1. Treatment – Delay 2. Medical Device-Related Unstageable PU - Hospital Acquired
Ward B19 @WARRIN	1	1. Alcohol / Substance Misuse
Halton Theatre 2	1	1. Complication of Procedure
Warrington Theatres 1	1	1. Unexpected Death

There were 17 concise incidents closed within Quarter 2.

Learning from Incidents and Assurance

The Patient Safety Manager continues to attend PLACE meetings in order to present Serious Incidents alongside the Investigating Officer. This enables feedback and assurance in real time through broad discussion with health partners. The Serious Incident Review Group has commented that the meeting is proving successful in providing appropriate assurance at PLACE. In addition, the Director of Governance and Quality presents at the Clinical Quality Focus Group any themes and trends and offers assurance to PLACE with learning actions identified.

Following the Root Cause Analysis (RCA) investigations of these incidents, the following themes were identified, and actions implemented. In order to measure the success of the learning, complaints, PALS, incidents and risk are monitored on a weekly basis to ensure a downward trend of the specific learning points noted below or timely escalation where required.

Lack of regular assessments of falls

An RCA was undertaken in relation to an inpatient who fell, fracturing her hip. The RCA found that the patient did not receive regular falls risk assessments, which would have identified that the patient was receiving sedative medication which would increase their falls risk. Unannounced falls walk arounds were planned for the area involved, in order to look at the nursing care being provided in relation to patients at risk of falls in real-time. In order to encourage learning to staff at all levels, Arrangements were made for junior ward staff members to attend the Weekly Harm Free care falls meeting. Bite-sized scenario teaching was also arranged for the Ward by the patient safety nurses, focussing on reduction and prevention of inpatient falls. Falls is supported by a QI programme.

Patient with risk factors not referred to the preterm clinic

An RCA was undertaken which identified that a patient with risk factors for a pre-term birth was not booked into the pre-term clinic. The consultant appointment was not made, which prevented the necessary screening to be arranged as per the pre-term policy. The patient subsequently experienced a difficult pre-term birth. In order to raise awareness within the Midwifery teams in relation to pre-term birth prevention as per saving babies lives 2 (SBL2), this incident has been utilised as a case study review. The 16 weeks pregnancy planner schedule is also being updated to prompt midwives to ensure any women who require a consultant appointment have this arranged; the midwife will contact antenatal clinic to make the appointment and inform the woman**.**

Patient's capacity not formally assessed

RCA conducted in relation to a patient who fell. It was determined that the patient's capacity had not been formally assessed, despite concerns being documented by an Occupational Therapist. Had the patient's capacity been assessed and been found to be reduced, it is likely the patient would have required enhanced care. A review of the process for identifying patients requiring enhanced care is being carried out to provide a wider high level conversation about clear documentation and communication amongst clinical teams. The Therapies Team are evaluating and improve MDT communication in relation concerns around patient capacity.

Referral to surgical team not triggered

An RCA was undertaken in relation to a patient who was not referred for review by the surgical team when presenting with acute abdominal pain. This was a delay in escalation. An action was implemented to develop and share a pancreatitis pathway to ensure correct escalation and to share learning. This will help to ensure that patients presenting with acute abdominal pain are reviewed by the correct clinical team.

Safety Alerts

WHH uses the daily safety brief to share learning on a wider scale, these are shared Trust wide via communications, and noted as pop-ups on computer screens and shared at daily staffing huddles. The below table provides examples of Safety Alerts issued by the Trust via the daily safety brief following incidents that occurred or were investigated in Quarter 4:

Subject	Detail	Date issued
Dosing of intravenous (IV) / oral paracetamol for adult patients with risk factors for hepatotoxicity.	There has been a minor harm incident where a patient with cirrhosis of the liver was prescribed and administered an overdose of intravenous (IV) paracetamol. This resulted in the patient being treated for a paracetamol overdose. **Action:** Recommendations shared Trust wide with specific advice for: Medical staff: When prescribing oral/IV paracetamol for an adult	13/09/22

	patient with risk factors for hepatotoxicity, a reduced dose of paracetamol should be considered as per the guidance within the alert. Nursing staff: When administering oral/IV paracetamol to a patient with risk factors of hepatotoxicity, if an appropriate reduced dose of paracetamol has not been prescribed, ask the medical team/on-call team to review the paracetamol dose and document the outcome in the patient's notes. Pharmacists: When clinically checking prescriptions for oral/IV paracetamol for patients with risk factors of hepatotoxicity, if an appropriate reduced dose of paracetamol has not been prescribed, ask the medical team/on-call team to review the paracetamol dose and document the outcome in the patient's notes. **Assurance**: We will know that this communication has had the desired impact by monitoring the number of incidents and complaints reported relating to this issue.	
Correct injection technique MUST be used when administering insulin with BD Autoshield Duo 5mm Safety Pen Needles for insulin pen devices	Incidents have occurred where patients may have not been receiving their correct insulin dose due to defective or incorrect use of BD Autoshield Duo 5mm Safety Pen Needles. Failure to deliver a full insulin dose can result in variable blood glucose levels, severe hyperglycaemia, ketosis and can result in diabetic ketoacidosis which can be life-threatening. To correctly administer insulin via an insulin pen device using a safety pen needle, a 2 unit insulin air shot MUST be completed prior to dialling the patient's usual insulin dose on the insulin pen device. This MUST be completed to ensure the patient receives their correct insulin dose and will identify if there are any issues with the safety pen needle or insulin pen device. **Action:** Recommendations shared Trust wide with specific advice for safe and appropriate administration. It is stipulated that a 2 unit insulin air shot MUST ALWAYS be completed prior to dialling the patient's usual insulin dose on the insulin pen device. **Assurance**: We will know that this communication has had the desired impact by monitoring the number of incidents and complaints reported relating to this issue. The incident profile is being reviewed.	21/07/22
Replacement of Bougies on CA trollies	A problem occurred on ICU during an airway exchange on a patient the Smiths Portex bougie available in ICU was too floppy and anaesthetic staff were unable to mould the bougie into the shape required to facilitate this, leading to an alternative having to be obtained. This could have caused a major problem **Action:** 1. Resuscitation training team to order alternative type of bougies for all resus trollies in the Trust and replace these once the alternatives are available 2. Resuscitation training team to discuss with Stores to ensure these are replaced in the resuscitation stock list 3. Resuscitation training team to update my kit check to reflect these changes once they are made to the trollies.	27/09/22

	Assurance: We will know that this communication has had the desired impact by monitoring the number of incidents and complaints reported relating to this issue, by confirming receipt of new bougies and dispatch with removal of previous.	

Never Events

Never Events from this Quarter

There were 0 Never Events opened in Quarter 2.

Duty of Candour

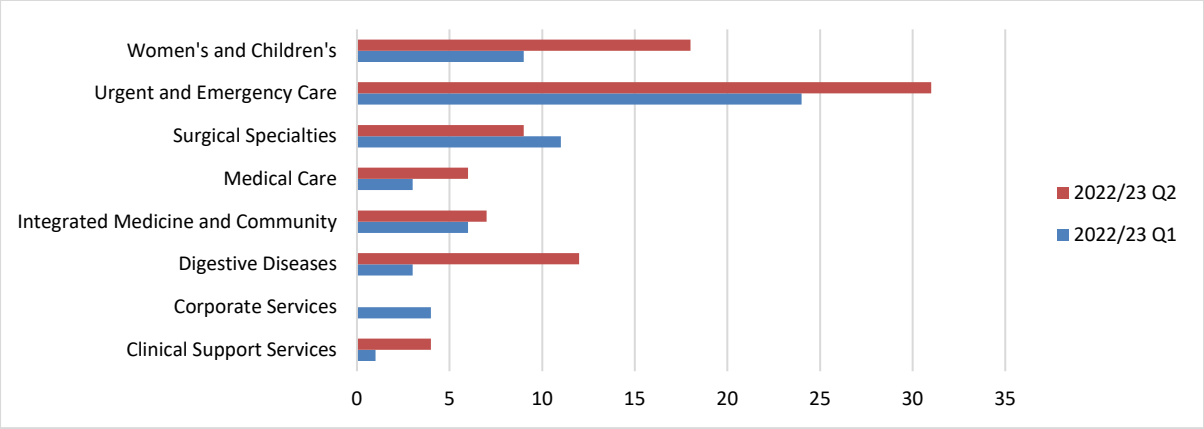
The Trust maintains its position of 100% compliance with Duty of Candour.

a. Learning from Complaints and PALS

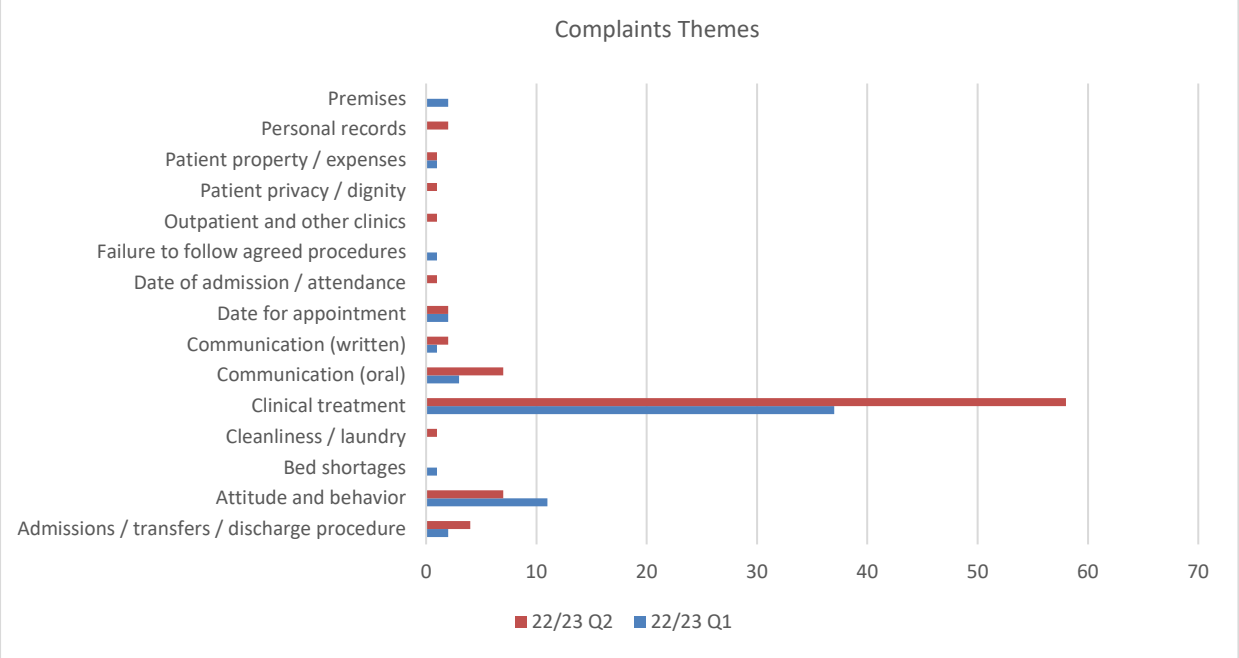
Complaints

Complaints received

As per the below graph, there was a 30% increase in complaints opened Trust-wide in Q2 (87 in Q2 versus 61 in Q1). The themes of the complaints received were reviewed which confirmed that there were no particular areas of concern. Although there was an increase between the Q2 and Q1 figures (87 in Q2 versus 61 in Q1), this is still a significant decrease from the same Quarter in 20/21, where 116 new complaints were opened. The themes of the complaints received are demonstrated in the graph further below. Corporate Services and Surgical Specialties saw a decrease in the number of complaints received. The remaining CBU's saw an increase in the number of complaints received, specifically Women's and children's, ED and Digestive Diseases. A thematic review of complaints in digestive diseases, women's and children's and clinical support services is underway.



