Warrington and Halton Teaching Hospitals NHS Foundation Trust

SUPPLEMENTARY PAPERS

WHH Board of Directors Meeting Part 1

Wednesday 30 March 2022
10.00am-12.30pm
Via MS Teams

Papers included for Approval

- BM/22/02/37 – Board Committee Cycles of Business (Finance and Sustainability Committee & Audit Committee)
- BM/22/03/38 – Charitable Funds Committee – Governing Document & Cycle of Business

Papers included for Assurance

- BM/22/03/39 – Freedom to Speak Up Bi-Annual Report
- BM/22/03/40 – Infection Prevention and Control
- BM/22/03/41 – Learning from Experience Report Q3
- BM/22/03/42 – Ockenden Progress Report – Maternity Self-Assessment Tool
- BM/22/03/43 – ATAIN Mortality Review
- BM/22/03/44 – Hospital Volunteer Report
- BM/22/03/45 – Learning from Death Review Report Q3
- BM/22/03/46 – Digital Board Report
- Equality Duty Assurance Report
- Equality, Diversity & Inclusion Strategy
- Workforce Equality Assurance Report

TRUST BOARD MEETING – PART 1 *(Held in Public)*
Wednesday 30 March 2022, 10.00am – 12.30pm
Via MS Teams

SUPPLEMENTARY PAPERS

MATTERS FOR APPROVAL					
BM/22/03/37 **PAGE 3**	Board Committee Cycles of Business for ratification: Audit Committee Finance & Sustainability Committee	***For approval***	Committee: Audit Committee/Finance & Sustainability Committee Date of Meeting: 17 February 22/21 March 22 Agenda Ref: AC/22/02/16 & FSC/22/03/55 Outcome:	***Paper***	John Culshaw Trust Secretary
BM/22/03/38 **PAGE 8**	Charitable Funds Committee Governing Document & Cycle of Business	***For approval***	Committee: Charitable Funds Committee Date of Meeting: 10 March 2022 Agenda Ref: CFC/22/03/10 b & c Outcome: Approved	***Paper***	John Culshaw Trust Secretary
MATTERS TO NOTE FOR ASSURANCE					
BM/22/03/39 **PAGE 16**	Freedom To Speak Up Bi-Annual Report	***To note for assurance***	Committee: Strategic People Committee Date of Meeting:23 March 22 Agenda Ref: SPC/22/03/25 Outcome: Noted	***Paper***	Kimberley Salmon-Jamieson Chief Nurse & Deputy CEO
BM/22/03/40 **PAGE 19**	Infection Prevention and Control (DIPC) Q3	***To note for assurance***	Committee: Quality Assurance Committee Date of Meeting:1 March 22 Agenda Ref: QAC/22/03/65 Outcome: Noted	***Paper***	Kimberley Salmon-Jamieson, Chief Nurse & Deputy CEO
BM/22/03/41 **PAGE 36**	Learning from Experience Report Q3	***To note for assurance***	Committee: Quality Assurance Comittee Date of Meeting: 1 March 22 Agenda Ref: QAC/22/03/68 Outcome: Noted	***Paper***	Kimberley Salmon-Jamieson, Chief Nurse & Deputy CEO
BM/22/03/42 **PAGE 64**	Ockenden Progress – Maternity Self-Assessment Tool	***To note for assurance***	Committee: Quality Assurance Comittee Date of Meeting: 1 March 22 Agenda Ref: QAC/22/03/64 Outcome: Noted	***Paper***	Kimberley Salmon-Jamieson Chief Nurse & Deputy CEO
BM/22/03/43 **PAGE 73**	ATAIN Mortality Review	***To note for assurance***	Committee: Quality Assurance Comittee Date of Meeting: 1 March 22 Agenda Ref: QAC/22/03/64 Outcome: Noted	***Paper***	Kimberley Salmon-Jamieson Chief Nurse & Deputy CEO
BM/22/03/44 **PAGE 91**	Hospital Volunteer Annual Report	***To note for assurance***	Committee: Strategic People Committee Date of Meeting: 23 March 22 Agenda Ref: XXXX Outcome:	***Paper***	Kimberley Salmon-Jamieson, Chief Nurse & Deputy CEO
BM/22/03/45 **PAGE 96**	Learning from Deaths Review Q3 Report	***To note for assurance***	Committee: Quality Assurance Committee Date of Meeting: 1 March 2022 Agenda Ref: QAC/22/03/69 Outcome: Noted for Assurance	***Paper***	Paul Fitzsimmons Executive Medical Director
BM/22/03/46 **PAGE 111**	Digital Board Report	***To note for assurance***	Committee: N/A (circulated to FSC for information)	***Paper***	Tom Poulter Chief Information Officer/SIRO

APPENDICES

- **Equality Duty Assurance Report – Page 126**
- **Equality, Diversity & Inclusion Strategy – Page 153**
- **Workforce Equality Assurance Report – Page 167**

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/22/03/37**			
SUBJECT:	**Cycles of Business 2022-2023** • **Audit Committee** • **Finance and Sustainability Committee**			
DATE OF MEETING:	30th March 2022			
AUTHOR(S):	John Culshaw, Trust Secretary			
EXECUTIVE DIRECTOR SPONSOR:	Simon Constable, Chief Executive			
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	SO1 We will.. Always put our patients first delivering safe and effective care and an excellent patient experience.	x		
	SO2 We will.. Be the best place to work with a diverse and engaged workforce that is fit for now and the future	x		
	SO3 We will ..Work in partnership with others to achieve social and economic wellbeing in our communities.	x		
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): **(*Please DELETE as appropriate)***	All			
EXECUTIVE SUMMARY *(KEY ISSUES):*	In order to provide assurance to the Trust Board, all Committees of the Board are required to refresh their Cycle of Business on an annual basis to assure itself that it will support the discharge of its duties before presenting to the Trust Board for formal ratification. The following Cycles of Business which had been approved at the appropriate Assurance Committees are presented for approval: - Audit Committee - Finance and Sustainability Committee			
PURPOSE: *(please select as appropriate)*	Information	Approval ✓	To note	Decision
RECOMMENDATION:	The Trust Board is asked to review and approve the 2021-2022 Cycles of Business as above			
PREVIOUSLY CONSIDERED BY:	• Audit Committee – 17th February 2022 (Agenda AC/22/02/17) • Finance & Sustainability Committee – 21st March 2022 (Agenda FSC/22/03/55)			
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: *(if relevant)*	None			

Warrington and Halton Teaching Hospitals NHS Foundation Trust

FINANCE & SUSTAINABILITY COMMITTEE
CYCLE OF BUSINESS 2022/23

AGENDA ITEM	EXEC LEAD	2022												2023		
		19.1.22	16.2.22	23.3.22	21.4.22	19.5.22	23.6.22	21.7.22	18.8.22	22.9.22	20.10.22	17.11.22	21.12.22	18.01.23	22.02.23	22.03.23
INTRODUCTION & ADMINISTRATION																
Apologies for Absence	**Chair**	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Declarations of Interest	**Chair**	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Minutes of the Last Meeting & Action Log	**Chair**	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Rolling attendance log + cycle of business	**Chair**	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Matters Arising	**Chair**	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
GOVERNANCE & COMPLIANCE																
Committee Terms of Reference	**Trust Sec**									X						
Committee Cycle of Business	**Trust Sec**			X												X
Committee Chair's Annual Report to Board	**Chair**					X										
Pay Assurance Report	**CPO**	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Risk Register	**Trust Sec**	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Deep Dive in relation to Risk Register (annual)	**Trust Sec**					X										
PAF Review and Refresh of Trust KPIs	**CFO&DCEO**		X												X	
Committee Effectiveness Review – 6 month	**Chair/T Sec**									XrepOct	X					
Committee Effectiveness Review – annual	**Chair/T Sec**			X repApr	X											
Strategy & Sustainability Report - Biannual (wef 09/2021)	**DS&P**			X								X				
Emergency Preparedness Annual Report (EPRR)	**COO**							X								
EPRR Assurance Letter/Compliance Statement	**COO**									X						
WLI MIAA Audit report update (monthly)	**COO**	X	X	X	X	X	X									
PERFORMANCE																
Corporate Performance Report (incl efficiency, productivity, utilisation, LOS, DNAs)	**COO**	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Digital Services HLB & Digital Board minutes	**CIO&SIRO**	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
FINANCIAL ASSURANCE																
Monthly Finance report, + - Capital Planning Group Minutes - Finance + Resources Group Minutes and escalation log - Commissioner Contract minutes - CPG detailed projection of each scheme	**CFO&DCEO**	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Capital Planning Group planning cycle annual review (wef June 2021)	**CFO&DCEO**						X									
Monthly CIP Report	**CFO&DCEO**	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Indicative Financial cost of harm annual report	**CFO&DCEO**					X										
COVID pay related expenditure **(1/4ly from 01/22, 04/22, 07/22, 10/22**	**CFO&DCEO**	X			X			X			X			X		
Capital Expenditure Approvals (schemes above £500k) wef May 2021 (as required)	**Exec Lead**	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Benefits Realisation Quarterly Report (wef 10/21)	**CFO&DCEO**		Q3			Q4			Q1			Q2			Q4	
Medical Staffing Review Quarterly Update (wef May 22)	**EMD**					X			X			X			X	

AGENDA ITEM	EXEC LEAD	2022												2023		
		19.1.22	16.2.22	23.3.22	21.4.22	19.5.22	23.6.22	21.7.22	18.8.22	22.9.22	20.10.22	17.11.22	21.12.22	18.01.23	22.02.23	22.03.23
ED Nurse Business Case Benefits Realisation (**due July 2022)**	**CN&DCEO** **CFO&DCEO**							X								

Clinical Services Shopping City Benefits Realisation (**due March 2023)**	**Dir S&P**															X
INVESTMENT																
Annual Capital Programme	**CFO&DCEO**		X												X	
PLANNING																
Operational Plan & Budgets	**CFO&DCEO**		X draft	X final											X draft	X final
Service Line Reporting Quarterly Report	**CFO&DCEO**		Q3			X full yr 22-23		Q1			Q2				Q3	
Reference Cost Report	**CFO&DCEO**	X final										X draft		X final		
CLOSING																
Key issues to the Board	**Chair**	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Any Other Business	**Chair**	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Next Meeting Date & Time	**Chair**	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X

AUDIT COMMITTEE – CYCLE OF BUSINESS
2022-2023

AGENDA ITEMS	OWNER	2022					2023
		17 FEB	28 APRIL	16 JUNE (YEAR END)	18 AUG	17 NOV	23 FEB
OPENING BUSINESS							
• Welcome, apologies, declarations of interest, cycle of business	**CHAIR**	X	X	X	X	X	X
• Review Minutes and Action Log	**CHAIR**	X	X		X	X	X
• Review rolling attendance log	**CHAIR**	X	X		X	X	X
• Approve Chair's key issue report items for escalation (post meeting)	**CHAIR**	X	X		X	X	X
QPS ASSURANCE							
• Update from Chairs of F&SC QAC CFC SPC & CROC!!!	**TA/MB/CR/JJ**	X	X		X	X	X
• Changes or Updates to BAF	**Trust Secretary**	X	X		X	X	X
INTERNAL AUDIT							
• Internal Audit Plan & Fees	**MIAA**	X					X
• Progress Report on Internal Audit follow-Up actions	**CFO & Deputy CEO**	X	X		X	X	X
• Internal Audit Progress Report on Follow-Up actions	**MIAA**	X	X		X	X	X
• Internal Audit Progress Report	**MIAA**	X	X		X	X	X
• Head of Internal Audit Opinion	**MIAA**		X				
• Internal Audit Charter Annual Report	**MIAA**		X				
EXTERNAL AUDIT							
• External Audit Plan & Fees	**GT**	X	X				X
• Report and Updates from External Audit	**GT**	X	X		X	X	X
• Annual Audit Letter (AC following year-end Audit Cttee)	**GT**				X		
• Renewal/Refresh of External Audit Contract (at term) **due Aug 2022**	**GT/AMcG/JC**				X		
COUNTER FRAUD							
• **FINAL** Annual Counter Fraud Plan	**MIAA**		X				
• Counter Fraud Progress Updates	**MIAA**	X	X		X	X	X
• Annual Counter Fraud Annual Report	**MIAA**		X				
FINANCE							
• Review Losses & Special Payments	**CFO & Deputy CEO**	X	X		X	X	X
• Review Quotation and Tender Waivers of Standing Financial Instructions	**CFO & Deputy CEO**	X	X		X	X	X
• Going Concern Report	**CFO & Deputy CEO**		X				
QPS GOVERNANCE AND COMPLIANCE							
• Annual report and accounts timetable and plans	**CFO & Deputy CEO**	X					X
• **Draft** Annual Governance Statement	**Trust Secretary**		X				
• **Draft** Annual Report	**CEO**		X				
• **Draft** unaudited Accounts & Financial Statements	**CFO & Deputy CEO**		X				
• Annual Report	**CEO**			X			
• Quality Account	**Dir Integrated Gov**			X			
• **Draft** Annual accounts accounting policies	**CFO & Deputy CEO**	X					X
• **FINAL** and Audited Accounts & Financial Statements	**CFO & Deputy CEO**			X			
• Head of External Audit Opinion Statement	**GT**			X			
• Review other reports and policies as appropriate – e.g. changes to standing orders – as arise, Freedom to Speak Up • Conflict of Interest Policy January 2024/Anti- Fraud Policy August 2023/Treasury Management Policy Aug 2023	**ALL**					FTSU Policy	
• Code of Governance Compliance + Compliance with Licence Annual Return – completion of FT4 Declaration, Condition G6 + certification of training of Governors Annual Report	**Trust Secretary**			X			
• Risk Management Annual Report update	**Dir Integrated Gov**				X		
• Code of Governance Compliance Declaration – e.g. changes as required	**Trust Secretary** ***(as req'd)***						
• Review of Trust Registers (e.g. Conflicts of Interest)	**Trust Secretary**					X	
• Terms of Reference x 2 years (due Feb 2022 + Feb 2024)	**Trust Secretary**						
• Cycle of Business Annual Review	**Trust Secretary**	X					X
• On-Call Annual Update Report	**Chief People Officer**				X		
• Overtime Annual Update Report	**Chief People Officer**				X		
• NW Skills Development Bi-Annual Report	**CFO & Deputy CEO**	X			X		X
• ICON Programme Bi-Annual Report	**CFO & Deputy CEO**	X			X		X