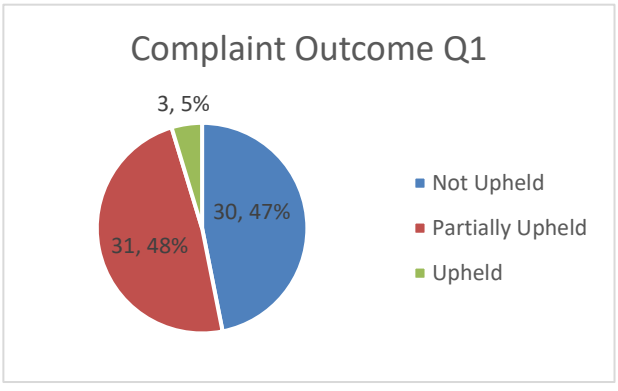
The themes of complaints received in Q1 vs Q2 are outlined within the below chart. Clinical Treatment remains the most common theme of complaints received. This category of complaints includes perception of delayed or misdiagnosis and delayed treatment. The number of complaints relating to this theme have increased from 37 in Q1 to 58 in Q2. This is triangulated with the themes noted within incidents and are reflected in the challenges created by operational and system pressures.

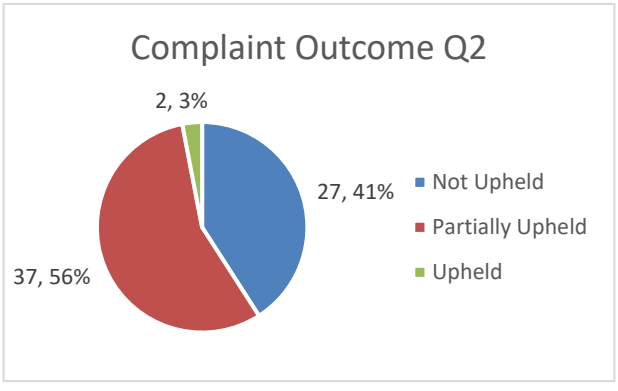


Complaints closed

There was an increase in the number of complaints closed in the Trust in Q2 (61 in Q1 versus 66 in Q2). All complaints were closed within timeframe in Q2. The below pie charts demonstrate the outcomes for complaints closed in Q1 vs Q2. In Q1 a greater percentage of complaints were not upheld (47% in Q1 vs. 41% in Q2), with more complaints being partially upheld in Q2 than in Q1 (48% in Q1 vs 56% in Q2). However, the percentage of complaints fully upheld was lower in Q2 than in Q1 (5% in Q1 vs. 3% in Q2). This data demonstrates that whilst more aspects of individual complaints have been upheld requiring apology, actions and explanation to be offered in Q2, fewer complaints were upheld overall in Q2 than in Q1.

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





Responsiveness

All specialties have responded to complaints within timeframe in Q2. The Trust had a target to respond to 90% of complaint on time and in Q2 the Trust continued to achieve 100%. The Trust continues to have 0 breached complaints and there are no complaints over 6 months old.

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

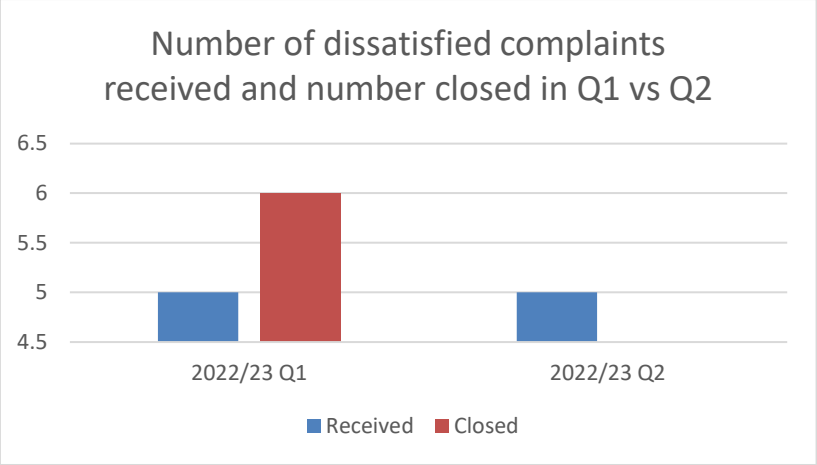
Actions resulting from Complaint investigations

The following table provides examples of complaints raised in Q2, and the actions taken to address the concerns raised and improve processes. For further assurance a complaints position with learning is provided quarterly to the Quality Assurance Committee. The Chairman also holds a monthly complaint meeting where a CBU or speciality will present a complaint, the lessons learnt, and actions implemented.

You Said….	We Did….
A medication error occurred whereby a patient was accidentally prescribed an incorrect (too low) dose of his Parkinson's medication.	The concerns were shared with the Doctor involved for individual learning. The concern was also shared with the Trust's Lead Clinical Education Pharmacist, who has recorded a training session for junior doctor induction on accurate drug history taking which will be disseminated to all junior doctors at their induction to the Trust. The concern has also been included in the Safer Times Prescriber newsletter.
A patient's fractured hip was not identified when her x-ray was reviewed in the urgent care centre.	The individual staff member involved undertook additional training on the identification of fractures. The Trust's induction slides for clinical staff were also updated to include a section on the identification of fractures on x-rays.

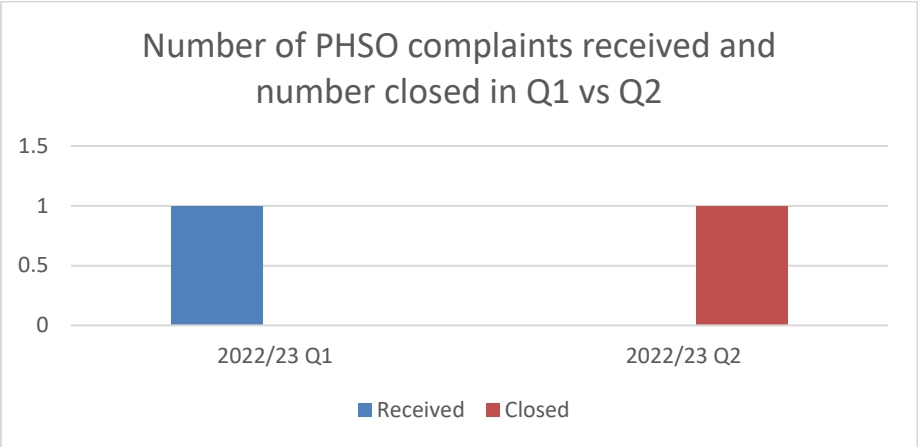
Dissatisfied Complaints

The below graph demonstrates the numbers of dissatisfied complaints received and closed in this Quarter vs. the previous Quarter. The Complaints Team is continuing to work with the CBUs to improve the quality and detail of the complaint responses to reduce the number of dissatisfied complaints. There has been no change in dissatisfied complaints received in Q2 vs Q1.



PHSO Complaints

There were no PHSO complaints received within Q2. PHSO complaints continued to be dealt with in a timely manner. There has been 1 PHSO complaint closed within Q2 which concluded that the care and treatment provided to the patient had been appropriate, however, did find that the Trust should have been clearer in communicating care decisions to the patient's relatives. The Trust has accepted these findings and is in the process of providing assurance to the PHSO in regard to future communication with patient relatives.



Formal Complaints Training

In Q2 the Complaints Team rolled out formal complaints training sessions across the Trust. These were held via Microsoft Teams and were well attended with 40 staff members attending across the 4 sessions that were held. The sessions provided training on:

- Your role in the complaints investigation
- How to investigate a complaint
- How to provide a good written complaints response
- How to prepare for a complaints resolution meeting
- Setting SMART actions and providing assurance

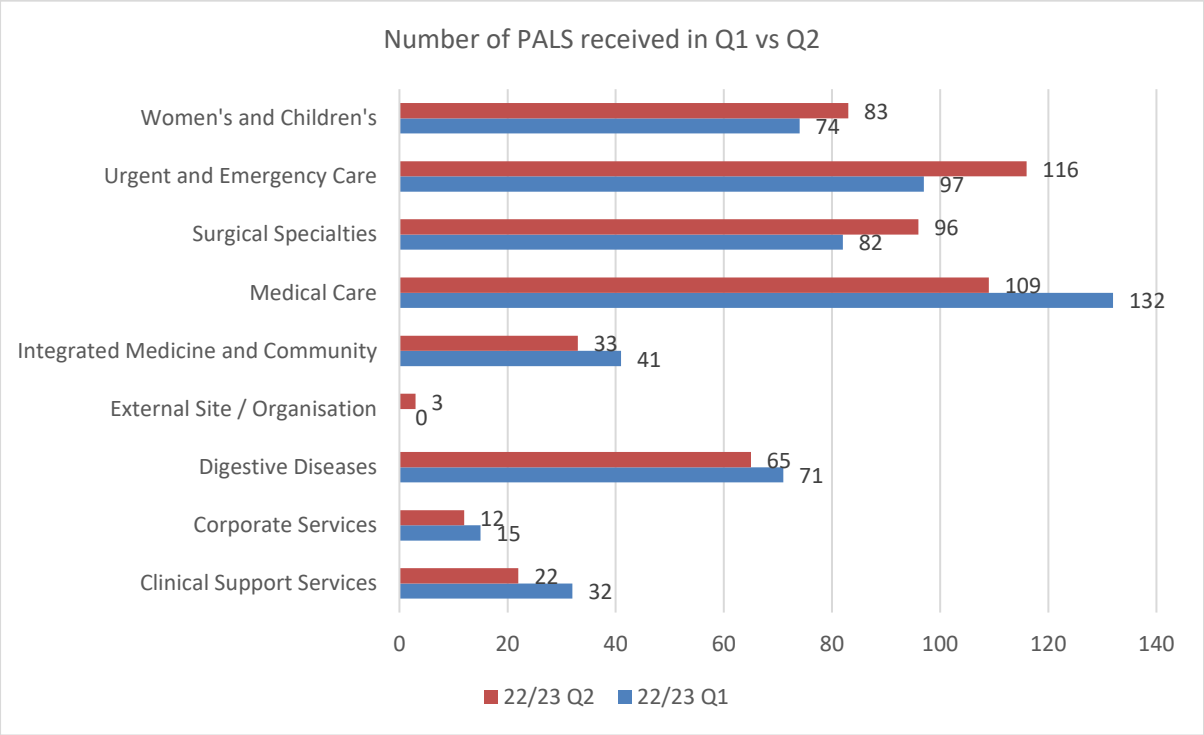
Feedback from attendees was positive, with staff reporting that they felt the session provided a better understanding of the Trust's expectations in relation to complaints investigations. Staff also explained that they felt the sections on reviewing and comparing two sample responses provided

good insight into how to word a response and the level of detail to be included. Further training sessions are planned to take place in Q3.

PALS

PALS closed in Quarter

In Q2 the Trust closed 536 PALS cases, a slight decrease compared with 542 closed in Q1. The below chart demonstrates the breakdown for PALS closed for each service.



PALS relating to the Urgent and Emergency CBU saw the biggest increase in cases received in Q2, with 116 cases received, compared with 97 received in Q1. This is reflective of incresed Emergency Department attendances. Comparison of ED complaints and PALS data demoinstrates efficient and effective resolve, ultimately reducing risk and supporting patient experience. This is a positive measure (31 complaints vs. 116 PALS). An increase in PALS cases have also occurred within Surgical Specialties and Women's and Children's. On review, these increases are linked to patient waiting times for appointments and procedures. These themes within the Surgical Specialties and Women's and Children's CBUs are also reflective of the national pressures seen across the NHS. Surgical Specialties and Women's and Children'scontinue to utilise the PALS service to respond to complaints quickly and informally in Q2 (Surgical Specialties – 9 complaints vs. 96 PALS and Women's and Children's 18 complaints vs. 83 PALS).

Actions resulting from PALS cases

You Said….	We Did….
A patient contacted PALS in relation to arrangements for a post-birth de-brief.	It has been agreed that a formal process for debriefing patients after birth will be introduced, to streamline the process.
Patient attended the Emergency Department and provided feedback	The feedback was shared with the Senior Management Team for the Emergency Department and the Patient

regarding the behaviour and attitude of staff members.	Experience Team to link in with the individual staff members involved to support better patient experiences.

b. Learning from Claims

Clinical Claims

Clinical Claims Received
There were 23 clinical claims received in Q2. This is a decrease from Q1, where 26 clinical claims were received.

Clinical Claims Closed
35 Claims were closed in Q2, 6 of which were with damages (totalling £680,108.71) (excluding the costs of instructing Trust solicitors). The number of claims remain stable. Damages were lower in Q2 than Q1 as fewer claims were closed and the values of the claims closed were lower on average than the previous quarter. Trauma and Orthopaedic claims will generally be high value.

Clinical Support Services	£20,557.75
Radiology	£20,557.75
Surgical Specialties	646.302.14
ENT	622.302.14
T&O	21.000.00
Urology	£3,000.00
Urgent and Emergency Care	£1,250.00
Emergency Medicine	£1,250.00
Women's and Children	£12,000.00
Paediatrics and Neonatology	£12,000.00

Non-Clinical Claims (Employee Liability/Public Liability)

Non-Clinical Claims Received
There were 4 non-clinical claims received in Q2. This is a decrease from 7 from Q1. The learning from these will be provided once they have been closed.

Non-Clinical Claims Closed
There was 1 employer Liability Claim closed in Quarter 2 with damages paid . There were 7 public liability claims closed - 6 with damages paid. Total damages paid: £27,766.06.

Improvements and changes arising from Claims

Following claims investigations for claims closed in Quarter 2, the following themes were identified, and actions implemented. In order to measure the success of the learning, complaints, PALS, incidents and risk are monitored on a weekly basis to ensure a downward trend or appropriate escalation in relation to the themes of the specific learning points noted below. A claims report is provided to each CBU meeting. In addition, there is a clinical claims review group that is attended by various clinicians. A newsletter is also produced which highlights key themes for learning.

Failure to suspect and/or diagnose inflammatory hip arthropathy
In Q2, a claim was closed where it was determined that there was a failure to diagnose inflammatory

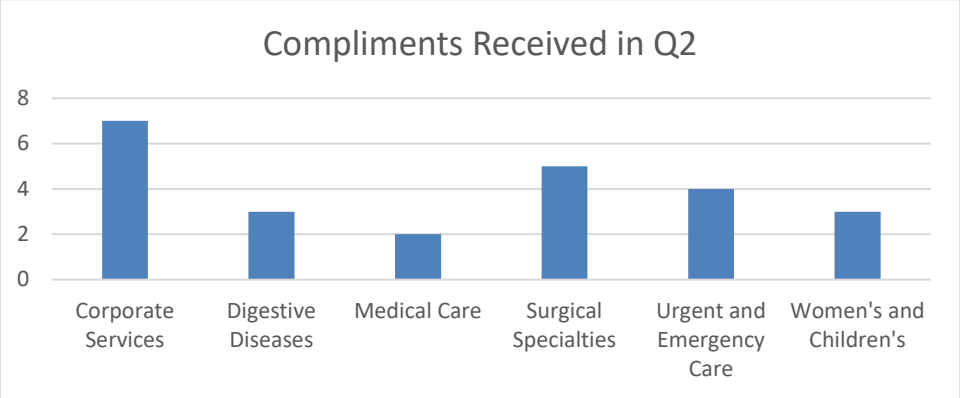
hip arthropathy in 2018 as the patient was discharged without an MRI scan being conducted. This resulted in the loss of the opportunity to have an intra-articular steroid injection which would have improved symptoms and delayed progression of the patient's condition. Although the individual staff member involved has left the Trust since the incident occurred, learning was shared with the wider Rheumatology Team regarding the importance of organising appropriate investigations when a patient presents with symptoms suggestive of inflammatory joint pain.

Delayed diagnosis and treatment for Stroke

In Q2, a claim was closed where it was alleged that a failure to investigate symptoms appropriately and to offer appropriate treatment prior to discharge in 2021 resulting in a patient suffering from a stroke and avoidable injuries. The investigation found that there had been a missed opportunity to prescribe anticoagulation therapy during an Emergency Department attendance. Learning resulting from this claim included Apixaban and Rivaroxaban being made available as take-home medication in the emergency department. All staff were made aware that AMU have take-home anticoagulation packs available. The Cardiology team set up an atrial fibrillation (AF) clinic for patients that present in new AF.

Learning from Compliments

A positive safety culture is one where compliments are fed back to staff in the same way that investigations are. Compliments are a really useful tool for the Trust to be able to identify what areas are working well. In Q2 the Trust received 24 compliments, this compares with 15 compliments which were received in Q1.



The Head of Complaints continues to monitor the logging of compliments on a monthly basis to ensure the numbers received are being accurately captured. This positive feedback is also shared with the CQC, however the Trust has not received a CQC engagement meeting since July 2022. These usually occur every 6 weeks. This has been escalated to the CQC by the Director of Governance.

c. Learning from the CBUs

The table in appendix 1 details points for learning identified in each CBU, following the review of incidents, complaints and claims with actions identified for assurance of learning.

d. Learning from our Staff

Ward of the Month

The Ward of the Month award was implemented in September 2022 and Ward C21 were the first winners of the award.

C21 were chosen as September's winners for working tirelessly over the past six months to implement a number of positive changes on the ward, which have resulted in improved patient outcomes and experience. By working together to a shared vision, they have achieved a reduction in the number of inpatient falls and hospital acquired pressure ulcers. Well done to the C21 team!

Looking after you: Financial Wellbeing

The Trust recognises that We have all had times when there have been worries about money and with prices increasing to heat and power our homes, to buy food and to travel it is important that we try and look after ourselves to minimise any additional pressures or stress. In order to support staff, the Trust has developed a financial wellbeing booklet full of useful resources and information which is accessible via the Intranet.

e. Learning from Patient Experience

Continued focus on learning from patient experiences:

- Introduction of Trust wide digital stories programme to drive quality improvement including dedicated stories to support communities in Halton and Warrington, specifically in Q2 the deaf community.
- Continuous engagement with community partners to continually learn and act on experience to improve outcomes.
- Attendance at external events, supporting Children and Young People and a Carers Event led by the Local Authority to share the Carers passport with the local community. The passport aims to ensure enhanced communication with carers whilst in hospital and to ensure patients individual needs and preferences are understood.

Strategy

- Launch of Patient Service User and Carers Diversity, Inclusion and Belonging Strategy 2022 – 2025 which was developed with extensive engagement from the communities we serve.
- Food and Drink Strategy was ratified at Quality Assurance Committee in August 2022. The strategy was developed with a multidisciplinary approach. Strategic objectives were identified through extensive triangulation of published reports, patient and staff feedback and through engagement with experts associated with nutrition and hydration.

f. Learning from Clinical Audit

National Audits

Summary:

The audit NPDA was established to compare the care and outcomes of all children and young people with diabetes receiving care from Paediatric Diabetes Units (PDUs) in England and Wales. It aims to address a series of questions relating to paediatric diabetes care, which include:

- What proportion of children and young people with diabetes are reported to be receiving key age-specific processes of diabetes care, as recommended by NICE?
- How many achieve outcomes within specified treatment targets?
- Are children and young people with diabetes demonstrating evidence of small vessel (microvascular) disease and/or abnormal risk factors associated with large vessel (macrovascular) disease prior to transition into adult services?

Results:

The majority of WHH sample is made up of type 1 diabetes (96.4%), 10–14-year-olds make up the biggest proportion of the sample (43.8%). The population ethnicity was predominantly white which is 98.5%. An overall health check completion rate for young people aged 12+ was conducted in 91.8% and the national average was 88.6%.

The table below shows the percentage of young people receiving the seven care processes for type 1 diabetes:

Key Care Process	Warrington	Northwest	England & Wales
HbA1c	**100%**	**99.5%**	**99.7%**
Blood Pressure	**96.3%**	**96.5%**	**96.5%**
Thyroid	**98%**	**88.6%**	**87.8%**
BMI	**100%**	**99.3%**	**99.3%**
Albuminuria	**77.8%**	**80.6%**	**79.1%**
Eye Screening	**68.5%**	**72.6%**	**74.5%**
Foot Examination	**100%**	**88.3%**	**84.3%**

The following actions were taken:

- Awareness was raised at the juniors doctors induction and various department teachings
- Communicated and escalated to the eye screening team
- The diabetes service participated in Royal College of Physicians (RCPCH) Quality Improvement collaborative on Carbohydrate counting

No action plan for improvement is required.

Assurance rating (using Trust assurance rating matrix):

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

<u>Local Audits</u>

An Audit of the Use of Radiology Alert Codes

Summary:

Radiology has a well-established process for the communication of urgent findings (with a ratified SOP). The reporting clinician will add an 'alert code' to the report either using digital dictation or VR. The alert codes have been reviewed and amended over time as the imaging service has developed. An alert code was introduced to enable Radiology to arrange follow up imaging (July 2020). Most recently an alert code was added for any positive VTE (Jan 2022). The aim of this audit. To ensure that current practice in Radiology is in line with the process detailed in the SOP and to ensure that the current process is safe and reliable.

Results:
The results of the audit are outlined in the following chart

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

no.	Standard	Present audit	Recommended
1	Was the alert actioned?	100%	100%
2	Was the receipt documented on CRIS?	81%	100%
3	Follow up Imaging arranged	99.4%	100%
4	VTE nurses alerted	100%	100%

Key Findings:

- Reports are being actioned effectively
- Follow up imaging is being booked appropriately
- The main area for improvement is noting the receipt of alerts/following up on unacknowledged alerts

Recommendation:

- Deep dive into the 45 patients whose alerts were not receipted
- Review the process for actioning alerts, to streamline and standardise the process

Assurance rating (using Trust assurance rating matrix):

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

g. Quarterly Learning Piece

World Sepsis Day

On 13th September 2022, World Sepsis Day took place and this was observed by the Trust. Learning was shared by the Patient Safety Improvement Nurses who explained that sepsis arises when the body's response to an infection injures its own tissues and organs. It can lead to shock, multi-organ failure and death – especially if it is not recognised early and treated promptly. Anybody can get sepsis, no matter their age or medical history.

Part of the Patient Safety Improvement Nurses' role is to audit the Trust's performance regarding management of sepsis. They review notes of patients diagnosed with sepsis to ensure that they were diagnosed and that treatment was commenced within a timely manner. For patients who have a 'red flag' for sepsis, the Sepsis 6 should be delivered **within an hour**.

Sepsis 6

- Oxygen (if required) to maintain oxygen saturations above 94%
- Blood cultures
- Lactate
- IV access
- Antibiotics
- Monitor urine output closely – start a fluid balance chart

Starting the Sepsis 6 within the hour is what initially gives patients with sepsis the best chance of recovery and survival.

What do we need from you?

We all need to work together to ensure that all patients with sepsis get the treatment they need.

- If you are a clinical member of staff, please ensure you complete the Sepsis e-learning package on ESR; this is an annual requirement
- If a patient looks unwell OR has a NEWS2 score of 5 or more AND there is suspicion of infection, sepsis should be considered: make sure the patient is escalated to nursing staff and for medical review immediately and start the sepsis pathway.
- ***Communicate clearly.*** Getting the sepsis 6 delivered within an hour can hinge on all healthcare professionals knowing and understanding clearly that sepsis is being diagnosed or suspected. This can be as simple as verbally confirming "We are treating the patient for sepsis" or "I think this patient may have sepsis" or "we are starting the sepsis 6"
- As always, ***document clearly.*** This is where the sepsis pathway is important, both as an aide memoire and a clear format to document when all elements of the sepsis 6 were completed and any variances. (For all adult inpatients, the sepsis pathway is on Lorenzo in Forms. Paediatrics and Maternity use paper pathways as well as our Emergency Department). Please ensure you are using the correct pathway for your patient (the pathways we use are: Ages 0-5, 5-11, 12+ and Pregnant or 6 weeks post-pregnancy)

h. Workstreams for Quarter 4

Complaints Monitoring and Improvement

Formal complaint responses continue to undergo close scrutiny through the complaints and senior Governance Team to review the quality of the responses. Where appropriate, the Complaints Team will continue to encourage staff to seek to resolve complaints via telephone conversations or local resolution meetings with complainants.

The Complaints Quality Assurance Committee (QAG) continues to meet monthly, focussing on a different CBU each time. These meetings are an opportunity for the Chairman to review the Trust's complaints position, and for CBUs to reflect and feedback upon the quality and detail included within their responses.

Complaints Satisfaction Service Questionnaire

This workstream has progressed in Quarter 2 and the draft questionnaire is awaiting approval. The Questionnaire will be available in both a physical and electronic format so that it is accessible to more service users. The Questionnaire is expected to go live in Quarter 3. The information gathered

from this survey will enable the Trust to understand what works well, and what can be improved, to better support our patients and families through the Complaints process.

Staff involved in incidents – Survey

This workstream has progressed in Quarter 3 and the questionnaire is awaiting approval. The survey is expected to be rolled out to a number of staff in Quarter 4 to gain initial feedback on the survey itself. The findings of this survey will assist the Governance Team in the delivery of training for RCA investigators and will also help us to better support staff involved in incidents.