AGENDA ITEMS	OWNER	2022					2023
		17 FEB	28 APRIL	16 JUNE (YEAR END)	18 AUG	17 NOV	23 FEB
EFFECTIVENESS							
• Committee Chairs Annual Report for Board & Council of Governors	**CHAIR**				X		
• Committee meeting effectiveness - annual review	**CHAIR**				**X (rep Nov)**	X	
DEEP DIVE REVIEWS							
• Commission and receive ANY additional scrutiny projects	**Dir Integrated Gov** ***(as req'd)***						
CLOSING							
• Private discussions with Internal and External Auditors and Counter-Fraud specialist as required – but at least annually	**CHAIR**	X			X		X
• Any Other Business	**CHAIR**	X	X	X	X	X	X

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/22/03/38**			
SUBJECT:	**Charitable Funds Governing Document & Cycle of Business**			
DATE OF MEETING:	30th March 2022			
AUTHOR(S):	John Culshaw, Trust Secretary			
EXECUTIVE DIRECTOR SPONSOR:	Simon Constable, Chief Executive			
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	SO1 We will.. Always put our patients first delivering safe and effective care and an excellent patient experience. SO2 We will.. Be the best place to work with a diverse and engaged workforce that is fit for now and the future SO3 We will ..Work in partnership with others to achieve social and economic wellbeing in our communities.	x x x		
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): **(*Please DELETE as appropriate)***	All			
EXECUTIVE SUMMARY *(KEY ISSUES):*	In order to provide assurance to the Trust Board, the Charitable Funds Committee is required to refresh the Governing Document & Cycle of Business every two years to assure itself that it will support the discharge of its duties before presenting to the Trust Board for formal ratification.			
PURPOSE: *(please select as appropriate)*	Information	Approval ✓	To note	Decision
RECOMMENDATION:	The Trust Board is asked to approve the Governing Document & Cycle of Business and recommends to the Board for ratification subject to the above.			
PREVIOUSLY CONSIDERED BY:	**Committee**	Charitable Funds Committee		
	Agenda Ref.	CFC/22/03/10 b		
	Date of meeting	10th March 2022		
	Summary of Outcome	Approved		
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: *(if relevant)*	None			

CHARITABLE FUNDS COMMITTEE

GOVERNING DOCUMENT

0. THE CHARITY

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

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

Its values are:

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

1. PURPOSE

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

2. AUTHORITY

The Committee is authorised to:

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

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

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

3. REPORTING ARRANGEMENTS

The Committee will have the following reporting responsibilities:

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

4. DUTIES & RESPONSIBILITIES

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

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

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

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

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

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

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

5. MEMBERSHIP

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

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

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

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

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

6. ATTENDANCE

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

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

7. QUORUM

A quorum shall be:

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

8. FREQUENCY OF MEETINGS

The Committee will meet on a quarterly basis.

9. ADMINISTRATIVE ARRANGEMENTS

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

10. REVIEW / EFFECTIVENESS

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

DATE: March 2022

NEXT REVIEW: March 2024

GOVERNING DOCUMENT - REVISION TRACKER

Name of Committee:	**CHARITABLE FUNDS COMMITTEE**
Version:	Issue No11
Implementation Date:	March 2022
Review Date:	24 Months from the approval date ie March 2024
Approved by:	Charitable Funds Committee
Approval Date:	Charitable Funds Committee XX XX XX and Trust Board XX XX XX

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

March 2019	**Quorum**	A quorum shall be: (2) non-executive directors (2) executive directors (or their nominated deputies)	CFC 7.03.2019 Trust Board 31.05.2019
June 2020	**Attendance**	Replace Head of Financial Services with Financial Planning Accountant Amend title to read - Deputy Director of Finance and Commercial Development Amend title of DoF + Commercial Development to read Chief Finance Officer Add Head of Fundraising Amend title of Director Community Engagement & Fundraising to Director Communications and Engagement	Issue 9 CFC 04.06.2020 Trust Board xx.xx.2020
June 2020	**Charitable Purpose**	To update the charitable purpose following Cttee approval in December 2019	Issue 9 CFC 04.06.2020 Trust Board xx.xx.2020
Sept 2021	**Membership**	To add the Chief People Officer to the membership	Issue 10 CFC Sept 2021 Trust Board 29.9.21
March 2022	**Reporting Arrangements**	Amend 'Key Issue Report' to Committee Assurance Report	XX XX XX
March 2022	**Duties & Responsibilities**	Committee to receive risk register on a quarterly basis	XX XX XX
March 2022	**Membership**	To add the Chief Nurse to the membership	XX XX XX
March 2022	**Attendance**	Add Trust Secretary	XX XX XX
March 2022	**Administrative Arrangements**	Update to admin arrangements	XX XX XX

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

CHARITABLE FUNDS COMMITTEE CYCLE OF BUSINESS 2021-23												
	Exec Lead		**June 2021**	**Sept 2021**	**Dec 2021**		**Mar 2022**	**June 2022**	**Sept 2022**	**Dec 2022**		**March 2023**
INTRODUCTION & ADMINISTRATION												
Apologies for Absence	Chair		X	X	X		X	X	X	X		X
Declarations of Interest	Chair		X	X	X		X	X	X	X		X
Minutes of the Last Meeting	Chair		X	X	X		X	X	X	X		X
Matters Arising+ Action Log	Chair		X	X	X		X	X	X	X		X
Rolling attendance	Chair		X	X	X		X	X	X	X		X
FUNDRAISING												
Fundraising Report + 1/4ly workplan	Director of Communications + Engagement		X	X	X		X	X	X	X		X
Charitable Funds Strategy	Director of Communications + Engagement			X			X					X
Annual Operational Plan	Director of Communications + Engagement						X					X
FINANCE												
Finance Report	Chief Finance Officer + Deputy CEO		X	X	X		X	X	X	X		X
Bid applications	Director of Communications + Engagement		X	X	X		X	X	X	X		X
Investment Strategy/update	Chief Finance Officer + Deputy CEO						X					X
Annual Review of Reserves Policy	Financial Planning Accountant		X					X				
Investment Guidance Annual update	Financial Planning Accountant		X					X				
GOVERNANCE & COMPLIANCE												
Governing Document (Due Sept 23)	Chair/Trust Secretary			X								
Cycle of Business	Chair/Trust Secretary						X					X
Charities Commission Checklist	Director of Communications + Engagement		X		X			X		X		
Charity Risk Register	Director of Communications + Engagement		X	X	X		X	X	X	X		X
Risk Strategy	Director of Communications + Engagement							X				
Annual Report and Accounts	Chief Finance Officer + Deputy CEO				X				Draft	FINAL		
Committee Chair's Annual Report to Board	Chair		X					X				
Committee Effectiveness Annual Review	Chair/Trust Secretary						X Circulate Report to June	X Receive				X Circulate Report to June
CLOSING												
Key issues to the Board	Chair		X	X	X		X	X	X	X		X
Any Other Business	Chair		X	X	X		X	X	X	X		X

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/22/03/39**			
SUBJECT:	**Freedom to Speak up**			
DATE OF MEETING:	30 March 2022			
AUTHOR(S):	Jane Hurst, Deputy Chief Finance Officer			
EXECUTIVE DIRECTOR SPONSOR:	Kimberley Salmon-Jamieson, Chief Nurse & Deputy Chief Executive			
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	SO1 We will.. Always put our patients first delivering safe and effective care and an excellent patient experience.	x		
	SO2 We will.. Be the best place to work with a diverse and engaged workforce that is fit for now and the future	x		
	SO3 We will ..Work in partnership with others to achieve social and economic wellbeing in our communities.			
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): **(*Please DELETE as appropriate)***	**#115** Failure to provide adequate staffing levels in some specialities and wards. Caused by inability to fill vacancies, sickness. Resulting in pressure on ward staff, potential impact on patient care and impact on Trust access and financial targets.			
EXECUTIVE SUMMARY ***(KEY ISSUES):***	From the 1st April 2021 to 31 December 2021 the FTSU team has managed 19 disclosures. The majority of which relate to culture, allegations of bullying and relationship issues within teams. The FTSU team continues to work closely with Care Group Leads, CBUs, HR and OD to support individuals and teams to resolve the issues that are highlighted. The FTSU team continues to engage with medical students and preceptorship nurses as they join the Trust to make them aware of FTSU. The wellbeing services across the Trust offer a good resource for FTSU to sign post staff to access further support.			
PURPOSE: ***(please select as appropriate)***	Information	Approval	To note x	Decision
RECOMMENDATION:	The Trust Board is asked to note the progress of Freedom To Speak Up.			
PREVIOUSLY CONSIDERED BY:	**Committee**	Strategic People Committee		
	Agenda Ref.			
	Date of meeting	24 March 2022		
	Summary of Outcome			
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None			

REPORT TO BOARD OF DIRECTORS

SUBJECT	Freedom to Speak Up	AGENDA REF:	BM/22/03/39

1. BACKGROUND/CONTEXT

The purpose of this paper is to update the Trust Board on the activity of the Freedom To Speak Up (FTSU) Team. From the 1st April 2021 to 31 December 2021 the FTSU team has managed 19 disclosures. April 2020 to 31 December 2020 saw higher levels with 29 however 10 of those related to the same issue in W&C.

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

FTSU continues to welcome new Champions with regular meetings to improve communication, there are currently around 25 Champions. Following changes in the Non Executive Directors FTSU has a new Non Executive Lead Julie Jaram, who will meet quarterly with FTSUG.

2. DISCLOSURES

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

Table 1 Disclosures in 2021/22

Quarter 1	4
Quarter 2	8
Quarter 3	7
Total	**19**

The cases can be grouped as follows:-

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

Behaviour, culture and relationships	15
Process	2
Patient safety	1
Staff levels	1
Total	**19**

There has been 1 patient safety concern raised relating to A&E demand and staffing, which was escalated immediately to the Chief Nurse & Deputy Chief Executive. Following review it was concluded that there was no patient safety issue and the concerns highlighted had already been managed through usual management support.

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

The 19 disclosures have been across a variety of operational and corporate areas. The professional groups of staff who have spoken up can be broken down as follows:-

- 3 midwives
- 2 administration / managers
- 7 nurses
- 2 health care support workers
- 2 pharmacy
- 2 ACP
- 1 other

No interlinking themes across the professions identified.

3. ACTIVITY

Activities have been limited during 2021 due to the ongoing COVID-19 pandemic. During the year, the team has continued to present to the medical student inductions. The team held a drop in day in July. FTSU Champions also attend induction for new preceptorship nurses and the international nurses to raise awareness.

4. LESSONS LEARNT

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

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

Issues disclosed have been raised with senior teams in each area to improvement communication including producing a "you said we did poster" (see **Appendix 1**) and highlighting the wellbeing offers available to all staff. Considering learning, a focus is to support line managers to further understand a FTSU disclosure is useful information to improve areas. The Trust has included FTSU awareness in the Line Manager Competency Passport to raise this awareness.

5. RECOMMENDATIONS

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

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/22/03/40**	
SUBJECT:	**Infection Prevention and Control Board Assurance Framework Compliance Report**	
DATE OF MEETING:	30 March 2022	
AUTHOR(S):	Lesley McKay, Associate Chief Nurse Infection Prevention & Control	
EXECUTIVE DIRECTOR SPONSOR:	Kimberley Salmon-Jamieson, Chief Nurse & Deputy Chief Executive	
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	SO1 We will.. Always put our patients first delivering safe and effective care and an excellent patient experience.	√
	SO2 We will.. Be the best place to work with a diverse and engaged workforce that is fit for now and the future	√
	SO3 We will ..Work in partnership with others to achieve social and economic wellbeing in our communities.	√
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): **(*Please DELETE as appropriate)***	**#1215** Failure to deliver the capacity required caused by the ongoing COVID-19 pandemic and potential environmental constraints resulting in delayed appointments, treatments, and potential harm **#1273** Failure to provide timely patient discharge caused by system-wide Covid-19 pressures, resulting in potential reduced capacity to admit patients safely. **#1272** Failure to provide a sufficient number of beds caused by the requirement to adhere to social distancing guidelines mandated by NHSE/I ensuring that beds are 2 metres apart, resulting in reduced capacity to admit patients and a potential subsequent major incident. **#1275** Failure to prevent Nosocomial Infection caused by asymptomatic patient and staff transmission or failure to adhere to social distancing guidelines resulting in hospital outbreaks **#1134** Failure to provide adequate staffing caused by absence relating to COVID-19 resulting in resource challenges and an increase within the temporary staffing domain **#1125** Failure to achieve constitutional access standards caused by the global COVID-19 Pandemic resulting in high attendances and occupancy, non-compliance for RTT, Diagnostics, Cancer and ED Performance **#1207** Failure to complete workplace risk assessments for all staff in at-risk groups, within the timeframes set out by NHSI/E. This will be caused by a lack of engagement in the set process by line managers, resulting in a failure to comply with our legal duty to protect the health, safety and welfare of our own staff, for which the completion of a risk assessment for at-risk members of staff is a vital component. **#1108** Failure to maintain staffing levels, caused by high sickness and absence, including those affected by COVID-19, those who are extremely vulnerable, those who are assessed as only able to work on a green pathway, resulting in inability to fill midwifery shifts. This also currently affects the CBU management team. **#1274** Failure to provide safe staffing levels caused by the mandated Covid-19 staff testing requirement, potentially resulting in Covid-19 related staff sickness/ self-isolation and the requirement to support internal testing; potentially resulting in unsafe staffing levels impacting upon patient safety and a potential subsequent major incident. **#1331** Failure to provide adequate bed capacity to care for level 1, 2 & 3 patients caused by the significant increase in attendances, including COVID-19 positive patients, resulting in potential harm.	