Junior Doctor Incident Training

The Patient Safety Manager continues to complete junior doctor training to support the understating of governance and how incidents are managed and progressed. During these sessions incidents are pick out to discuss, on occasions the junior doctors have pick out scenarios and completed a presentation these for discussion. The feedback received from these sessions is that they are informative and bring about positive discussion identifying workstreams where we can learn and work together to improve patient care. These sessions will continue in Q3 2022/2023.

3. RECOMMENDATIONS

The Trust Board is asked to note the contents of the report.

Appendix 1

Medical Care

We found….
Tracheostomy concern • A surgical tracheostomy was inserted under ENT and an endoscopic PEG inserted following NG feeding throughout the stay and a failed RIG insertion. • Patient was successfully weaned from high flow oxygen and discharged from ITU to the respiratory ward • Regular tracheostomy care continued 2-4hrly overnight and the tube holder strap /dressing was intact. • The tracheostomy tube came out during a wash by 2 health care assistants
We Acted….
• The senior Nurse checked the patient, noticed the tracheostomy tube was fully out, no bleeding from stoma site and patient not in any distress, Saturations 98-99% on room air. Obs stable. no oxygen required, continuously monitored MET Call made. • A size 4 tracheostomy was inserted as the Size 6 shiley had come out, noted to be patent. • staff responded well and followed the procedure as taught in their competency training • The Tracheostomy group are reviewing the possibility of training the Nursing staff to re site any tubes which come out

Integrated Medicine & Community

We found….
Blood glucose Not checked • Patient's blood glucose not checked at bedtime or overnight. • GOLD score 7 - has no hypo awareness. • Discharge delayed as unable to suggest any adjustments to insulin regime. • Patient's glucose levels have been variable with episodes of hypoglycaemia.
We Acted….
• Concerns regarding agency staff only on the ward due to staff shortages escalated to senior staff • Agency staff informed agency they did not have the required training / pass to complete blood glucose tests advised to request support from other wards • Incident shared via the weekly safety brief • Step by step guide made available of how to escalate any staffing issues or lack of appropriately trained staff.

Clinical Support Services

We found….

Laboratory Sample Issue

- A sample on a written form had additional marks seemed to indicated more requests than was made
- carcinoembryonic antigen test (CEA)performed -abnormal.
- Result telephoned to the speciality but as the test was not requested by the speciality advised forwarding the result to the GP
- GP emailed to ask whether the results were sent just for information and no further action was taken by them.
- The speciality did not respond to the GP for 35 days to say they had not requested the tests.
- Delay of over 2 months for follow up from sample collection

We Acted….

- Review the equipment in OPD for printing ICE forms
- Find out who provides training for the ICE system and advise all staff through the safety huddle of the issues possible with the manual blood forms and direct them to how training may be accessed
- As part of the safety alert advise staff that blood request profiles can be created for each speciality to make using the ICE system easier.
- Letters to the GP should be clearer to advise if the GP is expected to follow up. explore the possibility of creating a standard letter

Urgent & Emergency Care

We found….

51 year old patient was admitted due to feeling generally unwell with muscle aches. National Early Warning Score (NEWS) was 3 on arrival. There was a delay in this patient being seen by the medical team and no clinical staff were aware that this patient had a history of gestational diabetes from 17 years ago. When the patient was reviewed by the medical team and bloods taken due to her deterioration it was identified that the patient was in Diabetic Ketoacidosis (DKA). Urgent treatment was commenced however the patient required treatment on the Intensive Care Unit (ICU).

We Acted….

- All majors patients and known diabetic patients to have a blood sugar taken on admission.
- Triage education programme looking at the ability to elicit any past medical history at triage. Ensuring that GP information is available to the team at the hospital to ensure management and investigations can be instigated early.
- Commenced a Senior doctor in triage programme for the Emergency Department

Surgical Specialities

We found….

A patient was reviewed in the eye clinic in 2015 and the clinician requested a 6 month follow up and a plan of a review in the Glaucoma Assessment Clinic in 6 months' time. This follow up was not arranged. In April 2021 following an eye test the patient was referred back to the Ophthalmology Service due to concerns that he had not been reviewed in 4 years, and his intraocular pressures were raised. The patient was found to have advanced field loss in the right eye with irreversible glaucomatous damage to both optic nerves.

We Acted….

- Implemented the use of a failsafe system.
- E-outcome system monitored on a weekly basis to ensure all outcomes are completed.
- All patients issue with a new diagnosis of glaucoma/ ocular hypertension (raised intraocular pressure) with appropriate information leaflet
- All patients to receive a copy of the GP letter outlining the diagnosis and treatment regime.

Digestive Diseases

We found….

Patient had a delay of eight weeks in completing a Gastroscopy due to guidelines not being followed resulting in an investigation not being requested. When this investigation was completed it identified an early gastric carcinoma (stomach cancer).

We Acted….

- Development of a trust policy and standards of practice for management of patient with iron deficiency anaemia
- Exploring the possibility of iron deficiency anaemia clinics.

Women's & Children's

We found….

A woman attended Birth Suite with pre- eclampsia which resulted in her having a placental abruption. The baby needed to be transferred to a specialist unit for treatment. Baby has since recovered.

We Acted….

- Incident discussed on a daily safety brief.
- Review of the way results are managed within Antenatal day unit and Triage.
- Mandatory training discusses the case to highlight learning from real cases
- Individualised training has been addressed

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/22/11/159**			
SUBJECT:	**Guardian of Safe Working for Junior Doctors Combined Report for Q2, 2022/23**			
DATE OF MEETING:	24th November 2022			
AUTHOR(S):	**Fran Oldfield, Guardian of Safeworking Hours**			
EXECUTIVE DIRECTOR SPONSOR:	**Paul Fitzsimmons, Executive Medical Director**			
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	SO1 We will.. Always put our patients first delivering safe and effective care and an excellent patient experience. SO2 We will.. Be the best place to work with a diverse and engaged workforce that is fit for now and the future			
EXECUTIVE SUMMARY *(KEY ISSUES):*	The 2016 Junior Doctor Contract is fully established at WHH for all our Foundation Doctors and most of the CT/ST grades. The monitoring of the safe implementation of the contract is the responsibility of the Medical Education Department/Guardian of Safe Working (GSW). Issues regarding safe working hours, rota problems, educational or patient safety issues are recorded by Junior Doctors in the form of Exception Reporting via the Allocate System, which are then escalated to their responsible Educational Supervisors and monitored by the GSW. During Quarter 2 (July - Sept) 2022-23, 188 exception reports were submitted of which 3 were highlighted as an immediate patient safety concern. The majority 147 (78%) of exception reports relate to hours of working. 28 exception reports relate to missed educational opportunities and 9 exception reports submitted related to service support available to the doctor. The total number of exception reports for this quarter remains significantly above the normal variation.			
PURPOSE: *(please select as appropriate)*	Information ✓	Approval	To note	Decision
RECOMMENDATION:	The Trust Board is asked to note the report findings and progress made with implementing the Junior Doctor Contract and the level of assurance given that the Junior Doctors are working safely for their own health, and wellbeing and the safety of patients.			
PREVIOUSLY CONSIDERED BY:	**Committee**	Strategic People Committee		
	Agenda Ref.			

	Date of meeting	23/11/22
	Summary of Outcome	
FREEDOM OF INFORMATION STATUS (FOIA):	Choose an item.	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	Choose an item.	

REPORT TO BOARD OF DIRECTORS

SUBJECT	Guardian of Safe Working for Junior Doctors Quarterly Report – **Q2 2022-23 (1st July – 30th Sept 2022)**	**AGENDA REF:**	**BM/22/11/159**

1. BACKGROUND/CONTEXT

The 2016 Junior Doctor Contract is now well established at WHH; rotas for medical trainees are fully compliant, and systems are in place to allow work schedule reviews to be undertaken if there are persistent problems with individual rotas. Most trainees engage with their Educational Supervisors (ES) and Guardian of Safe Working (GSW) if any new issues develop. Issues can also be highlighted via the Junior Doctors Forum, held bi-monthly, which is attended by the Director of Medical Education, Executive Medical Director, HR Colleagues, Rota Managers, and the Guardian of Safe Working (GSW).

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

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

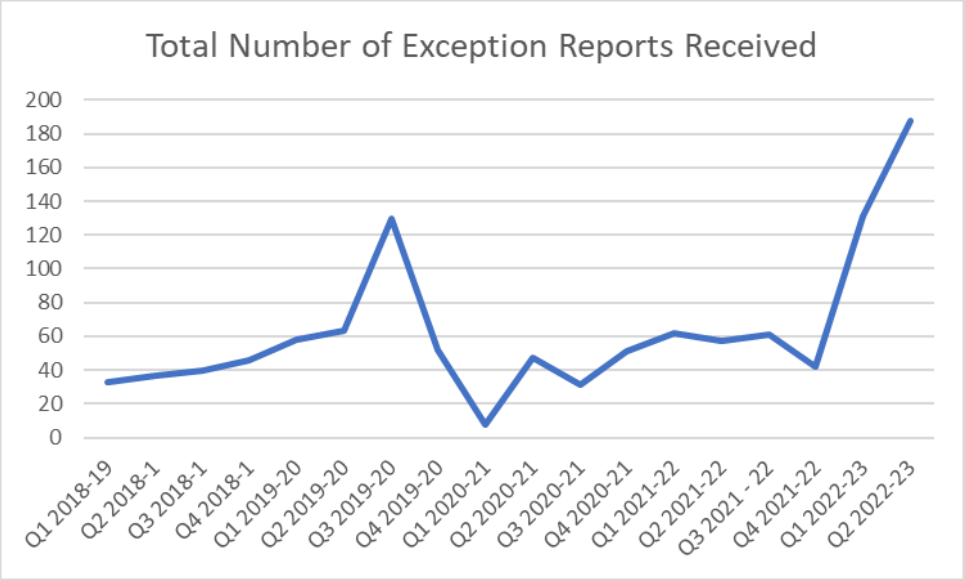
As part of the monitoring of the 2016 Contract for Junior Doctors, the GSW is also required to submit data relating to the number of trainees hosted by WHH on the 2016 contract to the Lead Employer, who is responsible for presenting a quarterly report to the St Helens and Knowsley Trust Board.

2. KEY ELEMENTS

Exception Reporting (July – Sept 2022)

During Q2, 2022 - 2023, 188 exception reports were submitted, this continues to follow the trend of increasing numbers of reports over recent quarters. In total, 150 of those exception reports were submitted by junior doctors during August and September.

Chart 1 below illustrates pre and post pandemic reporting trends:



Themes for Q2 (July – Sept 2022)

Increasing Numbers of Exception Reports

Whilst the number of exception reports continues to increase, this must be viewed as a positive change. During the junior doctors' induction programme in Aug a concerted effort was made to increase awareness and understanding of the exception reporting process in order to breakdown the barriers to reporting and encourage the junior doctors to engage. The feedback received from this induction was excellent and a significant improvement on previous induction feedback. Whilst the numbers of exception reports have increased, there are no concerns that there are any significant new issues that have caused the rise in reporting, rather a general increase in reporting across the board, from all specialities and all grades. It is hoped that if junior doctors feel empowered to report 'minor' concerns then there will be no barriers to reporting when significant issues arise. The GSW and Medical Workforce Administrator have discussed the increasing number of exception reports experienced at the Trust at the Regional Guardian Forum and it has been acknowledged that this is a trend that has been identified across the Region.

T&O

In the last report it had been noted that 62% of all exception reports were submitted by T&O doctors. This has reduced significantly to 13% during the Q2 and reflects the huge improvements made by the T&O department over the last few months. Achievements made as a part of the comprehensive action plan have resulted in improved working conditions, improved junior doctor morale and therefore patient safety. The Foundation School Programme Directors, Medical Director and Chief Registrar are continuing to monitor the situation in T&O and are getting regular feedback from juniors working in this department.

Feedback will also be monitored via the Junior Doctors Forum. One Immediate Safety Concern report was submitted by a T&O F2 doctor, and this will be discussed in detail below.

Immediate Safety Concerns

Immediate safety concern ERs were submitted on 3 occasions during Q2.

The first ISC was submitted by a T&O doctor reporting problems faced by some junior doctors when trying to book radiological investigations for patients. This was leading to delays in diagnosis and treatment due to excessive delays in booking scans. This had been a concern brought up at the recent JDF by doctors across multiple specialities and was in the process of being resolved at the time of the ISC report. The fact that the junior reported this as an ISC meant resolution of the issue was expedited and assurance has now been received that this problem has been resolved. This highlights the importance of the ISC reporting process but also that processes are in place to ensure any issues highlighted as an ISC are acted on quickly.

The other two ISCs were from an O&G doctor and a medical doctor relating to isolated incidents of understaffing in these departments. It is believed these issues were due to particularly busy days along with understaffing. These concerns have been escalated and managed by individual departments and will continue to be monitored by the GSW.

Summary

- Number of exception reports raised = 188
- Number of work schedule reviews that have taken place = 1
- ERs flagged as immediate safety concerns = 3
- Fines that were levied by the Guardian = 0

Exception Reports (ER) over past quarter	
Reference period of report	01/07/22 - 30/09/22
Total number of exception reports received	188
Number relating to immediate patient safety issues	3
Number relating to hours of working	147
Number relating to pattern of work	4
Number relating to educational opportunities	28
Number relating to service support available to the doctor	9
***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.*	

Whilst we continue to monitor ongoing delays in sign off of Exception Reports, we have again in the last Quarter seen real progress in this area. This improvement is almost certainly as a result of the efforts made during the induction programme and also regular reminders being sent by the Medical Trainees Workforce Administrator. At the end of Q1 there were 88 unresolved ERs, and at the time of writing this report there were 59 unresolved ERs. With the

increase in numbers of reports, this demonstrates an obvious improvement in resolution of those reports. The GSW and Medical Trainees Workforce Administrator will continue to monitor outstanding exception reports and encourage continued engagement from both trainees and educational supervisors.

The most recent JDF meeting was well attended and there continues to be strong engagement between Junior Doctors' Representatives, the Chief Registrar, the DME and GSW.

3. ACTIONS REQUIRED/RESPONSIBLE OFFICER

Nil

4. MEASUREMENTS/EVALUATIONS

ER outcomes: resolutions	
Total number of exceptions where TOIL was granted	57
Total number of overtime payments	59
Total number of work schedule reviews	6
Total number of reports resulting in no action	25
Total number of organisation changes	9
Compensation	0
Unresolved	97
Total number of resolutions	**156**
Total resolved exceptions	**144**

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

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

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

5. TRAJECTORIES/OBJECTIVES AGREED

1. Exception Reports should be completed ASAP, but no later than 14 days of the Exception being submitted through Allocate.
2. Where the trainee is seeking payment as compensation, the report should be submitted within 7 days.

3. For every ER submitted, either for payment or TOIL, it is the Educational Supervisor who is required to respond to the ER within 7 days. Alternatively, the ES can delegate this to the Clinical Supervisor if appropriate
4. The Junior Doctor needs to indicate their "acceptance" or "escalate" to the next stage (Level 1 Review). It is only following confirmation of acceptance, that the ER can be closed.
5. If an ER is not actioned within 7 days, the MWA will review an issue an email to expedite sign-off in line with the new SOP for exception reporting.

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

6. MONITORING/REPORTING ROUTES

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

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

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

7. TIMELINES

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

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

8. ASSURANCE COMMITTEE

SPC

9. RECOMMENDATIONS

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

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/22/11/160**	
SUBJECT:	**Winter Plan**	
DATE OF MEETING:	30th November 2022	
AUTHOR(S):	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. SO2 We will.. Be the best place to work with a diverse and engaged workforce that is fit for now and the future SO3 We will ..Work in partnership with others to achieve social and economic wellbeing in our communities.	X
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): **(*Please DELETE as appropriate)***	**#224** If there are capacity constraints in the Emergency Department, Local Authority, Private Provider and Primary Care capacity then the Trust may not meet the four hour emergency access standard and incur recordable 12 hour Decision to Admit (DTA) breaches, resulting in potential risks to the quality of care and safety to patient, staff health and wellbeing, Trust reputation, financial impact and below expected patient experience. **#1215** If the Trust does not have sufficient capacity (theatres, outpatients, diagnostics) because of the ongoing COVID-19 pandemic then there may be delayed appointments and treatments, and the trust may not be able to deliver planned elective procedures causing possible clinical harm and failure to achieve constitutional standards. **#1273** If we continue to experience system-wide Covid-19 pressures, then we may be unable to provide timely patient discharge and experience potential reduced capacity to admit patients safely. **#1134** If we see an increase in absence relating to COIVD-19, then we may experience resource challenges and an increase within the temporary staffing domain. **#115** Failure to provide minimal staffing levels in some wards and departments. Caused by vacancy position, current sickness levels and absence due to COVID 19. Resulting in depleted staffing levels, potentially impacting the ability to provide basic patient care and treatment.	
EXECUTIVE SUMMARY *(KEY ISSUES):*	• This document defines the response from Warrington and Halton Teaching Hospitals to the challenges of winter and the demand for urgent care. • Winter planning commenced in August 2022 and included collaborative planning meetings with system partners. • Winter NHSE planning guidance was published on 12th August 2022 and updated on 18th October 2022. This document addresses the national priorities for winter and defines the local planning in place to support resilience this winter.	
PURPOSE: *(please select as appropriate)*	Information | Approval | **To note** | Decision	
RECOMMENDATION:	The Trust Board is asked to note the arrangements for winter 2022-2023	
PREVIOUSLY CONSIDERED BY:	**Committee**	Finance + Sustainability Committee
	Agenda Ref.	
	Date of meeting	23/11/22

	Summary of Outcome	Presentation noted
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None	

REPORT TO BOARD OF DIRECTORS

SUBJECT	Winter Plan	AGENDA REF:	BM/22/11/160

1. BACKGROUND/CONTEXT

Winter planning commenced in August 2022 and included collaborative planning meetings with system partners.

The key activities identified will be reviewed constantly with the changing situation and through direction from NHS England.

Nationally, in delivering the winter plan, the NHS aims to achieve:

- 92% hospital occupancy
- Reducing C2 response to the 18-minute standard,
- Reducing ambulance handover delays
- Reducing crowding in A&E departments and ensure that no patient spends more than 12 hours in A&E
- Ensuring timely discharge from hospitals
- Maintaining patient safety

Three key actions have been identified as having the most significant impact upon achieving the above objectives:

- **Increasing capacity** to reduce overall occupancy within hospital to improve Emergency Department (ED and ambulance service performance.
- **Increasing care at home for patients upon discharge** which will release a proportion of the 375k bed days lost this calendar year due to delayed discharge.
- **Maximising the use of alternative pathways** to enable EDs to be reserved for patients requiring an Emergency Medicine skillset.

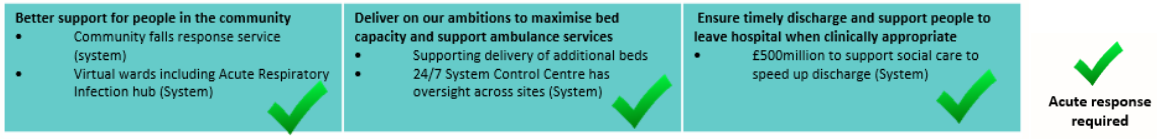
The details of Winter Plan 2022-23: National Objectives and ICB winter hub arrangements.

The NHSE planning guidance, published on 12th August 2022 draws particular attention to eight objectives:

Prepare for variants of COVID-19 and respiratory challenges, including an integrated COVID-19 and flu vaccination programme.	**Increase capacity outside acute trusts,** including the scaling up of additional roles in primary care and releasing annual funding to support mental health through the winter	**Increase resilience in NHS 111 and 999 services,** through increasing the number of call handlers to 4.8k in 111 and 2.5k in 999.	**Target Category 2 response times and ambulance handover delays,** including improved utilisation of urgent community response and rapid response services, the new digital intelligent routing platform, and direct support to the most challenged trusts.
Reduce crowding in A&E departments and target the longest waits in ED, through improving use of the NHS directory of services, and increasing provision of same day emergency care and acute frailty services.	**Reduce hospital occupancy,** through increasing capacity by the equivalent of at least 7,000 general and acute beds, through a mix of new physical beds, virtual wards, and improvements elsewhere in the pathway	**Ensure timely discharge,** across acute, mental health, and community settings, by working with social care partners and implementing the 10 best practice interventions through the '100 day challenge'.	**Provide better support for people at home,** including the scaling up of virtual wards and additional support for High Intensity Users with complex needs

Acute response required

On 18th October 2022, NHSE released an update 'Going further on our winter resilience plans' and this alluded to the above along with the following highlights relevant to acute trusts.



Warrington and Halton Teaching Hospitals NHS Foundation Trust Winter Response

2022 has continued to present several challenges and there is a significant risk of these being compounded by anticipated winter pressures. OPEL 4 has been declared on two occasions this calendar year, on 28th March and between 11th and 13th October. Over the past 12 months there has been a continued increase in the number of inpatients who do not meet the criteria to reside, and the super stranded number (21 days + length of staff) has remained above 130 in recent months. Challenges regarding the exit flow elating to Pathway 1 patients have continued meaning winter escalation beds have been used earlier compared to in previous years.

It is anticipated that there may be some additional demands this winter: -

- Increasing community rates / new variants of COVID-19
- Managing influenza alongside COVID-19, with winter 2022/23 predicted to have an increased incidence of influenza compared with the previous two winters
- Sustained or increased attendances in the ED
- Increased demands on the Trust's capacity
- Maintaining elective activity safely
- Workforce challenges

The emphasis of Winter Planning (2022/23) is to ensure safe, patient-focused care across our system.

Internal priorities for winter includes the areas identified below:

- Increasing community rates / new variants of COVID-19
- Managing influenza alongside COVID-19, with winter 2022/23 predicted to have an increased incidence of influenza compared with the previous two winters
- Sustained or increased attendances in the ED
- Continued rise on NC2R and Super stranded to levels not seen before, resulting in increased demands on the Trust's capacity

- Maintaining elective activity safely and ensuring the Elective restoration and recovery plan is maintained (78-week delivery)
- Workforce challenges
- Paediatric demand – increased RSV and respiratory attends
- Managing periods of industrial action
- Providing robust plans to support winter energy resilience plans.

2. KEY ELEMENTS

2.0 The drivers of the WHH Winter Plan are outlined in the table below

Prepare for variants of COVID-19 and respiratory challenges • Flu campaign launched September 2022 • COVID-19 Autumn booster campaign • Respiratory winter escalation ward plan • Launch of the Acute Respiratory Infection virtual ward	**Deliver on our ambitions to maximise bed capacity and support ambulance services** • Winter escalation plan with up to 51 escalation beds identified (varying degrees of operational impact and risk) • Pilot use of red cards to support NWAS handover times in ED
Reduce crowding in A&E departments and target the longest waits in ED, reduce hospital occupancy and ensure timely discharge • Full utilisation of SDEC as an assessment area • Hot clinics through SDEC (currently confirmed for Respiratory, Cardiology, AKI and further adoption by Frailty and Planned Care services) • GP direct referrals to SDEC and exploration of NWAS direct arrivals • Home for Christmas Campaign December 2022 – January 2023 • Weekend consultant cover – business case approved and this will support patient flow across 7-days • Virtual wards for Respiratory, Cardiology and Palliative Care. Frailty to follow • Frailty in reach in ED twice per week and consideration of extended hours for FAU	**Ensure timely discharge and support people to leave hospital when clinically appropriate** • Continued senior oversight of NCTR patients • The Integrated Hospital Discharge Team are recruiting an additional 15 employees to support a 7-day service by December 2022. This is to support the reduction of internal delays associated with the completion of referral documentation in addition to working with patients to promote their independence and wellbeing following a hospital stay
Continue to support elective activity • Ongoing commitment to reducing long waiting patients in line with nationally agreed trajectories and plan to eliminate any patients waiting over 78 weeks for treatment by the end of the financial year • Outpatient Transformation Group and Surgical Transformation Group managing the reduction of the elective waiting list by significantly improving the productivity • Winter elective plan to support delivery of trajectories	**Wider Winter Schemes** • Christmas and New Year holiday planning across Planned Care, Unplanned Care and Clinical Support Services • Workforce incentives to support clinical and nursing staffing across holiday periods and during peak winter pressures • Operational management plan compliments the on-call / OOH shifts by doubling-up at weekends and over holiday periods • Daily system partner meetings continue • Planning for impacts of Industrial Action • Energy Resilience – Preparation for winter rota disruptions

2.1 Prepare for variants of COVID-19 and respiratory challenges

In preparation for challenges pertaining to infection prevention and control, the trust has initiated the vaccination programme for both seasonal influenza and for the COVID-19 booster vaccine. Uptake of these vaccines will be monitored by Occupational Health and Wellbeing, in collaboration with the Infection Prevention and Control team.