<table>
<tr><td>EXECUTIVE SUMMARY
(KEY ISSUES):</td><td colspan="4">This report provides a summary of infection prevention and control activity for Quarter 3 (Q3) of the 2021/22 financial year and highlights the Trust's progress against infection prevention and control key performance indicators.

National healthcare associated infection (HCAI) reduction targets were published in July and are as follows: -
• E. coli bacteraemia ≤ 81 cases
• Klebsiella spp. bacteraemia ≤ 23 cases
• P. aeruginosa bacteraemia ≤ 4 cases
• Clostridium difficile ≤ 44 cases
• MRSA bacteraemia cases = Zero tolerance
• MSSA bacteraemia cases – no threshold set

In Q3 Trust apportioned HCAIs included: -
• 16 E. coli bacteraemia cases with year to date (YTD) 53
• 6 Klebsiella spp. bacteraemia cases with YTD 16
• 2 P. aeruginosa bacteraemia cases with YTD 3
• 8 Clostridium difficile cases with YTD 31
• Nil MRSA bacteraemia cases with YTD 0
• 6 MSSA bacteraemia cases with YTD 22

Covid-19 cases were detected: -
• 387 (0-2 days) with YTD 790
• 28 (3-7 days) with YTD 60
• 23 (8-14 days – probable healthcare associated) with YTD 29
• 28 (15+ days – definite healthcare associated) with YTD 36

• 3 Covid-19 outbreaks in Q3</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 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/22/03/65</td></tr>
<tr><td></td><td colspan="2">Date of meeting</td><td colspan="2">1 March 22</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 Document in Full</td></tr>
<tr><td>FOIA EXEMPTIONS APPLIED:
(if relevant)</td><td colspan="4">None</td></tr>
</table>

SUBJECT	Infection Prevention and Control Q3 report 2021/22	Agenda Ref:	BM/22/03/40

1. BACKGROUND/CONTEXT

This report provides an overview of infection prevention and control activity for Quarter 3 (Q3) of the 2021/22 financial year (FY). The report highlights the Trust's progress against Healthcare Associated Infection (HCAI) targets and the response to the Covid-19 Pandemic.

NHS England/Improvement (NHSE/I) use Clostridioides (Clostridium) difficile (C. difficile) infection rates to assess Trust performance. Both avoidable and unavoidable cases are considered for regulatory purposes.

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

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

In July 2021 NHSE/I published quality requirements for Trusts to minimise healthcare associated C. difficile and GNBSIs, using 2019 calendar year data as a baseline. WHH HCAI thresholds are shown in table 1.

Table 1: HCAI Thresholds for 2021/2022

HCAI	Reduction	WHH Threshold 2021/22
C. difficile	Minus 1 case	≤44
E. coli	Minus 5%	≤81
Klebsiella spp.	Minus 5%	≤23
P. aeruginosa	Minus 5%	≤4

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

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

A cluster of Covid-19 cases is defined as 2 cases arising within the same ward/department over a 14-day period. Further investigation is undertaken to assess if cases are linked, and if linked this is considered an outbreak and reporting is carried out in line with NHSE/I guidance.

2. KEY ELEMENTS

HCAI data

RAG rating of Trust performance for HCAIs by month is shown in Table 2. Breakdown by ward is included at appendix 1.

Table 2: HCAI data by month

Indicator	Threshold	Position	A	M	J	J	A	S	O	N	D	Total
C. difficile	≤44	Under trajectory	4	6	4	6	1	2	1	3	4	31
MRSA bacteraemia	Zero tolerance	On trajectory	0	0	0	0	0	0	0	0	0	0
MSSA bacteraemia	No target	No target	4	4	2	1	4	1	3	3	0	22
E. coli bacteraemia	≤81	Under trajectory	9	6	8	4	6	4	4	5	7	53
Klebsiella spp. bacteraemia	≤23	Under trajectory	1	2	1	2	3	1	3	1	2	16
P. aeruginosa bacteraemia	≤4	On trajectory	0	1	0	0	0	0	0	1	1	3

Clostridium difficile

All Trust apportioned cases undergo post infection review. Ribotyping of all hospital onset/healthcare associated and community onset/healthcare associated cases has not identified any links between Trust apportioned toxin positive cases. Cases are within trajectory.

Gram positive bacteraemia

Nil cases of MRSA bacteraemia reported in Q1, Q2 & Q3. The Trust has been MRSA Bacteraemia free for a rolling 15-month period and the Trust is on target at the end of Q3.

Year to date (YTD) figures for MSSA bacteraemia are shown in the table above. There is a mixture of likely primary sources (appendix 1), noting some are due to deep seated infections and not preventable. Supportive training has been provided to wards where cannula associated infections occurred and wider sharing of learning taken to Trust-wide safety brief.

Gram negative bacteraemia (GNBSI)

YTD figures for GNBSI cases are shown in the table above. The Trust is below threshold for all GNBSIs at the end of Q3. The likely primary source for the majority of GNBSIs is urinary tract.

The GNBSI Prevention Group meetings continue with phase one ward (A2, A4, A5, A6, A7, A8, B14, B19) and the Quality Academy. Areas of focus include: - hydration, continence management, reducing use of urinary catheters and improving care where required, hand hygiene (including patients) and urinary tract infection detection/management.

Comparative data for HCAI rates for the 2020/21 FY with other Northwest (NW) Trusts, is included in appendix 2. The Trust has lower case numbers/rates for all mandatory data except Klebsiella where the Trust numbers/rates are in a median position between both local delivery system partners. The Trust is a low outlier for C. difficile cases. Review of sampling indicates an increase in testing during Q3 and therefore the low outlier position is not associated with a reduction in sampling.

Outbreaks/Incidents

Covid-19

Covid-19 cases detected in and up to the end of Q3 are detailed below: -

- 387 (0-2 days) with YTD 790

- 28 (3-7 days) with YTD 60
- 23 (8-14 days – probable healthcare associated) with YTD 29
- 28 (15+ days – definite healthcare associated) with YTD 36

- 3 Covid-19 outbreaks

Q3 saw an increase in patient admissions with Covid-19 in October and December, which mirrors a rise in community prevalence data. Hospital onset cases by CBU and ward is shown in appendix 3. All cases detected ≥ day 8 of admission where there is no prior positive Covid-19 result in the last 90 days undergo root cause analysis (RCA). Point of Care testing in the Emergency Department is directing appropriate patient placement to Covid/non-Covid admission areas.

All activities continue in response to the Covid-19 pandemic including promotion of hand hygiene, use of personal protective equipment and social distancing. The programme of Fit Testing of FFP3 respirators has continued. Restoration of visiting remains on hold due to high local prevalence with exceptions made on compassionate grounds.

Trust compliance with the NHSE/I Board Assurance Framework (version 1.8) linked to the Code of Practice on prevention of Healthcare Associated Infections has been reassessed and submitted to Trust Board. An action plan has been developed to support minor gaps in assurance.

Three Covid-19 outbreaks were reported in Q3, associated with peaks in Covid-19 admissions during October and December. Root cause analysis investigations are in progress.

Next steps include: -

- Increase uptake of LAMP testing for staff
- Continue to provide and reinforce updates on Covid-19 IPC precautions
- Continue to review RCA findings from nosocomial cases
- Vaccination as a Condition of Deployment implementation

Infection Prevention and Control Training

Training compliance by month is shown in Table 3. Overall compliance with Mandatory training was 88% at the end of December.

Table 3 Infection Control Training compliance

Infection Control Training	A	M	J	J	A	S	O	N	D
Level 1 – Non-Clinical	92%	91%	90%	89%	89%	89%	89%	89%	90%
Level 2 - Clinical	82%	83%	83%	82%	83%	83%	83%	84%	85%
Overall % of staff trained	**87%**	**87%**	**87%**	**86%**	**86%**	**86%**	**86%**	**87%**	**88%**

The Infection Prevention and Control Nurses (IPCNs) have provided 3 virtual training sessions per week via Live MS Teams events to drive up compliance. Clinical Business Unit (CBU) with compliance below 85% have been directed to set improvement trajectories. Additional training sessions have been offered by the IPCNs to support the CBUs.

Environmental Hygiene

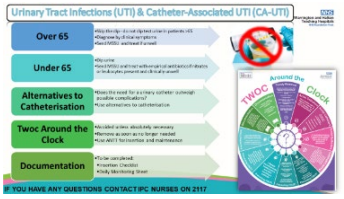
Good progress is being made by the task and finish group to implement the revised National Standards of Healthcare Cleanliness (April 2021). Areas have been reassigned for cleaning category and wording of the

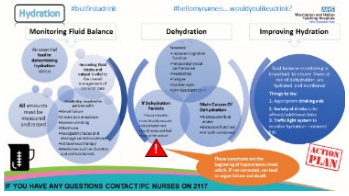
Commitment to cleanliness charter is being reviewed to make it more patient/visitor focussed. An action plan (appendix 4) is in place, monitored by Infection Control Sub-Committee.

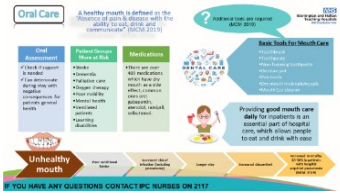
Awareness raising events

The Infection Prevention and Control Team carried out focussed awareness raising activity on: -

- GNBSI prevention using the ward Topic Boards in October

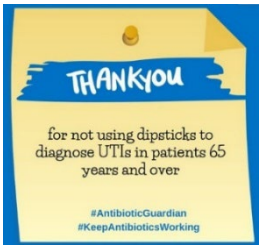






- Antimicrobial Stewardship using desktops in November

World Antimicrobial Awareness Week. The Consultant Microbiologists, Lead Pharmacist in Antimicrobial Stewardship and the Infection Prevention and Control Team shared information on social media and via the Good Morning WHH email message on Monday 22nd November. The messages focussed on spreading awareness not resistance and key messages to support stewardship including good infection prevention practices alongside smart prescribing choices.



- Covid-19 safety using desktops in December

3. ACTIONS REQUIRED/RESPONSIBLE OFFICER

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

4. IMPACT ON QPS

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

5. MEASUREMENTS/EVALUATIONS

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

6. TRAJECTORIES/OBJECTIVES AGREED

HCAI	Reduction	WHH Threshold 2021/22
C. difficile	Minus 1 case	≤44
E. coli	Minus 5%	≤81
Klebsiella	Minus 5%	≤23
P. aeruginosa	Minus 5%	≤4

- One of the Trust's quality priority targets has been revised in line with the NHSE/I published thresholds to reduce healthcare associated GNBSIs by 5% by March 2022
- The zero tolerance to avoidable MRSA bacteraemia cases remains in place

Work streams will continue to:-

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

7. MONITORING/REPORTING ROUTES

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

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

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

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

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

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

8. TIMELINES

- 2021/22 FY

9. ASSURANCE COMMITTEE

- Infection Control Sub-Committee

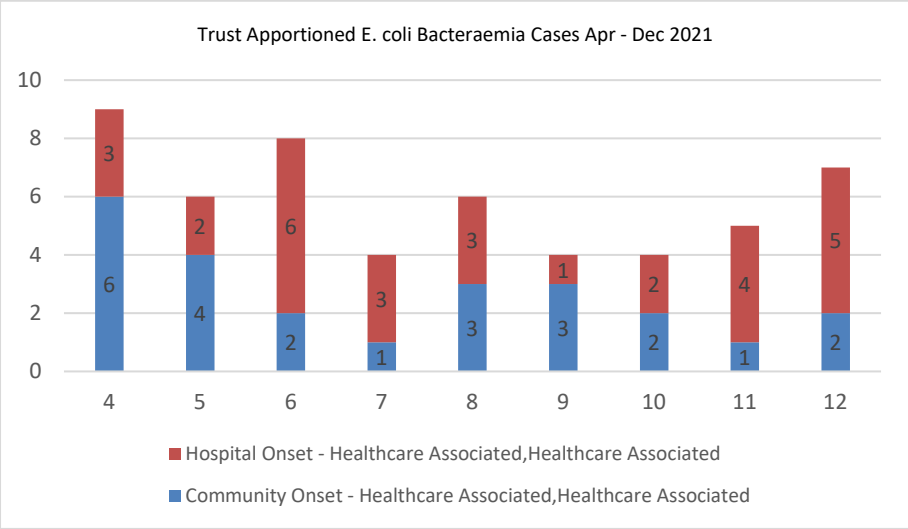
10. RECOMMENDATIONS

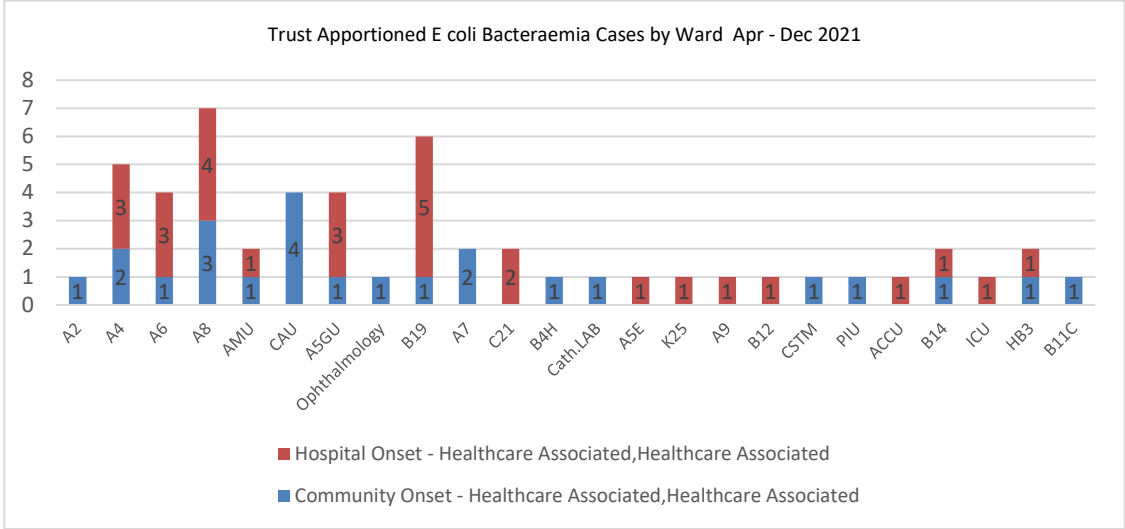
The Trust Board is asked to receive the report and note the exceptions reported and progress made.