A ward escalation plan has been developed to support the management of respiratory challenges along with norovirus and c difficile. Embedded learning from surges in COVID-19 between 2020 and 2022 supports the identification of A9 as the primary COVID-19 cohort ward, with use of B18 for enhanced respiratory care. Wards A8 and A7 are considered as the next escalation steps, along with side rooms in speciality areas as appropriate. Any additional escalation requirements will be considered using surveillance details and in consideration of activity in the region. National direction will be followed as appropriate.

For influenza, the escalation advice is to escalate in cubicles and bioquell pods on B18 and A1 can be utilised to manage cohorting of patients with influenza. As above, escalation planning will be reconsidered based on the demand.

To support the management of norovirus, it is advisable to isolate in the area where cases emerge and avoid patient moves as far as it is practical to do so.

Outbreaks will be managed in line with IPC policy and procedures.

2.2 Reduce crowding in A&E departments and target the longest waits in ED, reduce hospital occupancy and ensure timely discharge

2.3 Same Day Emergency Care (SDEC)

SDEC has been embedded in the organisation since July 2022, replacing the previous Combined Assessment Unit (CAU) which had been operational since January 2020.

The following benefits are recognised in respect of UEC Emergency Flow:

- Reduction in time waiting for assessment, plan, and review of patients
- Increased numbers of patients seen, assessed, treated, and discharged through the unit as Ambulatory patients not requiring a core bed, due to expanded opening hours
- Planned reassessment times for appropriate patients thus preventing unnecessary hospital in-patient stays and streamlined care.

SDEC will remain pivotal in delivering assessment capacity during the winter months. The SDEC task and finish group remains in place to monitor activity and ensure full efficiency of the unit. In its infancy, the unit has assessed on average 25+ patients per day and continues to develop with e-referrals from GPs and the UTC. Respiratory, AKI and Cardiology clinics are in place and are occurring weekly. Additional hot clinics are in consideration in Planned Care and Frailty services. Models for GPs to refer directly to SDEC and NWAS direct arrival for GP referrals are being explored with the ICB. Further developments will be reported through the Winter Planning Group.

2.4 ED Ambulatory

The current ED Ambulatory Model functions from for 24hours, 7 days per week. This will continue to ensure the following:

- Improved patient experience as patients are more likely to receive the right care from the right staff in the right place
- Adherence to HEE expectations regarding the review of pathways for GP accepted medical patients
- Significant contribution to NHSI's improvement programmes - eliminating corridor care, ambulance turnaround time, managing attendance surges

- Improved responses to governance issues - an improvement in arrival to initial treatment times
- Support the delivery of an increase in zero length of stay admissions

2.5 Frailty

An extended frailty service is being reviewed ahead of winter. A reviewed model includes consideration of either extended hours Monday to Friday or a 7-day service. Confirmation of a plan for a winter frailty model is due by the end of November. The frailty team provide inreach to the ED twice per week. Data metrics are reported as part of the bed meetings enabling oversight of the demand and efficiency of the service. A Frailty virtual ward is also in the stages of lanbing and will be live in January 2023.

2.6 Weekend Consultant Cover

The business case to support 7-day consultant cover was approve in October 2022. Recruitment and rota scheduling are live ahead of winter to support the 7-day model.

2.7 Winter Escalation Plan

Learning from previous winters, particularly 2021- 2022, has been considered as part of the planning for this year's winter pressures. In preparation for escalation through winter 2022-2023, the escalation beds noted below have been considered when capacity planning. Staffing these escalation wards from a clinical, nursing and therapy perspective will require consideration and is considered as a risk.

- B3 on the Halton site will remain open as an escalation area and can accommodate up to 33 patients
- A10 (formerly CAU/ RFD) escalated to support up to a maximum of 16 patients and identified as a winter escalation ward
- B4 on the Halton site as additional escalation to 12 beds (pending review of elective activity)
- Additional beds on B4 will be considered as a stepdown ward
- Other areas are being considered as part of the escalation plan

Patient criteria and staffing models have been developed as part of the winter ward escalation plan. The A10 ward model and patient criteria has been approved and recruitment is ongoing. A Flex Bundle, approved in September 2022, identifies the steps required when opening escalation beds.

2.8 Virtual Wards

A Palliative, Respiratory and Frailty virtual ward will be in place this winter with the aim of reducing hospital capacity. The Planned Care team are also considering options for virtual wards for appropriate services within the care group.

The Acute Respiratory Infection (ARI) virtual ward had its soft launch on 18th October. A staffing model is in place to support the ARI virtual ward, onboarding and impact will be monitored as winter respiratory infections increase. Engagement with the ARI hub will take place once the ICB model is established.

2.9 Ensure timely discharge and support people to leave hospital when clinically appropriate

2.10 Winter Flow Team - Discharge

Once an individual no longer needs to be in an acute setting, it is best for the patient to return to their own home or another community setting as quickly as possible; it is recognised nationally and internationally that staying in hospital for longer than is necessary can lead to significant physical and mental decompensation.

Following a stay in hospital, most people can return home without any further support. However, for some people, further support will be needed ranging from a very short period, to support for the rest of their lives.

This support can include:

- Pathway 0: Informal support, support from the voluntary care sector (VCS), a return home to an already established package of care or 24-hour care setting, aids or adaptations made to their home, Care call/ first responder support.
- Pathway 1: Home with a further period of recovery via reablement services or with a domiciliary package of care, input from primary healthcare services at home, aids or adaptations made to their home
- Pathway 2: A period of recovery in a 24-hour bed-based setting, a transitional, short-term move to allow long-term care needs to be assessed when the actual level of care required can be more accurately assessed
- Pathway 3: Support which is only available in a residential or more specialist nursing home, which will last for a long period and often for the rest of their lives.

2.11 Discharge Lounge

The discharge lounge was opened in November 2018. The suite which has 2 beds, and 12 chairs is open between the hours of 8-8 on weekdays and 10-6 on weekends and provides a comfortable environment in which patients who can safely leave the ward but are still

awaiting transport or supply of medication can wait for the next part of their journey home. The discharge lounge is a useful setting to support early discharges and bed capacity.

2.12 Transfer of Care Hub

The transfer of care hub (TOC) is an integrated multi-disciplinary team based on the Warrington site. The team are fundamental in delivering a smooth and coordinated discharge process. The team consists of Warrington and Halton NHS teaching hospital foundation trust (WHH), Warrington borough council (WBC) , Halton borough council (HBC), Bridgewater community healthcare foundation trust (BWCHFT), Healthy and Home (VCS link workers) and Warrington ICB.

To support the challenges associated with supporting people to return home and avoid the adverse consequences of a long length of stay for winter 2022-2023 the transfer of care hub has received an investment of £450,000 from the adaptive reserve fund and are recruiting an additional 15 employees to support a 7-day service by December 2022 and support the reduction of internal delays associated with the completion of referral documentation in addition to working with people to promote their independence and well-being following a hospital stay. The introduction of a new role 'TOC co-ordinator' to oversees pathway 1-3 flow out of hospital has been introduced to minimise 'missed opportunities' and to ensure that social care demand is highlighted to the local authority and all available capacity is utilised.

The TOC has undergone service development in 2022 with an aim to meet the outcomes set out in the white paper '***Integration and Innovation: working together to improve health and social care for all (February 2021)'*** and to streamline processes by December 2022 to minimise unnecessary work which result in delays in discharge or duplication due to system intra-operability failures. Following consultation in October 2022 a new integrated management structure is being implemented with employees from WHH, WBC and BCHFT all reporting into a single line management employed by WHH to fulfil a shared vision and strategy 'Working together with people to live well'.

A twice daily intermediate tier MDT has been established to support flow out of ED, SDEC, FAU, AMU into the Urgent Community response service, Care call, assisted living, intermediate care at home and intermediate bed based services same day and to ensure that all in-patients have a timely discharge with pathways 1 and 2. A twice weekly system capacity planning meeting has also been established to ensure that capacity meets demand.

In addition, the IHDT are implementing a range of initiative including complex discharge passports for known LLOS/ returning complex patients, methods to identify complex discharges early in the patient journey and wider programmes identified in the 100 Day Challenge guidance. This work is monitored though the Discharge Improvement task and finish group.

2.13 Continue to support elective activity

2.14 Elective activity and 78 week waits

The Trust remains committed to reducing long waiting patients in line with nationally agreed trajectories and plan to eliminate any patients waiting over 78 weeks for treatment by the end of the financial year.

To support the continuation of Elective recovery during winter a focus has been on internal efficiencies to increase and optimise planned lists.

The Outpatient transformation project group has been established to support internal efficiencies with a focus on improving DNA rates, decreasing short notice hospital cancellations, and improving clinic utilisation. In addition to this the project group is putting in standardise processes and promoting the use of advice and guidance, patient initiated follow up clinics and virtual clinics.

The Surgical transformation project group focuses on the implementation of a GIRFT high volume low complexity (HVLC) programme. This programme will contribute to the reduction of the elective waiting list by significantly improving the productivity with which HVLC procedures are carried out.

As part of phase 1 there has been 6 procedures identified.

- Hand surgery
- Inguinal Hernias
- Lap Chole's
- Hysteroscopy
- Dental
- Cataracts

The teams are working at pace to agree standardised pathways and adopt best practice, as well as pooling capacity and resources, to deliver excellent clinical outcomes and equity of access to care for their population.

As part of a PDSA cycle patients waiting +78weeks will be identified and lists will be confirmed using specific staffing models. Once the testing phase has been completed there will be an evaluation of each procedure list and each of the pathways will be reviewed including the pre-op and listing part of the pathway.

2.15 Planned Care

2.16 Surgical Specialties:

The Christmas and New Year rota has been agreed for Trauma and Orthopaedics, Urology, ENT and Ophthalmology and these were agreed at the most recent business meetings in September.

Theatre cases at CSTM; Surgical Specialties are planning for Thursday 22nd December and Friday 23rd December that day cases only are to be listed to allow for CSTM to close over Christmas weekend, and the same for Wednesday 28th December to Friday 30th December heading into the New Year bank holiday weekend.

Trauma Coordinator cover has been agreed.

2.17 Digestive Diseases:

Medical Staffing (rotas to be provided closer to the time)

- Surgical Consultant on-call covered for Christmas / New Year period.
- Gastro GI bleed rota covered for Christmas / New Year period.
- Request for Gastro Consultant weekend ward rounds in January.
- Additional inpatient endoscopy lists to compensate for lost sessions during the bank holiday.
- Junior Doctors - currently out to locum agencies for additional 2 x FY2 and 1 x FY1 junior doctors to support over Christmas /new year period.
- Junior doctor staffing for A5 Elective will depend upon theatre activity.

2.18 Endoscopy

- The current plan is for sessions to continue as normal across both sites except weekend and bank holidays.

2.19 Pre-Op

- Clinics to continue as normal except Christmas & New Year weekends and bank holidays.

2.20 Winter Plan for Theatre Activity

The winter plan for elective activity through our operating Theatres at WHH has previously been aimed at maximising activity on the Halton site whilst reducing throughput at Warrington, this acts to support the acute site during the weeks most affected by the seasonal bed and staffing pressures, and by taking a pro-active approach it has been proven to increase productivity through theatres by reducing the need to cancel sessions at short notice.

2.21 Elective Plan

The winter plan for elective activity through our operating Theatres at WHH is aimed at maximising activity on the Halton site whilst reducing throughput at Warrington, this acts to

support the acute site during the weeks most affected by the seasonal bed and staffing pressures, by taking a pro-active approach it has been proven to increase productivity through theatres by reducing the need to cancel sessions at short notice.

Due to the impact of the Covid pandemic in 20/21 it was not necessary to implement a plan, however as a direct result of the lost activity during this period a modified approach was implemented over the festive period and into the New Year of 21/22, this supported the recovery effort and backlog in all surgical specialties.

The 21/22 plan ensured that activity on the Halton site remained un-affected whilst the Warrington site saw a minimal decrease in the schedule capacity. It is proposed that the plan for 22/23 will reflect the previous year and follow the same fundamental principles.