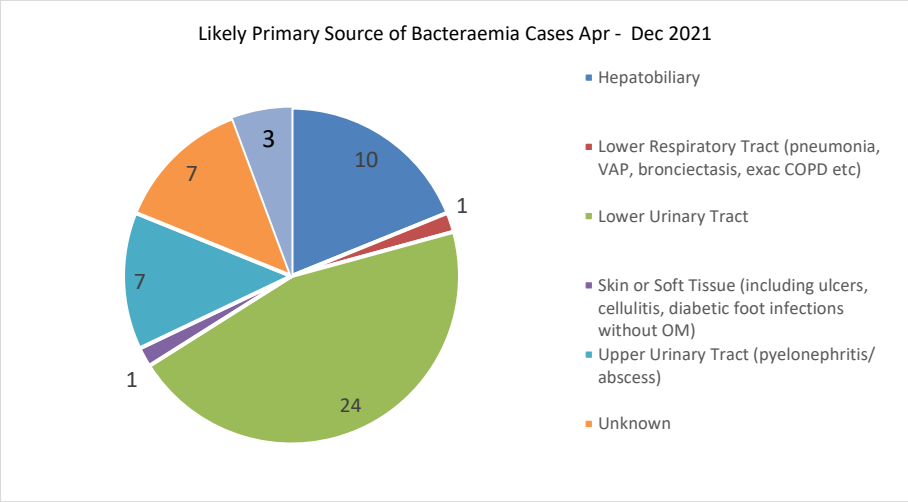
Appendix 1 Healthcare Associated Infection Data Apr – Dec 2021

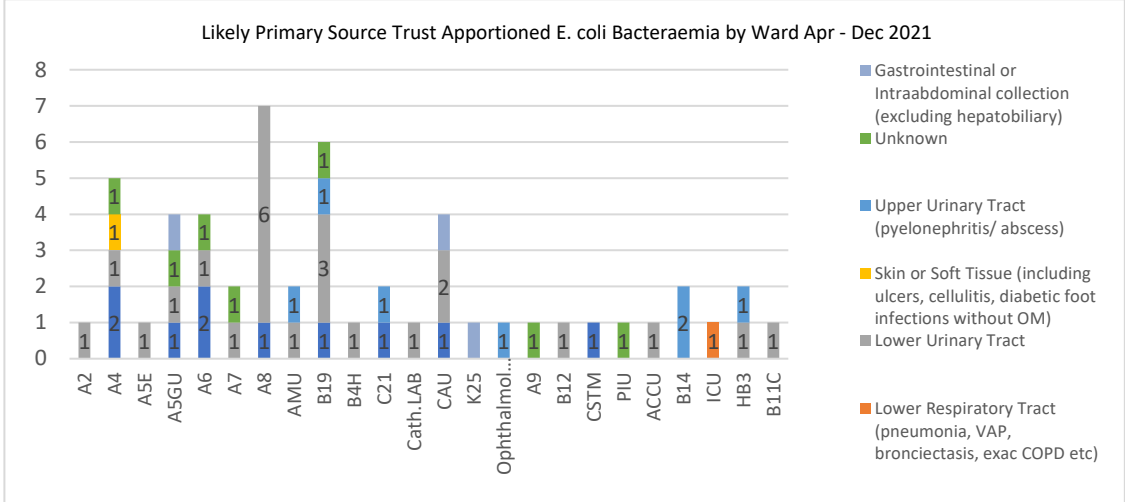
Threshold = 81 cases
YTD Total = 53

Gram Negative Bloodstream Infection: E. coli



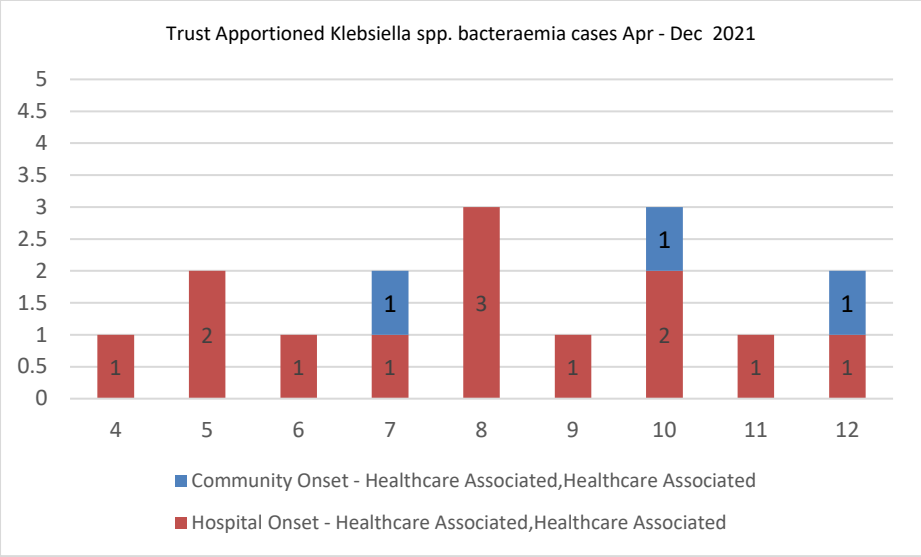


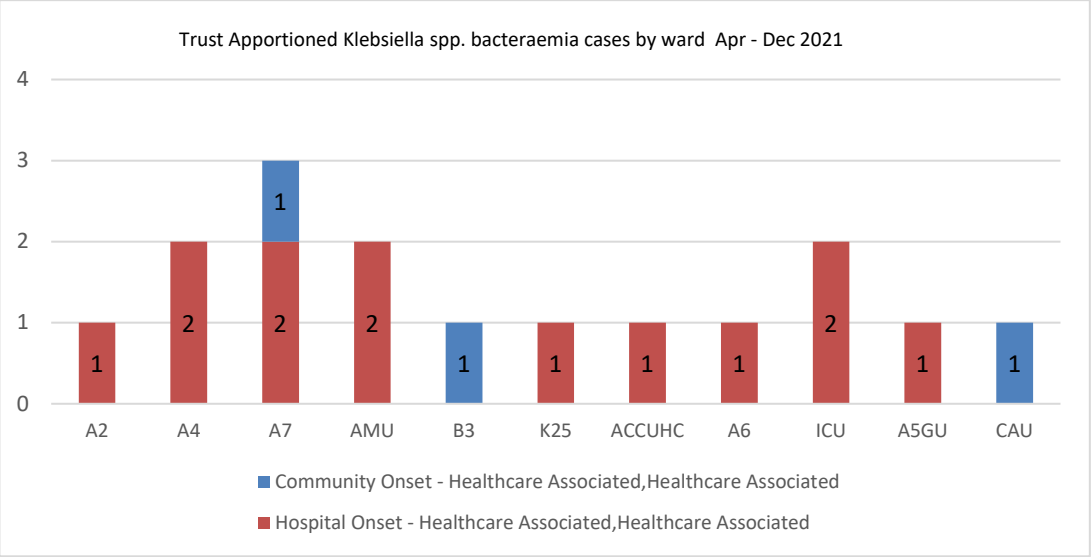


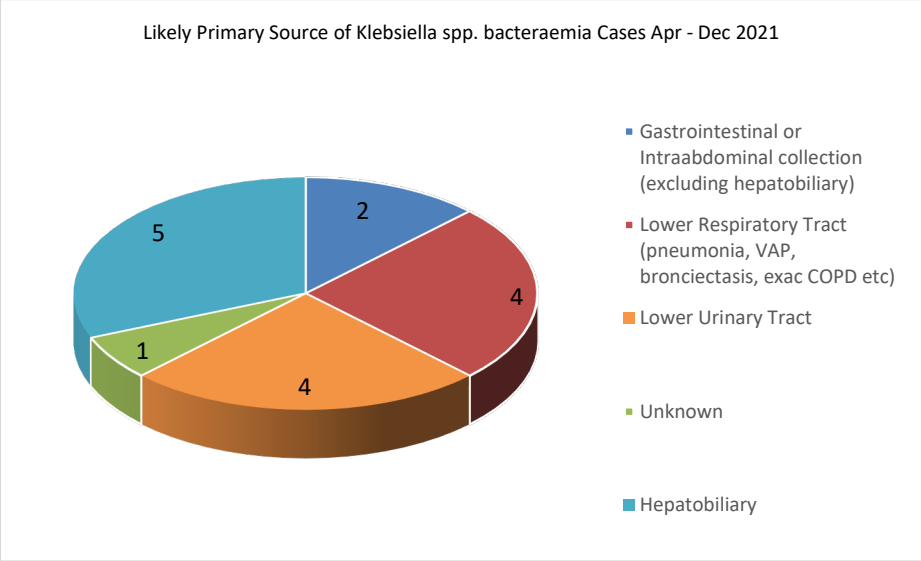


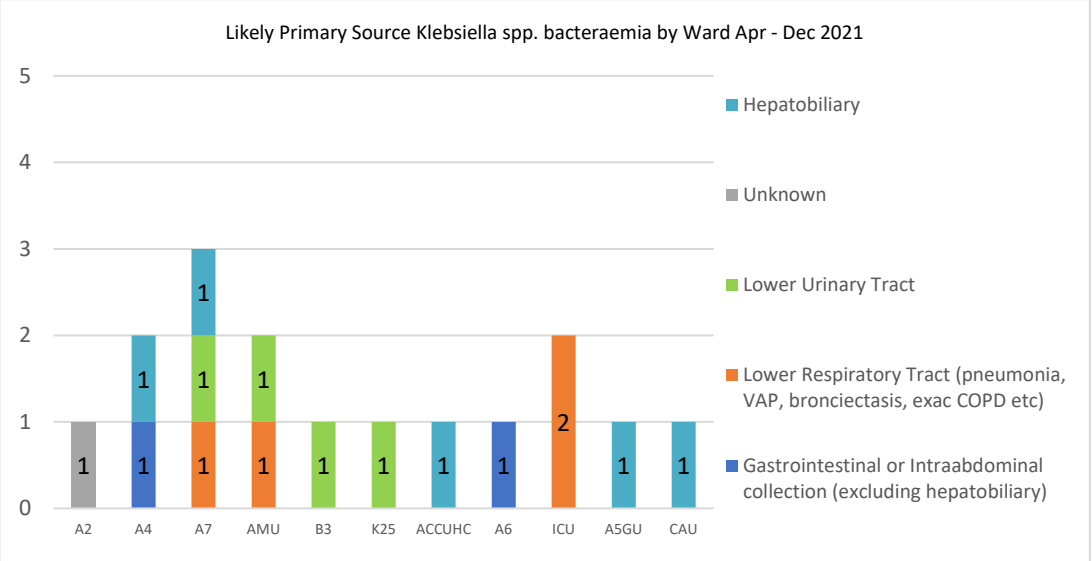
Gram Negative Bloodstream Infection: Klebsiella spp.

Threshold = 23 cases
YTD Total = 16 cases



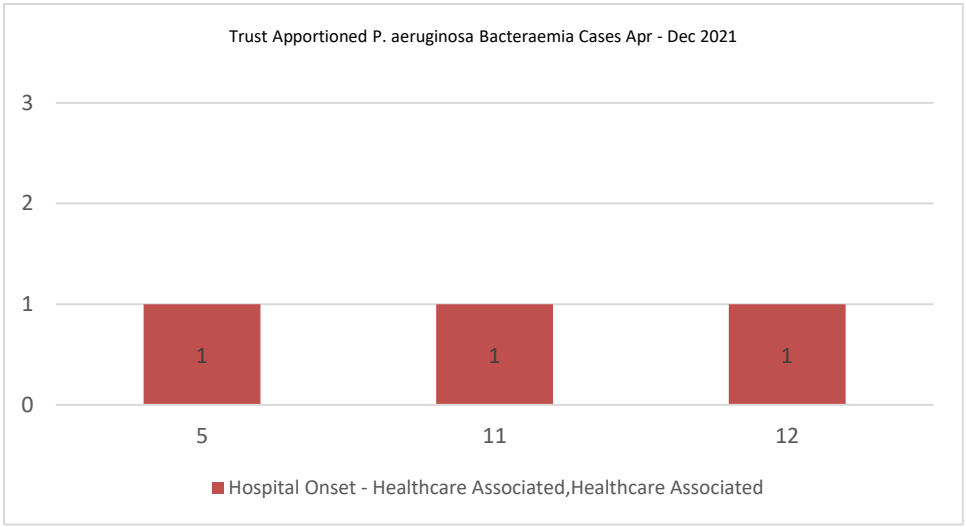


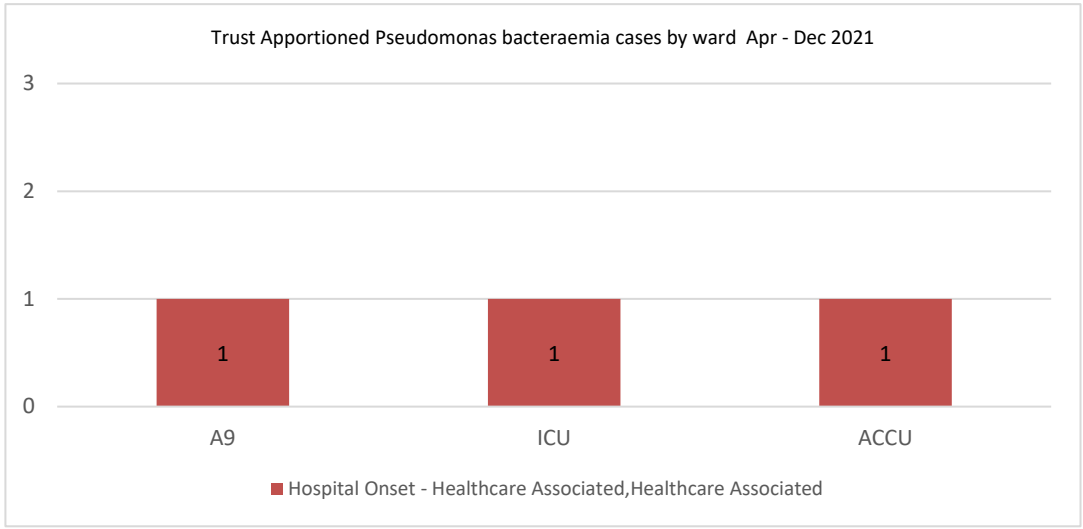


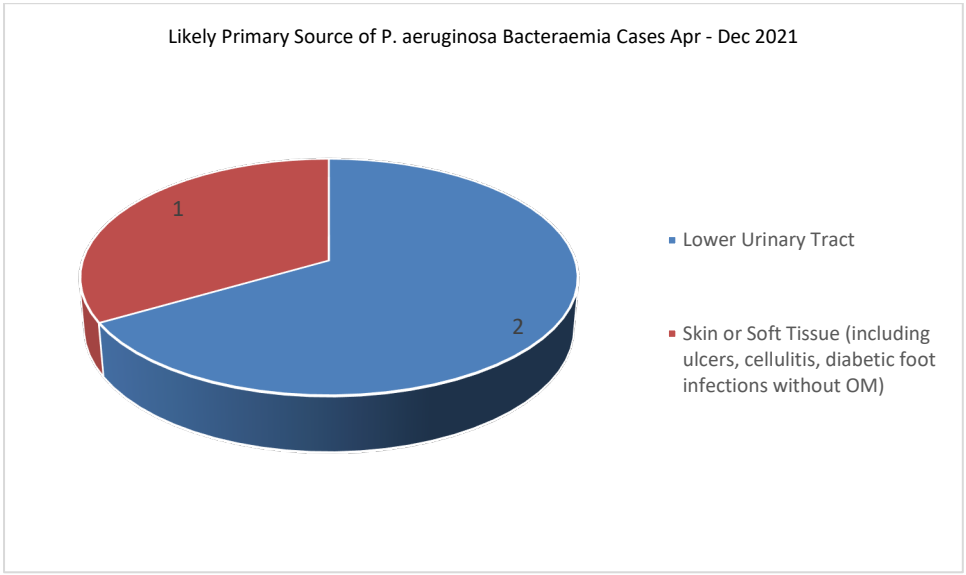


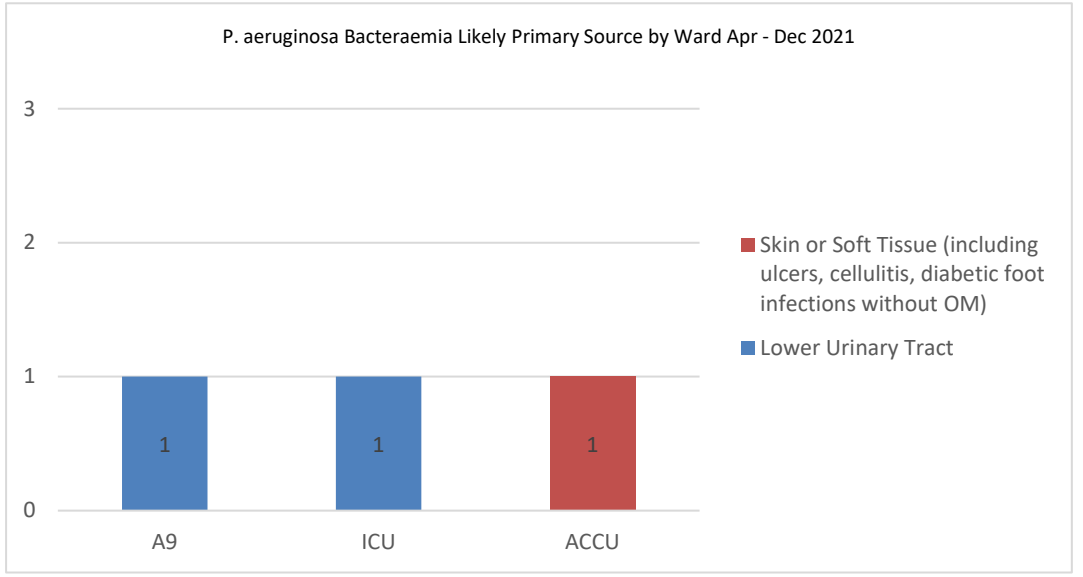
Gram Negative Bloodstream Infection: Pseudomonas aeruginosa (P. aeruginosa)

Threshold = 4 cases
YTD Total = 3



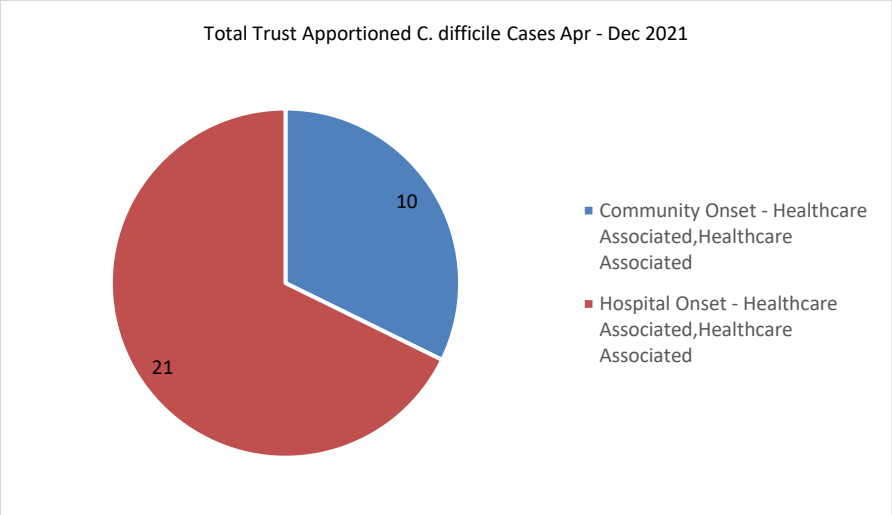


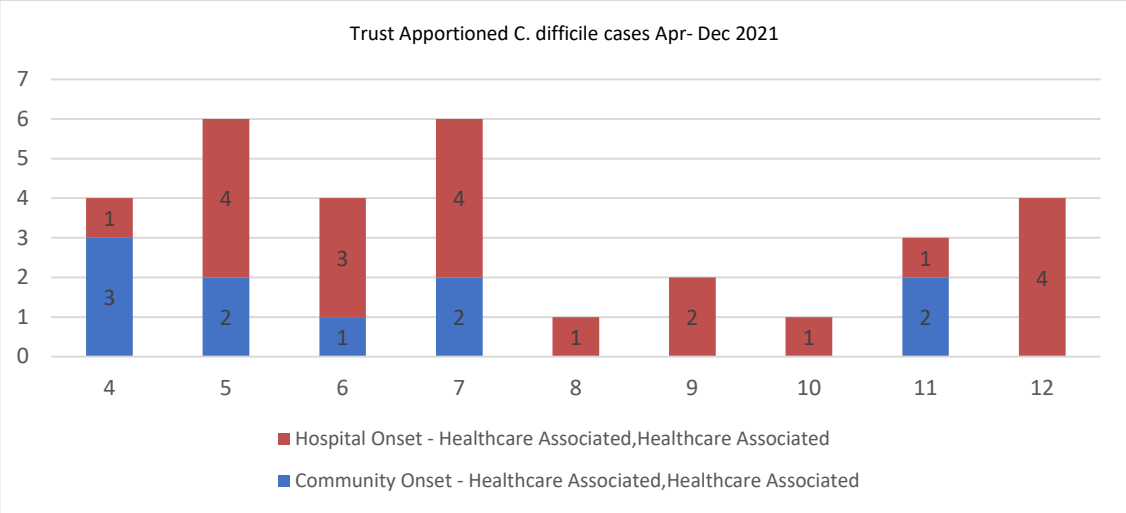


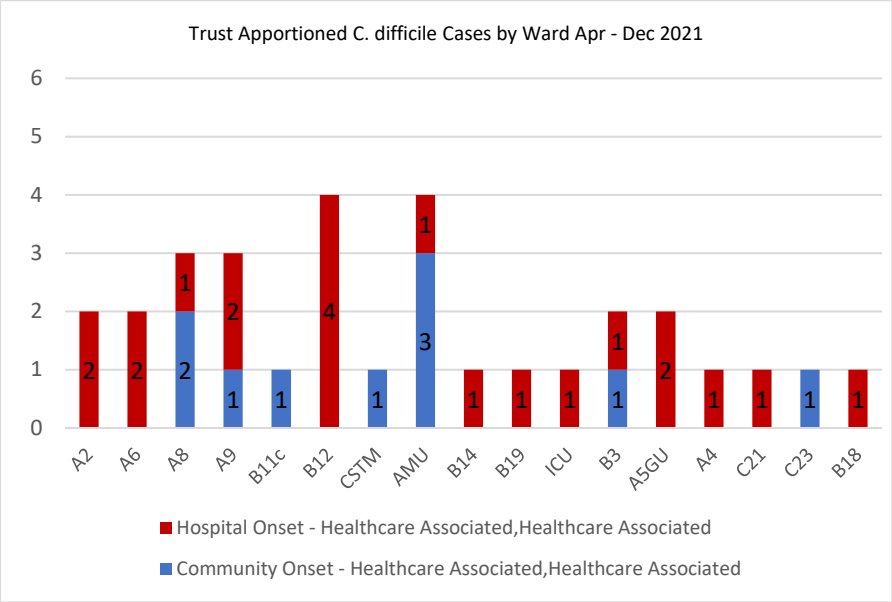


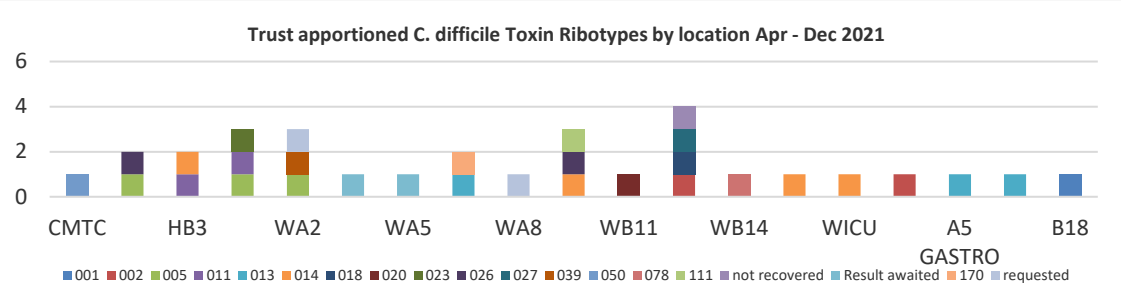
Clostridioides difficile (C. difficile)