Work is now underway to build the Theatre schedules for the new year through to the end of March 23, this will aim to provide a 3 month lead time for CBU's to plan consultant rota's and for the Waiting List Departments to schedule patients in advance, the schedules will then continue to be managed in-line with the 6-4-3 process at the weekly Theatre Scheduling meetings and list content will be agreed at the weekly List Planning meetings.

This year Christmas Day & Boxing Day fall on a Sunday & Monday respectively, therefore it is proposed that all theatres will be fully operational for the week commencing 19th December. List content will be restricted to day cases only on the Halton site to ensure that all patients are discharged prior to the wards closing for the festive period on Christmas eve, Friday 23rd December.

Bank Holiday Monday 26th & Tuesday 27th December will be emergencies only at Warrington, the remainder of this week will have a reduced elective programme consisting of 1 CFT/urgent Theatre and 1 Ophthalmic Theatre daily. For the 2 weeks that follow, an additional Theatre will be opened each week meaning the dept is fully functional by w/c 9th January.

Halton site 28th – 30th December, all elective theatres will be open with day cases only this week.

Elective Maternity lists will not be affected by this plan with exception to the BH's. Additional elective sessions may be accommodated by request only. No elective cases to be booked outside of the dedicated elective sessions

All critical non-elective services will be maintained which include Emergency, Trauma and Maternity Theatres.

*On Christmas Day Emergency & Trauma Theatres will be amalgamated as in previous years, equal priority must be given to both services for life or limb threatening cases.

This plan is displayed below:

		Warrington					Halton			CSTM			
	Day	Th4	Th5	Th6	Th8	Mat Elect	Th1	Th2	CT	Th1	Th2	Th3	Th4
W/C 19.12.22	Mon												
	Tue					am/pm							
	Wed												
	Thur					am/pm							
	Fri												

		Warrington					Halton			CSTM			
	Day	Th4	Th5	Th6	Th8	Mat Elect	Th1	Th2	CT	Th1	Th2	Th3	Th4
W/C 26.12.22	Mon	BH	BH	BH	BH	BH	BH	BH	BH	BH	BH	BH	BH
	Tue	BH	BH	BH	BH	BH	BH	BH	BH	BH	BH	BH	BH
	Wed												
	Thur					am/pm							
	Fri												

		Warrington					Halton			CSTM			
	Day	Th4	Th5	Th6	Th8	Mat Elect	Th1	Th2	CT	Th1	Th2	Th3	Th4
W/C 02.01.23	Mon	BH	BH	BH	BH	BH	BH	BH	BH	BH	BH	BH	BH
	Tue					am/pm							
	Wed												
	Thur					am/pm							
	Fri												

		Warrington					Halton			CSTM			
	Day	Th4	Th5	Th6	Th8	Mat Elect	Th1	Th2	CT	Th1	Th2	Th3	Th4
W/C 09.01.23	Mon												
	Tue					am/pm							
	Wed												
	Thur					am/pm							
	Fri												

The Winter Plan for elective Theatre activity has been developed to support the seasonal bed pressures on the acute site although there is a significant reduction in the number of closed sessions in comparison to previous years, this works on the principal that it's often easier to reduce activity than to increase it in line with any competing pressures at the time. All teams are asked not to reduce staffing numbers to reflect the activity and to maintain agency usage, this will support any unforeseen escalation or requirement to increase activity at short notice.

Should the winter pressures not be as severe as anticipated then there is the possibility of restoring a full programme sooner than planned.

Elective Maternity lists will not be affected by this plan with exception to the BH's. Additional elective sessions may be accommodated by request only. **No elective cases must be booked outside of the dedicated elective sessions**

All critical non-elective services will be maintained which include Emergency, Trauma and Maternity Theatres.

2.22 Womens and Children's

Winter Planning Respiratory and RSV Surge in Paediatrics

Winter planning within paediatrics has recently been stepped up as RSV cases have increased and paediatric capacity in Cheshire and Merseyside has been facing recent pressure both in the ED and in the bed base. RSV is the most common childhood respiratory infection. The surge is being monitored by UKHSA and in response to the situation in Cheshire and Merseyside, NHSE have implemented the Gold and Silver Command structure, where WHH are participants. Learning from 2021 has been embedded in the CBU approach to the management of RSV in Paediatrics. Senior managers have received training regarding escalation processes and the approach to mutual aid across Cheshire and Merseyside.

2.23Clinical Support Services
2.24 Pharmacy

The following actions are in place to provide additional support over the winter period;

- Improve the ability to manage demand for TTOs and medicines reconciliation: Recruit to vacancies; Deploy technical ward-based working rota (Mon-Fri); Engage with locum agencies to cover rota gaps (clinical and dispensary).

- Porters: Deploy "late run" porter to deliver medicines at 7pm, to avoid delivery delays and ward staff being required to attend pharmacy if medicines require out of hours processing.

- Discharge Lounge Support: Liaise with IM&C to generate funding to recruit a pharmacy technician to support the priority processing of discharge prescriptions and flow for the discharge lounge.

2.25 Diagnostics

Diagnostics will continue to support patient flow within the Trust by appropriately staffing departments throughout the winter period.

There has been a focus to maintain inpatient turnaround across the 7 days. This will continue during the winter period. Additional staffing numbers have been provided to ensure there is no reduction in flow at weekends, and the Warrington site is an IP only site for CT and one MRI across the 7 days. Plain film and Ultrasound have increased working days to maintain capacity. Again, this is across the 7 days and will continue during the winter period.

For the Christmas period cross-sectional imaging, plain film imaging and Ultrasound imaging will be available every day for IP and urgent cases only.

Christmas Day activity follows the business as usual out of hours model, which is urgent cases only. ED will be supported as business as usual.

To further support the flow within the Trust portering staff are provided, a 24/7 Radiology portering system is in place to support patient flow to and from all areas of Radiology. This system will continue through the festive period.

The department also always has a Radiology Consultant on call.

Pathology will operate a 7-day service for all tests and flu testing will be offered routinely at weekends from the end of October.

2.26 Mortuary Capacity

Excess deaths nationally, and in the Warrington area, have created additional pressures on the mortuary capacity at WHH. The trust mortuary team will continue to engage with local Funeral Directors to support and expedite transfers into settings within the community. Transfers to the Halton hospital site will also provide added mitigation. Although there are challenges with capacity, business continuity plans allow for use of bariatric spaces. The Security Team have been briefed on capacity and escalation plans. Clinical Support Services will continue to monitor the risk around mortuary capacity and collaborate with the regional planning team for consideration of a Nutwell storage facility if necessary.

2.27 AHP and Midwifery

An action plan is in place which is being overseen by the Trust's Chief Nurse to ensure;

- All rotas will be in place for ward cover, including Christmas rotas which will be locked down in November 2022
- Staffing levels in place and reviewed x2 per day at the daily staffing meeting, escalation process in place for accessing temporary staffing
- Senior nurse on site along with the site managers – additional 7-day matron rota in place
- Non-essential meetings are cancelled during periods of escalation.

2.28 Additional Local Schemes

2.29 Planning for Peaks in Demand over Weekends and Bank Holidays

The Trust will implement the following initiatives to improve the ability to manage demand across winter:

2.30 Red to Green – an ongoing Trustwide initiative with the aim to decompress the ED and enhance discharge planning. This process is supported by senior operational managers, matrons and ward managers. The red-to-green process is generally stepped up when the trust is at full capacity, or at the discretion of the Chief Operating Officer / Director of Operations and Performance.

2.31 No Right to Reside senior MDT daily meetings – this touch point is chaired by a senior operational manager or lead nurse and is represented by colleagues in planned care and unplanned care, clinicians and the IHDT. The aim of the group is to ensure any barriers to discharge are discussed and the escalation of issues that could delay discharges occurs.

2.32 Home for Christmas – the annual campaign will launch on 19th December, where there will be coordinated efforts to enhance discharges to support capacity particularly over the bank holiday periods, noting the Christmas holiday falls across a weekend and with two subsequent bank holidays this December. Learning from the four-day Jubilee bank holiday will be embedded to support the Christmas campaign.

2.33 Weekend planning – A weekly touchpoint remains in place to ensure safe and coordinated plans across weekends.

- Weekend planning templates populated by all CBUs and core services
- A weekly weekend handover takes place at 16.30pm every Friday
- 10am Weekend huddles and additional upon the SMOC discretion
- Weekly encouragement of ICE referrals and discharge planning for over the weekend period
- Weekend Discharge Ward Rounds
- Discharge Lounge over 7 Days
- Discharge details are shared on Fridays and these incorporate plans between Friday to Tuesday when the information is readily available
- IHDT 7-day working
- Early identification of B3/ A10 / B4 patients – preparation on Fridays to support weekend moves and capacity planning

2.34 Operational Management Support

During the winter period to provide senior leadership and visibility the Executive and Senior Manager on call rotas will be in operation. There is a plan to increase Senior Manager cover on site at the weekends to facilitate an onsite presence from 08:00 – 22:00 each day, initially with support on Sundays before Christmas and with additional support on Saturdays starting in January 2023. A double-up of support has been requested for the public holidays that follow Christmas Day. There will be a continued use of weekend handover meetings (Friday at 16:30) for agreement and review of all weekend plans as well as Huddles throughout the weekend (Saturday and Sunday at 10am and when additionality is required). These meetings are supported by the Executive on-call, Senior Manager on call, Matron Site

Manager and Patient flow team, with support from Infection Prevention and Control and clinical teams as required.

The Trust has continued to invest in dedicated supernumerary medical and nurse leadership within the AED department. Leads are positioned to coordinate staff response to surges in activity within the different AED sub-specialty areas and attend the Trust command / control meetings throughout the day. There is a nursing and medical lead coordinator on every shift 7 days a week.

Care Groups continue to work on their Christmas and winter rota plans across clinical, nursing and operational services.

2.35 System Partners Collaboration

Daily system partners meetings remain in place. These are attended by Executive Directors / senior leads from WHH, Warrington Local Authority, Halton Local Authority, Cheshire & Merseyside ICB and Bridgewater. Situation reports across services are shared along with any plans that support capacity and demand on a daily basis.

2.36 Transport provision

The CBU Manager for IM&C is in liaison with transport services to review the delivery and operational model across winter. Additional alternatives to ambulance transport are being considered.

2.37 Severe weather

The Trust has a contract in place with a supplier who grits both sites. The suppliers are on the priority order list, due to the contracts with Local Authorities. The Trust also have gardeners attending the site early, who will also grit the entrances around the site and also complete Basford's and Wellfield Street.

In the case of heavy snow fall, then it is the responsibility of all staff to assist in clearing and moving snow.

The Trust also have access to Marave, who can hire snow ploughs and associated equipment as a priority, which the Trust has used in the past. All grit bins around the site are filled prior to the start of winter and the Trust has a small stock of salt to refill.

2.38 Oversight and incident management arrangements

The Trust will work with the ICB to ensure that oversight arrangements and associated support are appropriately focused on winter resilience and the delivery of elective recovery. As the NHS continues to operate at Level 3 Incident Response, WHH will continue to engage with the local system response arrangements. Seven-day reporting against the UEC sitrep will start from Monday 31st October, however the Corporate Information Team are unable

to support these arrangements and the Associate Director of Information has been engaging with NHSI regarding weekend uploads taking place on a Monday.

The ICB are yet to confirm the requirements associated with the 24/7 System Control Centre (SCC). Until plans are confirmed, the first and second on-call managers can be contacted out of hours and the Trust maintains a single point of contact email address, monitored in line with the NWROC hours 08.00-18.00 seven days per week. It is likely that weekend calls will be stepped up to support the management of winter pressures.

2.39 7-Day UEC Reporting

From the week commencing 31st October 2022, 7-day UEC sitrep and performance reporting was stepped up for winter. The weekend performance reporting will be managed between the Chief Operating Officer, Director of Operations and Performance, Associate Director of Unplanned Care and CBU Manager for UEC. The weekend UEC sitrep submission will be entered by the Corporate Information Team.

2.40 Industrial Action

In October, following several declared intentions from Trade Unions to ballot members for industrial action, the trust stepped up a response group to plan for the likely staffing and service implications on proposed strike days. The recent ballot results from Royal College of Nursing (RCN) did not meet the mandate for industrial action at WHHFT, however the trust continue to assess and exercise preparedness for any future potential instances of industrial action.