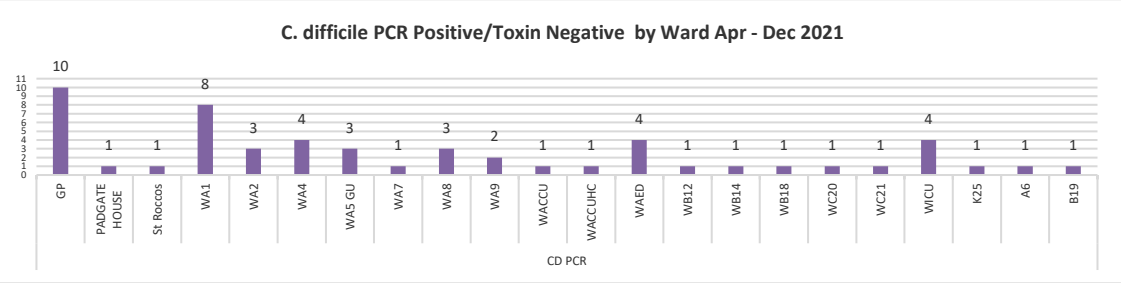
Threshold = 44 cases
YTD Total = 31





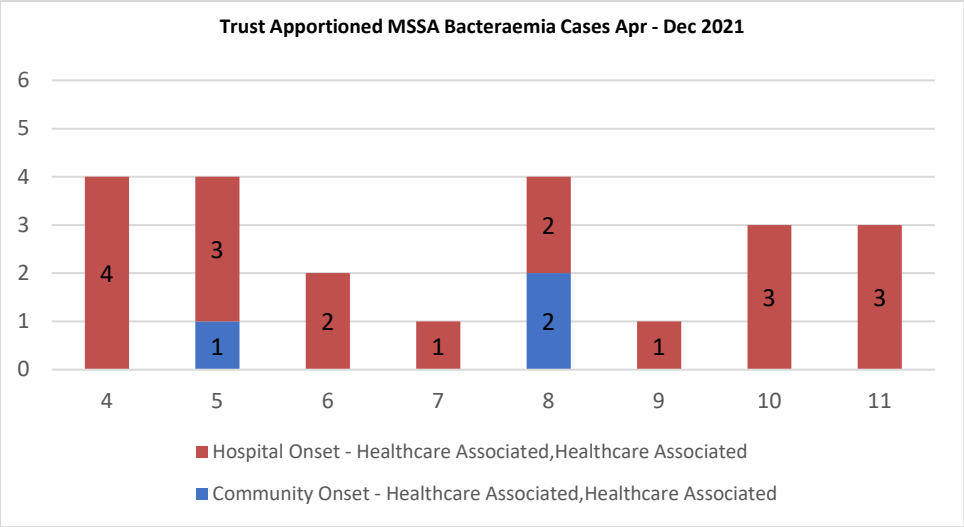


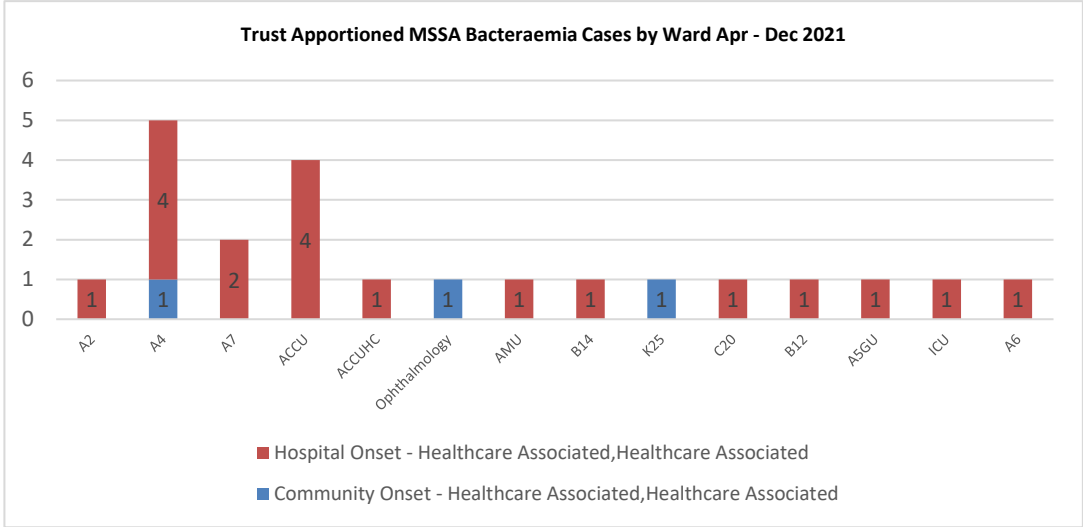


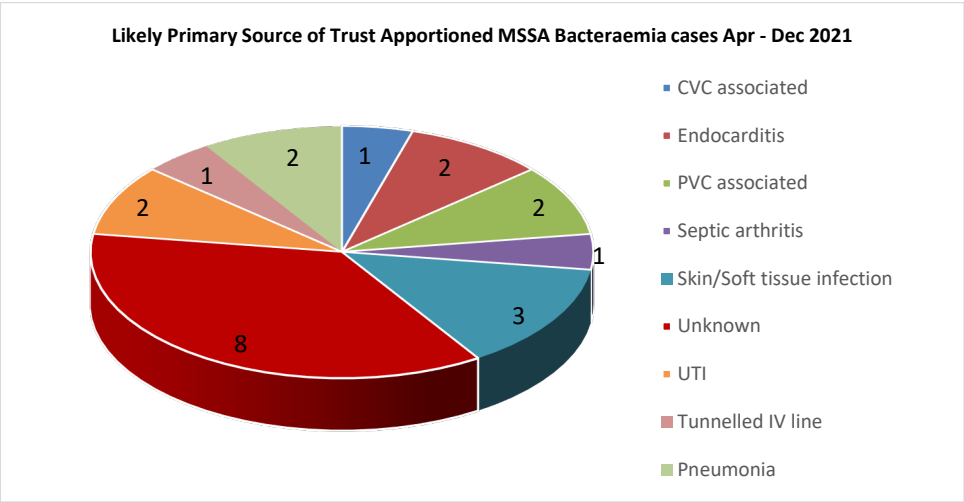


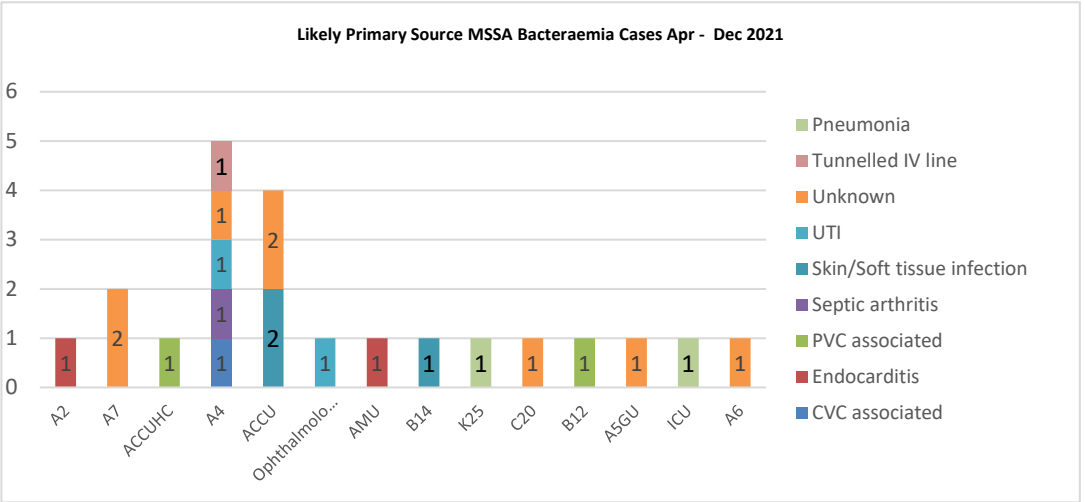
Gram Positive Bloodstream Infection: Meticillin Sensitive Staphylococcus aureus (MSSA)

No Threshold set









Appendix 2 Comparison of Healthcare Associated Infection Data Across the Northwest

MRSA annual tables: healthcare associated cases & rates by Trust

Organisation Name	January to December 2021	Rate per 100,000 bed days	Significance
ALDER HEY CHILDREN'S NHS FOUNDATION TRUST	1	1.8	
BLACKPOOL TEACHING HOSPITALS NHS FOUNDATION TRUST	7	3.2	
BOLTON NHS FOUNDATION TRUST	2	1.0	
COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST	1	0.7	
EAST CHESHIRE NHS TRUST	1	1.0	
EAST LANCASHIRE HOSPITALS NHS TRUST	3	1.0	
LANCASHIRE TEACHING HOSPITALS NHS FOUNDATION TRUST	1	0.4	
LIVERPOOL HEART AND CHEST HOSPITAL NHS FOUNDATION TRUST	0	0.0	
LIVERPOOL WOMEN'S NHS FOUNDATION TRUST	0	0.0	
LIVERPOOL UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	1	0.2	Low (0.001)
MANCHESTER UNIVERSITY NHS FOUNDATION TRUST	15	2.4	
MID CHESHIRE HOSPITALS NHS FOUNDATION TRUST	2	1.0	
NORTH CUMBRIA INTEGRATED CARE NHS FOUNDATION TRUST	1	0.6	
PENNINE ACUTE HOSPITALS NHS TRUST	3	1.2	
SALFORD ROYAL NHS FOUNDATION TRUST	7	1.9	
SOUTHPORT AND ORMSKIRK HOSPITAL NHS TRUST	2	1.8	
ST HELENS AND KNOWSLEY TEACHING HOSPITALS NHS TRUST	2	0.8	
STOCKPORT NHS FOUNDATION TRUST	1	0.5	
TAMESIDE AND GLOSSOP INTEGRATED CARE NHS FOUNDATION TRUST	3	2.5	
THE CHRISTIE NHS FOUNDATION TRUST	1	2.0	
THE CLATTERBRIDGE CANCER CENTRE NHS FOUNDATION TRUST	1	4.6	
THE WALTON CENTRE NHS FOUNDATION TRUST	0	0.0	
UNIVERSITY HOSPITALS OF MORECAMBE BAY NHS FOUNDATION TRUST	0	0.0	
WARRINGTON AND HALTON TEACHING HOSPITALS NHS FOUNDATION TRUST	0	0.0	
WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FOUNDATION TRUST	1	0.4	
WRIGHTINGTON, WIGAN AND LEIGH NHS FOUNDATION TRUST	3	2.0	
North West	59	1.2	

MSSA annual tables: Trust cases & rates

Organisation Name	January to December 2021	Rate per 100,000 bed days	Significance
ALDER HEY CHILDREN'S NHS FOUNDATION TRUST	17	31.1	
BLACKPOOL TEACHING HOSPITALS NHS FOUNDATION TRUST	45	20.7	
BOLTON NHS FOUNDATION TRUST	32	16.4	
COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST	22	15.2	
EAST CHESHIRE NHS TRUST	18	18.0	
EAST LANCASHIRE HOSPITALS NHS TRUST	68	23.4	High (0.025)
LANCASHIRE TEACHING HOSPITALS NHS FOUNDATION TRUST	39	14.4	
LIVERPOOL HEART AND CHEST HOSPITAL NHS FOUNDATION TRUST	10	25.0	
LIVERPOOL WOMEN'S NHS FOUNDATION TRUST	1	3.7	Low (0.025)
LIVERPOOL UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	87	16.6	
MANCHESTER UNIVERSITY NHS FOUNDATION TRUST	138	21.6	High (0.025)
MID CHESHIRE HOSPITALS NHS FOUNDATION TRUST	18	9.4	Low (0.025)
NORTH CUMBRIA INTEGRATED CARE NHS FOUNDATION TRUST	31	17.5	
PENNINE ACUTE HOSPITALS NHS TRUST	44	17.3	
SALFORD ROYAL NHS FOUNDATION TRUST	32	8.5	Low (0.001)
SOUTHPORT AND ORMSKIRK HOSPITAL NHS TRUST	17	15.3	
ST HELENS AND KNOWSLEY TEACHING HOSPITALS NHS TRUST	47	18.9	
STOCKPORT NHS FOUNDATION TRUST	23	12.2	
TAMESIDE AND GLOSSOP INTEGRATED CARE NHS FOUNDATION TRUST	16	13.4	
THE CHRISTIE NHS FOUNDATION TRUST	14	28.0	
THE CLATTERBRIDGE CANCER CENTRE NHS FOUNDATION TRUST	3	13.7	
THE WALTON CENTRE NHS FOUNDATION TRUST	12	30.5	
UNIVERSITY HOSPITALS OF MORECAMBE BAY NHS FOUNDATION TRUST	30	15.1	
WARRINGTON AND HALTON TEACHING HOSPITALS NHS FOUNDATION TRUST	26	14.7	
WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FOUNDATION TRUST	25	11.1	Low (0.025)
WRIGHTINGTON, WIGAN AND LEIGH NHS FOUNDATION TRUST	28	19.1	
North West	843	16.8	

C. difficile annual tables: cases & rates by Trust

Organisation Name	January to December 2021	Rate per 100,000 bed days	Significance
ALDER HEY CHILDREN'S NHS FOUNDATION TRUST	3	5.5	Low (0.001)
BLACKPOOL TEACHING HOSPITALS NHS FOUNDATION TRUST	112	51.5	High (0.001)
BOLTON NHS FOUNDATION TRUST	81	41.5	High (0.025)
COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST	60	41.4	
EAST CHESHIRE NHS TRUST	6	6.0	Low (0.001)
EAST LANCASHIRE HOSPITALS NHS TRUST	50	17.2	Low (0.001)
LANCASHIRE TEACHING HOSPITALS NHS FOUNDATION TRUST	119	43.8	High (0.001)
LIVERPOOL HEART AND CHEST HOSPITAL NHS FOUNDATION TRUST	8	20.0	
LIVERPOOL WOMEN'S NHS FOUNDATION TRUST	0	0.0	
LIVERPOOL UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	135	25.7	
MANCHESTER UNIVERSITY NHS FOUNDATION TRUST	176	27.6	
MID CHESHIRE HOSPITALS NHS FOUNDATION TRUST	32	16.7	Low (0.001)
NORTH CUMBRIA INTEGRATED CARE NHS FOUNDATION TRUST	52	29.4	
PENNINE ACUTE HOSPITALS NHS TRUST	73	28.7	
SALFORD ROYAL NHS FOUNDATION TRUST	38	10.1	Low (0.001)
SOUTHPORT AND ORMSKIRK HOSPITAL NHS TRUST	46	41.3	High (0.025)
ST HELENS AND KNOWSLEY TEACHING HOSPITALS NHS TRUST	54	21.7	
STOCKPORT NHS FOUNDATION TRUST	48	25.4	Low (0.025)
TAMESIDE AND GLOSSOP INTEGRATED CARE NHS FOUNDATION TRUST	39	32.6	
THE CHRISTIE NHS FOUNDATION TRUST	43	86.1	High (0.001)
THE CLATTERBRIDGE CANCER CENTRE NHS FOUNDATION TRUST	18	82.4	High (0.025)
THE WALTON CENTRE NHS FOUNDATION TRUST	9	22.9	
UNIVERSITY HOSPITALS OF MORECAMBE BAY NHS FOUNDATION TRUST	85	42.9	High (0.025)
WARRINGTON AND HALTON TEACHING HOSPITALS NHS FOUNDATION TRUST	40	22.7	Low (0.025)
WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FOUNDATION TRUST	68	30.3	
WRIGHTINGTON, WIGAN AND LEIGH NHS FOUNDATION TRUST	56	38.2	
North West	1451	28.9	

E. coli annual tables: cases & rates by Trust

Organisation Name	January to December 2021	Rate per 100,000 bed days	Significance
ALDER HEY CHILDREN'S NHS FOUNDATION TRUST	8	14.6	Low (0.001)
BLACKPOOL TEACHING HOSPITALS NHS FOUNDATION TRUST	96	44.2	
BOLTON NHS FOUNDATION TRUST	61	31.3	
COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST	35	24.1	Low (0.025)
EAST CHESHIRE NHS TRUST	31	31.0	
EAST LANCASHIRE HOSPITALS NHS TRUST	148	50.9	High (0.001)
LANCASHIRE TEACHING HOSPITALS NHS FOUNDATION TRUST	113	41.6	
LIVERPOOL HEART AND CHEST HOSPITAL NHS FOUNDATION TRUST	5	12.5	Low (0.001)
LIVERPOOL WOMEN'S NHS FOUNDATION TRUST	6	21.9	
LIVERPOOL UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	199	37.9	
MANCHESTER UNIVERSITY NHS FOUNDATION TRUST	219	34.4	
MID CHESHIRE HOSPITALS NHS FOUNDATION TRUST	32	16.7	Low (0.001)
NORTH CUMBRIA INTEGRATED CARE NHS FOUNDATION TRUST	102	57.7	High (0.001)
PENNINE ACUTE HOSPITALS NHS TRUST	74	29.1	
SALFORD ROYAL NHS FOUNDATION TRUST	60	16.0	Low (0.001)
SOUTHPORT AND ORMSKIRK HOSPITAL NHS TRUST	52	46.7	
ST HELENS AND KNOWSLEY TEACHING HOSPITALS NHS TRUST	90	36.2	
STOCKPORT NHS FOUNDATION TRUST	51	27.0	Low (0.025)
TAMESIDE AND GLOSSOP INTEGRATED CARE NHS FOUNDATION TRUST	49	41.0	
THE CHRISTIE NHS FOUNDATION TRUST	30	60.1	High (0.025)
THE CLATTERBRIDGE CANCER CENTRE NHS FOUNDATION TRUST	13	59.5	
THE WALTON CENTRE NHS FOUNDATION TRUST	12	30.5	
UNIVERSITY HOSPITALS OF MORECAMBE BAY NHS FOUNDATION TRUST	108	54.4	High (0.001)
WARRINGTON AND HALTON TEACHING HOSPITALS NHS FOUNDATION TRUST	62	35.2	
WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FOUNDATION TRUST	59	26.3	Low (0.025)
WRIGHTINGTON, WIGAN AND LEIGH NHS FOUNDATION TRUST	58	39.6	
North West	1773	35.3	

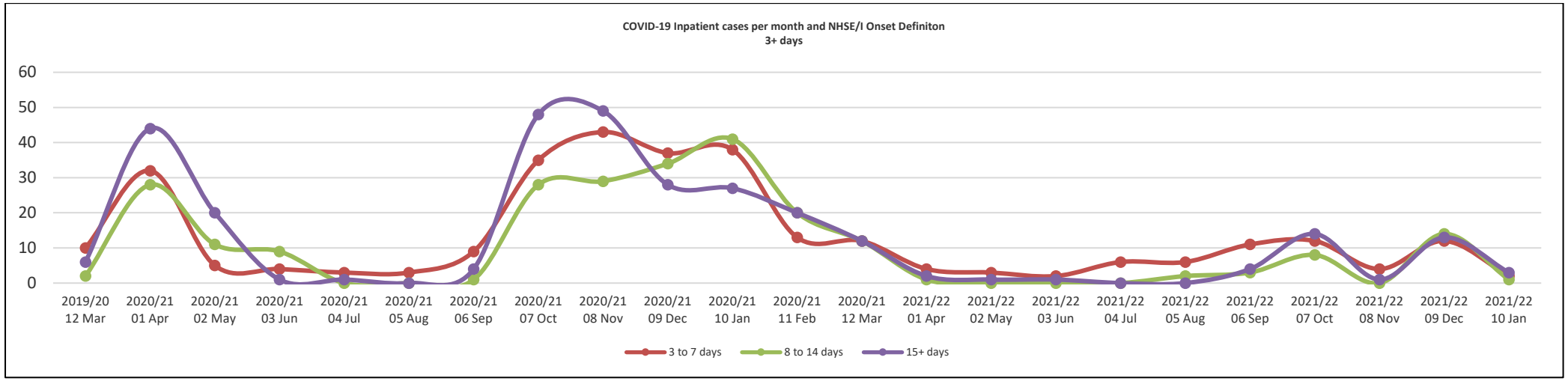
Klebsiella annual tables: Trust cases & rates

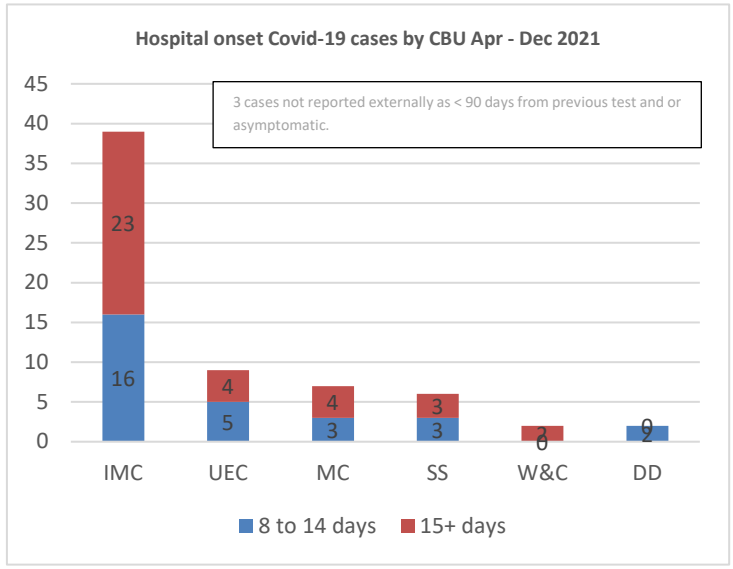
Organisation Name	January to December 2021	Rate per 100,000 bed days	Significance
ALDER HEY CHILDREN'S NHS FOUNDATION TRUST	18	32.9	High (0.025)
BLACKPOOL TEACHING HOSPITALS NHS FOUNDATION TRUST	52	23.9	High (0.025)
BOLTON NHS FOUNDATION TRUST	12	6.2	Low (0.001)
COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST	25	17.2	
EAST CHESHIRE NHS TRUST	4	4.0	Low (0.001)
EAST LANCASHIRE HOSPITALS NHS TRUST	57	19.6	
LANCASHIRE TEACHING HOSPITALS NHS FOUNDATION TRUST	30	11.1	
LIVERPOOL HEART AND CHEST HOSPITAL NHS FOUNDATION TRUST	1	2.5	Low (0.001)
LIVERPOOL WOMEN'S NHS FOUNDATION TRUST	0	0.0	
LIVERPOOL UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	93	17.7	
MANCHESTER UNIVERSITY NHS FOUNDATION TRUST	146	22.9	High (0.001)
MID CHESHIRE HOSPITALS NHS FOUNDATION TRUST	12	6.3	Low (0.001)
NORTH CUMBRIA INTEGRATED CARE NHS FOUNDATION TRUST	29	16.4	
PENNINE ACUTE HOSPITALS NHS TRUST	45	17.7	
SALFORD ROYAL NHS FOUNDATION TRUST	39	10.4	Low (0.025)
SOUTHPORT AND ORMSKIRK HOSPITAL NHS TRUST	16	14.4	
ST HELENS AND KNOWSLEY TEACHING HOSPITALS NHS TRUST	23	9.2	Low (0.025)
STOCKPORT NHS FOUNDATION TRUST	25	13.2	
TAMESIDE AND GLOSSOP INTEGRATED CARE NHS FOUNDATION TRUST	17	14.2	
THE CHRISTIE NHS FOUNDATION TRUST	19	38.0	High (0.025)
THE CLATTERBRIDGE CANCER CENTRE NHS FOUNDATION TRUST	8	36.6	
THE WALTON CENTRE NHS FOUNDATION TRUST	5	12.7	
UNIVERSITY HOSPITALS OF MORECAMBE BAY NHS FOUNDATION TRUST	22	11.1	
WARRINGTON AND HALTON TEACHING HOSPITALS NHS FOUNDATION TRUST	21	11.9	
WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FOUNDATION TRUST	21	9.3	Low (0.025)
WRIGHTINGTON, WIGAN AND LEIGH NHS FOUNDATION TRUST	18	12.3	
North West	758	15.1	

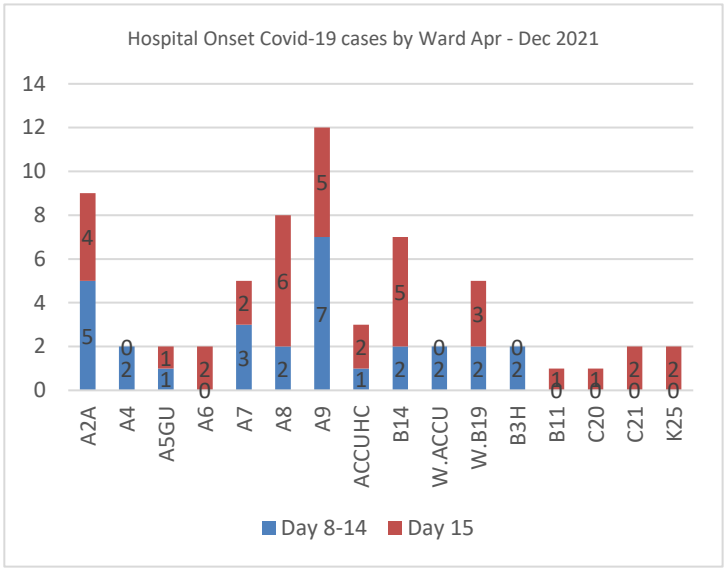
Pseudomonas aeruginosa annual tables: Trust cases & rates

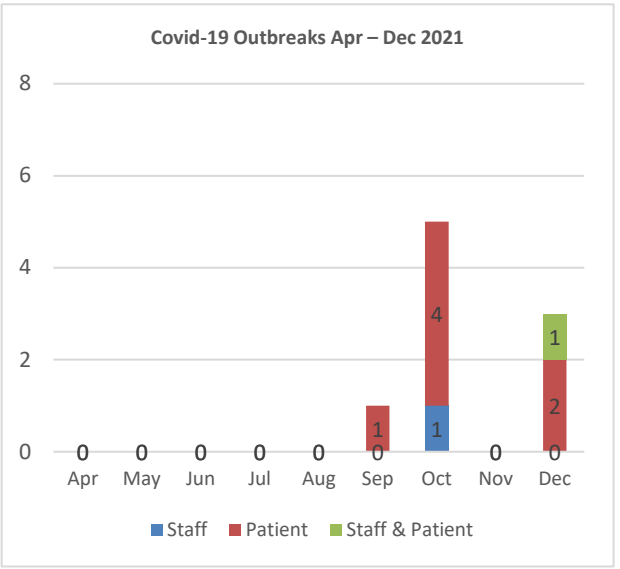
Organisation Name	January to December 2021	Rate per 100,000 bed days	Significance
ALDER HEY CHILDREN'S NHS FOUNDATION TRUST	2	3.7	
BLACKPOOL TEACHING HOSPITALS NHS FOUNDATION TRUST	21	9.7	High (0.025)
BOLTON NHS FOUNDATION TRUST	2	1.0	Low (0.001)
COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST	10	6.9	
EAST CHESHIRE NHS TRUST	1	1.0	Low (0.025)
EAST LANCASHIRE HOSPITALS NHS TRUST	7	2.4	Low (0.025)
LANCASHIRE TEACHING HOSPITALS NHS FOUNDATION TRUST	16	5.9	
LIVERPOOL HEART AND CHEST HOSPITAL NHS FOUNDATION TRUST	2	5.0	
LIVERPOOL WOMEN'S NHS FOUNDATION TRUST	0	0.0	
LIVERPOOL UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	22	4.2	
MANCHESTER UNIVERSITY NHS FOUNDATION TRUST	50	7.8	High (0.025)
MID CHESHIRE HOSPITALS NHS FOUNDATION TRUST	1	0.5	Low (0.001)
NORTH CUMBRIA INTEGRATED CARE NHS FOUNDATION TRUST	15	8.5	
PENNINE ACUTE HOSPITALS NHS TRUST	10	3.9	
SALFORD ROYAL NHS FOUNDATION TRUST	11	2.9	Low (0.025)
SOUTHPORT AND ORMSKIRK HOSPITAL NHS TRUST	8	7.2	
ST HELENS AND KNOWSLEY TEACHING HOSPITALS NHS TRUST	13	5.2	
STOCKPORT NHS FOUNDATION TRUST	2	1.1	Low (0.001)
TAMESIDE AND GLOSSOP INTEGRATED CARE NHS FOUNDATION TRUST	8	6.7	
THE CHRISTIE NHS FOUNDATION TRUST	16	32.0	High (0.001)
THE CLATTERBRIDGE CANCER CENTRE NHS FOUNDATION TRUST	0	0.0	
THE WALTON CENTRE NHS FOUNDATION TRUST	2	5.1	
UNIVERSITY HOSPITALS OF MORECAMBE BAY NHS FOUNDATION TRUST	13	6.6	
WARRINGTON AND HALTON TEACHING HOSPITALS NHS FOUNDATION TRUST	7	4.0	
WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FOUNDATION TRUST	8	3.6	
WRIGHTINGTON, WIGAN AND LEIGH NHS FOUNDATION TRUST	4	2.7	
North West	251	5.0	

Appendix 3 Covid-19 Cases









Appendix 4 Action Plan Revised Cleanliness Standards

RAG

Purple	Action not initiated
Red	Action initiated but missed deadline, review required
Amber	On track but risk to meeting target date
Green	On track to meet target date
Blue	Action completed; assurance provided

No	Lead	Mandatory requirements	Actions	RAG	Target Date	Current Position (Assurance)	Completion Date
1	IPC and FM	Replace 4 risk area categories (VHR, HR, Significant and LR) with 6 functional risk categories.	Move current 4 categories into 6 for the purposes of monitoring and agree with IPC.		December 2021	Areas allocated to 6 new categories - FR1-FR6. Agree with IPC.	
2	Head of Facilities	Revision of the 2007 cleaning frequencies	Complete gap analysis of current cleaning frequencies against new ones.		January 2022	Completed FR1. FR2-6 to complete.	
3	Head of Facilities	Identify 50 elements requiring cleaning and produce cleaning specification	Complete cleaning specification for 50 elements.		January 2022	Completed FR1. FR2-6 to complete.	
4	Lead Nurses, IPC, FM	Produce a schedule of cleaning responsibilities	Agree cleaning responsibilities and produce a matrix.		February 2022	Draft Roles and responsibilities document awaiting sign off	
5	IPC Team, FM, PE, Comms	Implement a Star rating system for display in Wards/ departments	Review star rating poster Agree process and locations of display		March 2022	Reviewed poster	
6	IPC Team, FM, Lead Nurses		Agree star rating rectification escalation process flowchart		March 2022	Not yet started	
7	Lead Nurses, IPC, FM, PE	Develop a management efficacy audit to provide assurance	Produce Trust audit. Agree frequency		May 2022	Not yet started	

No	Lead	Mandatory requirements	Actions	RAG	Target Date	Current Position (Assurance)	Completion Date
		that cleaning is being carried out effectively.	Agree MDT Team with patient rep				
8	IPC Team, FM, PE, Comms	Display a Commitment to cleanliness charter	Edit suggested template Agree location of display		March 2022	Partially complete	
9	Facilities Contracts Manager	Consider use of IT to carry out auditing	Assess available software Suppliers and produce a BC for funding		April 2022	One Supplier reviewed. Business plan being produced to secure funding.	