Notice of industrial action will be served 14-days in advance of any activity. A Tactical response plan has been devised for any confirmed days of industrial action, with the response covering the week leading to and the recovery from the incident.

National guidance first published on 2nd November 2022, and updated on 22nd November, is being used to complete a self-assessment measuring preparedness for industrial action. Care Groups and Corporate Services have identified their derogation of services with a focus on patient safety and consideration of aligning to what Christmas Day, Bank Holiday or night shift service levels would be.

Industrial action for each Trade Union will present differing challenges, and consideration has been given to any indirect industrial action affecting the trust (i.e. RCN action in surrounding trusts, NHS Ambulance Trust action). An action plan is in place with oversight from the Associate Chief People Officer and EPRR Manager, senior nursing colleagues, Care Group triumvirates, Communications, Volunteers and Finance.

An ICB led exercise (Exercise Arctic Willow) has been initiated for completion by providers for 2nd December 2022. This exercise aims to test the resilience of providers and the interdependencies existing within the system. A system exercise is scheduled for Tuesday

29th November 2022. The industrial action working group will continue to meet weekly and will monitor the status of the Union ballot outcomes and proposed dates for the industrial action.

Industrial Action is on the corporate risk register and mitigation is being monitored and the HR and EPRR lead for industrial action continue to engage with the ICB for further direction and communications. The Industrial Action working group will continue to meet weekly and will monitor the status of the Union ballot outcomes and proposals for the industrial action.

2.41 Energy Resilience – Preparation for winter rota disruptions

The Electricity Supply Emergency Code (ESEC) describes steps which the UK Government could take to deal with: an electricity supply emergency of the kind envisaged in section 3(1)(b) of the Energy Act 1976 - "there exists or is imminent in the United Kingdom an actual or threatened emergency affecting fuel or electricity supplies which makes it necessary in Her Majesty's opinion that the government should temporarily have at its disposal exceptional powers for controlling the sources and availability of energy". Winter energy resilience has been covered in national press and NHSE recently stepped up a working group to plan for potential winter energy disruptions.

It is suggested that the power disruptions are low-risk and are unlikely to happen, however it is pertinent to plan for potential disruptions.

Indications are that there would have to be preparations for one of two scenarios, with the first being the most likely.

1. Energy rota disturbances across a load block (area on one energy load) for a period of three hours either between 06.00 and 10.00 or between 18.00 and 22.00
2. A dynamic model with less structured/ planned outages.

Areas within the load block would be without electricity, this includes local infrastructure, traffic lights, supermarkets, schools, etc.

Halton is a protected site and would not be impacted upon by rota disruptions.

Due to configuration of the national grid we are unable to keep power on during any planned interruption to power in Warrington. The trust therefore need to plan for a 3 hour planned interruptions to power at Warrington Hospital.

WHH has 9 back-up generators across the Warrington and Halton campus and monthly generator testing takes place. This provides mitigation for any planned or unplanned electricity outages away from the protected sites.

Any rota disconnection should be communicated 24 hours in advance, meaning there is limited time for actions and planning, but with an Energy Resilience Group established, it is felt these disruptions can be planned for any managed.

The generators would enable critical services to be maintained, but mitigation would be required to ensure appropriate energy use.

There would likely be an impact on WHH sites as surrounding areas would not have access to electricity. Management of the public is a significant area for consideration

As advised, WHH will continue to prepare for worst case scenario- these energy disruptions might not occur, but planning is essential and therefore an operational management group will be stepped up to support the response. Risks associated with electricity rota disruptions will be considered and a review of the trust Fuel Plan is in place taking more extreme energy disruption into account. The Associate Director of Estates and Facilities Management EPRR lead continue to monitor the national and regional position.

2.42 Warrington Place Winter Plan

WHH have continued to engage with system partners to collaborate and support planning for winter 2022-2023. Along with the content of this winter planning document, priority responses for Warrington are shown in Figure 1, 2 and 3, below.

Figure 1 – Warrington priorities for Winter 2022-2023.

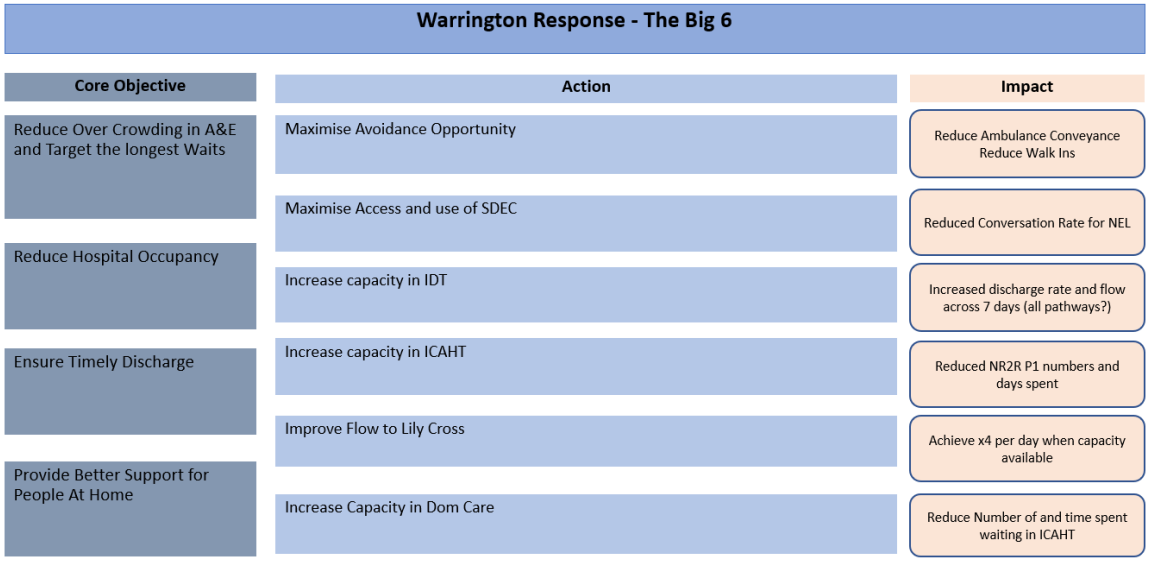


Figure 2 – Warrington Place Action Pan to address Winter Plan

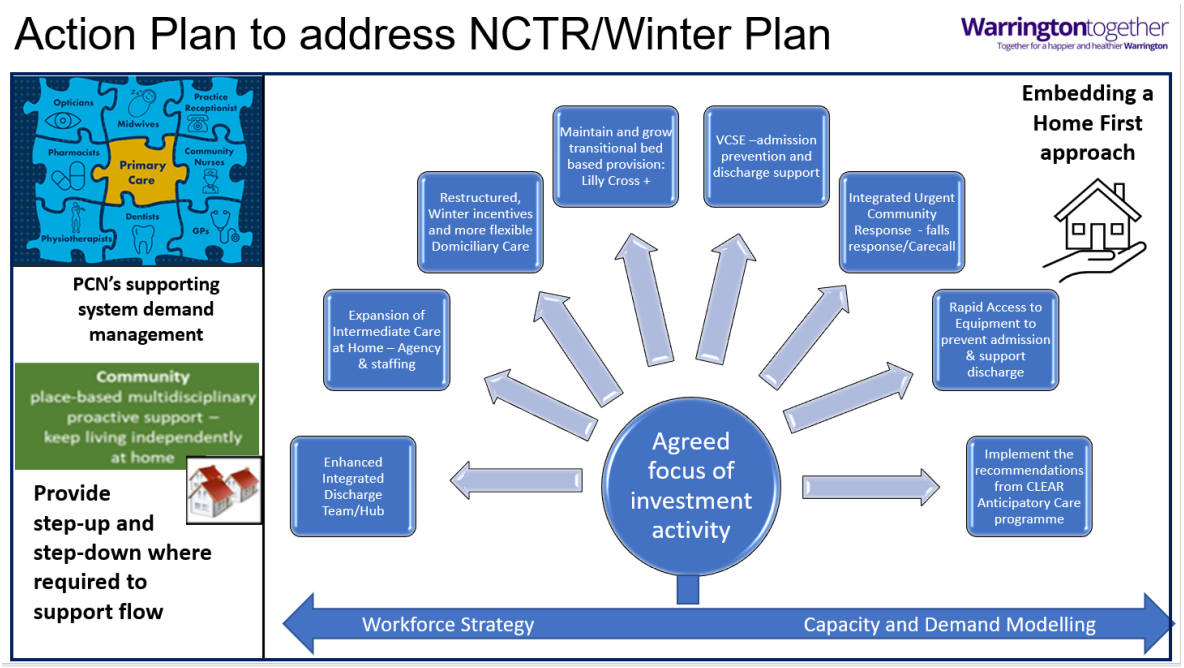
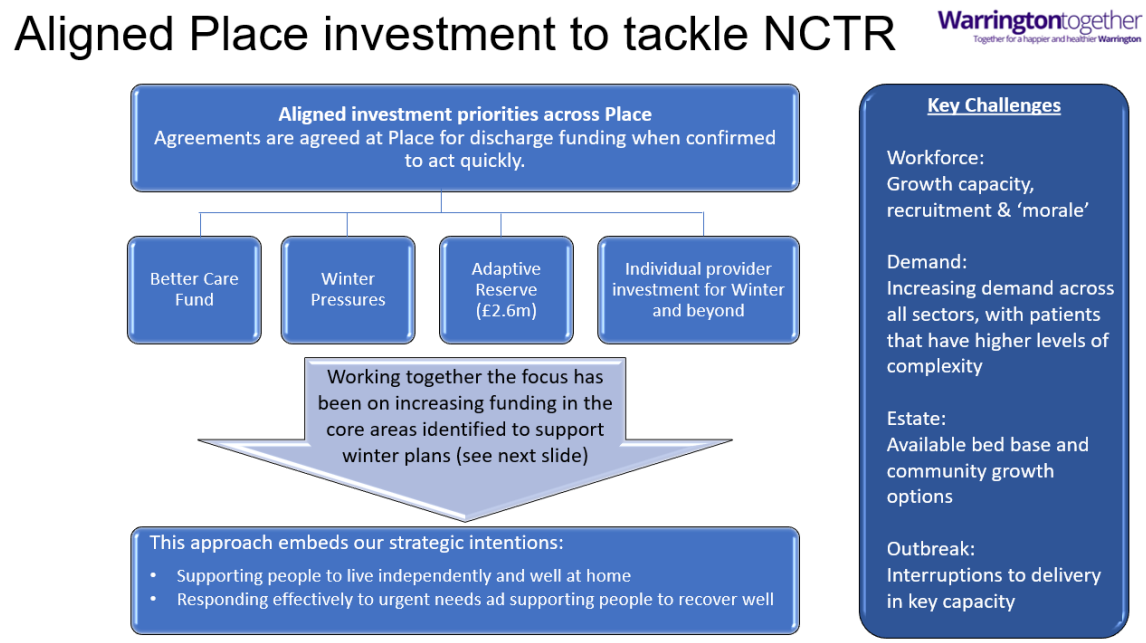


Figure 3 – Aligned Place investment to support Winter Plan



3. ACTIONS REQUIRED/RESPONSIBLE OFFICER

Monitoring the impact of winter pressures, measuring the success of the schemes outlined in this report and colloboaration with system partners and the ICB to ensure oversight of challenges and

Lead Officers

- Dan Moore- Chief Operating Officer is the designated Lead Executive Director with responsibility for Emergency Planning, including winter planning, within the Trust.
- The Accountable Officer is currently supported by Rachel Clint, EPRR Manager.

4. IMPACT ON QPS?

The Trust are complying with and reviewing national guidance in relation to winter planning, winter pressures are likely to impact on QPS.

"This will be the most challenged winter yet"

5. MEASUREMENTS/EVALUATIONS

Performance, capacity and demand will be monitored through the ICB.
A debrief will occur to capture learning from Winter 2022-2023.

6. TRAJECTORIES/OBJECTIVES AGREED

To implement the trust winter plan.

7. MONITORING/REPORTING ROUTES

Winter planning updates continue through the Winter Planning Group, Event Planning Group and the Finance and Sustainability Committee.

8. TIMELINES

This report is presented annually to the Board.

9. ASSURANCE COMMITTEE

Event Planning Group, held monthly.

10. RECOMMENDATIONS

The Board asked to note the contents of the winter plan.