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/22/03/41**			
SUBJECT:	**Learning from Experience, Quarter 3**			
DATE OF MEETING:	30th March 2022			
AUTHOR(S):	Layla Alani, Director Governance and Quality			
EXECUTIVE DIRECTOR SPONSOR:	Kimberley Salmon-Jamieson, Chief Nurse & Deputy Chief Executive			
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	SO1 We will.. Always put our patients first delivering safe and effective care and an excellent patient experience. SO2 We will.. Be the best place to work with a diverse and engaged workforce that is fit for now and the future SO3 We will ..Work in partnership with others to achieve social and economic wellbeing in our communities.			x
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): **(*Please DELETE as appropriate)***	reputation, financial impact and below expected patient experience. **#1215** Failure to deliver the capacity required caused by the ongoing COVID-19 pandemic and potential environmental constraints resulting in delayed appointments, treatments and potential harm **#1289** Failure to deliver planned elective procedures caused by the Trust not having sufficient capacity (Theatres, Outpatients, Diagnostics) resulting in potential delays to treatment and possible subsequent risk of clinical harm.			
EXECUTIVE SUMMARY ***(KEY ISSUES):***	The following report provides an overview of the Learning from Experience Report. The information within the Learning from Experience report is extracted from the Datix system and other Clinical Governance reports for Incidents, Complaints, Claims, Health & Safety and Clinical Audit related to Quarter 3, 2021/22			
PURPOSE: ***(please select as appropriate)***	Information	Approval	To note x	Decision
RECOMMENDATION:	The Board of Directors is asked to note the contents of the paper.			
PREVIOUSLY CONSIDERED BY:	**Committee**	Quality Assurance Committee		
	Agenda Ref.			
	Date of meeting	22 March 2022		
	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	Learning from Experience	AGENDA REF:	BM/22/03/41

1. BACKGROUND/CONTEXT

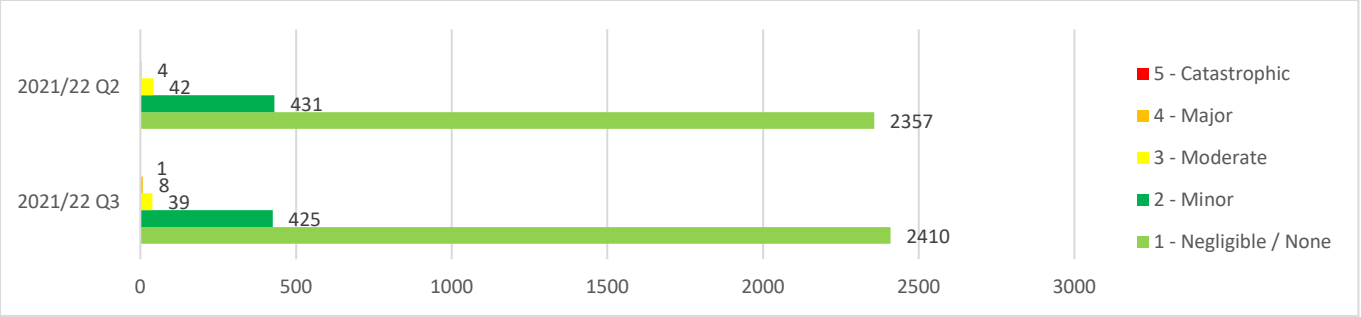
This report relates to the period 1st October to 31st December 2021 (2021/22 Q3). It contains a quantitative and qualitative data analysis (using information obtained from the Datix risk system) of incidents, complaints, claims, health & safety and clinical audit. The report includes a summary of themes, trends and key findings identified in Quarter 3 with specific recommendations to support learning across the organisation.

2. KEY ELEMENTS

a. Learning from Incidents

Reporting Position

There was a 1.73% positive increase in incident reporting across the Trust in 2021/22 Q3 (2834 in 2021/22 Q2 vs 2883 in 2021/22 Q3). There was a marginal increase in incidents causing moderate to catastrophic harm in 2021/22 Q3 (46 in 2021/22 Q2 vs 48 in 2021/22 Q3). The number of no harm incidents reported increased by 2.25% in Q3. Incident reporting is within normal variation.



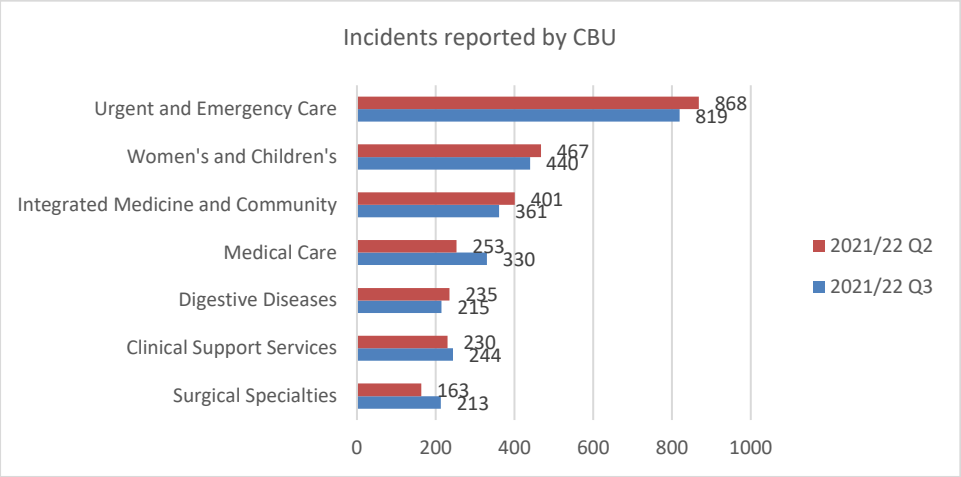
The above graph shows that one incident was deemed as catastrophic in Q3. 8 were deemed as major. 39 were deemed as moderate and the rest minor or negligible. The incident deemed as catastrophic was noted for general surgery. However, it is important to note that incidents should not be defined by their 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 2622 incidents were reported across the 6 CBUs and Clinical Support Services in Quarter 3, this has increased from 2617 when compared to Quarter 2.

In Quarter 3, Urgent and Emergency care reported the highest number of incidents (819), this was also the case in Quarter 2, a likely consequence of the increased activity being experienced nationally. Of those reported in Quarter 3, 99.51% of these were minor or negligible harm. This demonstrates that the Urgent and Emergency Care CBU is promoting a culture of positive incident

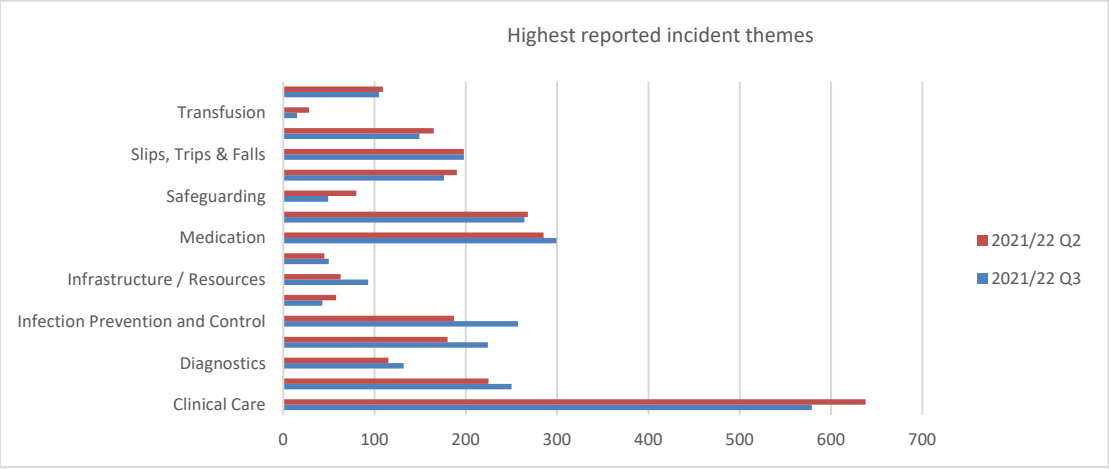
reporting. Integrated Medicine and Community has reported 361 incidents in Quarter 3 when compared to 401 in Q2. This is a decrease of 11% but is still within statistical control. In order to improve reporting culture further, the report to improve campaign continues to be shared on a weekly basis with the CBU via the governance managers. The governance managers also offer a daily prompt to all CBUs when reviewing incidents. In addition, bespoke Datix training will be offered by the senior administrator for Datix over the next Quarter. A 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 infection prevention and control, health and safety and infrastructure/ resources increased in Q3. Incidents reported relating to clinical care, safeguarding and staffing decreased in Q3.

As per the below graph, incidents relating to clinical care continue to be the most commonly reported at 579 and 96.72% of these incidents were minor or negligible harm. When we look at these figures relating to clinical care incidents reported in Quarter 3 (560 reported, 96.71% minor or negligible harm) and also those reported in Quarter 2 21/22 (619 reported, 97.02%), we can demonstrate that WHH continues to evidence a positive reporting culture.



<u>Incident Themes</u>

In Quarter 3 there has been a significant positive increase in the number of infection prevention and control incidents reported (37.4%). This is indicative of the on-going work of the infection prevention

& control team in fostering a culture of increased vigilance around infection control across the organisation and incident reporting when there is not. In order to support this on-going piece of work, the Quality Improvement Team have developed a Gram-Negative Bloodstream Infections (GNBSI) collaborative. The aim of this collaborative is to reduce healthcare associated GNBSI by 5% by March 2022 and will focus on hot spot areas as noted within the Datix system. Reduction of GNBSI has been identified as a 2021/22 Trust quality priority. A change package outlining evidence-based interventions will be developed in Quarter 4 (revised due to operational pressures), for all wards to implement. Work is also in progress to update and develop relevant trust wide policies and training.

Serious and Concise Incidents closed within Quarter 3

There were 5 Serious Incidents closed within Quarter 3. This is a decrease from Quarter 2, where there were 7 Serious Incidents closed. This indicates a positive reduction, as the number of serious harms has reduced by 29% which has meant that less serious incident reports are open on the system to close.

There were 14 concise incidents closed within Quarter 3, this is a decrease from Quarter 2, where 23 concise incidents were closed. This indicates a positive reduction, as the number of moderate harms has reduced by more than 45% which has meant that less concise reports are open on the system to close.

Learning from Incidents and Assurance

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

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

Patients appointments not received due to human factors
There were two RCAs that related to patient who had been lost to follow-up due to human factors.

Colposcopy:
The contributory factors within the RCA was that there were gaps in knowledge about tasks required to be completed and a lack of communication in the changeover of staff who were managing the bookings. In order to address the omissions a Standard Operating Procedure (SOP) was developed as a step-by-step guide for staff completing Colposcopy follow-up appointments and a weekly check to ensure safety netting was in place (see appendix for SOP and snap shot below).

Breast:
The other RCA in Breast related to patient lost to follow-up, after had a consultant had left the Trust. There was no clear process in realigning the Consultants caseload. The RCA identified missed opportunities to ensure that patients within this group were allocated. As a result of this incident,

there is formalised escalation processes between the appointments team and the CBU's to ensure information is being escalated and shared with the relevant staff. This SOP is audited on a monthly basis.

Colposcopy Standard Operating Procedure – Administrative Team			
Lead executive	Chief Operating Officer		
Author's details	Suzanne Johnson, Lead colposcopy nurse Anna Howard, Senior Nurse/Cervical Screening Provider Lead		
Type of document	Standard Operating Procedure		
Target audience	Women's Health Patient Access Team, Colposcopy Clinicians. Appointments Team 4		
Document purpose	To ensure colposcopy appointments are booked in line with NHSCSP KPI target. To ensure administrative processes are followed and protocols adhered to by all staff		
Ratification meeting	Appropriate governance meeting		
Approving meeting	Local SOP		
Implementation date	Monday, 16 December 2019	Review date	15 December 2024
WHH Documents to be read in conjunction with			
Document change history			
Version	1.1		
What is different?	Change in cytology services		
Appendices/electronic forms			
What is the impact of change?	This will ensure robust systems in place for escalation of colposcopy patients.		
Training requirements	For Outpatients appointments teams to be aware of breach dates and to flag which cannot be made within that time frame. CSPL to ensure administrative are updated on any changes to NHSCSP KPI targets		
Keywords	Colposcopy. Administrative. Appointments. KPI		

*A copy of the full SOP is included as appendix one within this report

Inadequate Documentation

4 of the RCAs completed in Quarter 3 found that documentation errors or omissions were root causes or direct contributory factors in the incidents. In order to address the documentation omissions identified in the Digestive Diseases RCA relating to documentation, whereby comfort rounds and body maps were incomplete, a pressure ulcer collaborative was commenced within the CBU, and a test of change implemented through link nurse involvement. Device checklists have been implemented and rolled out across the Trust. This supports the monitoring of patient skin when devices are in use and key areas to monitor (see appendix 2). There have been no other RCAs noted within the quarter relating to this trend, but this is monitored centrally via Governance and any on-going trend will be highlighted.

There was a Women's & Children's RCA relating to the maternity unit closure. One of the issues picked up in the investigation was that children and midwifery guidance does not give clear instruction in relation to when a trust is nearing full capacity. This should result in internal escalation, however, does not provide a proforma to capture actions taken to address amber concerns. It was therefore felt that there was no clear communication trail and decision log when in amber status and what proceeding actions were taken. The actions taken were the introduction of a Maternity Escalation Flow Chart to support staff decision making (appendix 3).

Communication

2 out of the 5 RCAs found issues identified with communication between teams. The first RCA was a Surgical RCA whereby a patient had an uncontrolled major haemorrhage and passed away as a result. The findings of the report were that there was no clear direction from the specialist teams when advice was sought. As a result of this and to improve communication an educational meeting between the vascular network and the trust has been organised to discuss the management of major haemorrhage and vascular emergencies, February 2022.

Another report which relates to communication was an acquired pressure ulcer on Ward A4. Issues that were identified were miscommunication between the Emergency department Ward A4 and the Tissue Viability Team. Actions put in place to support communication between areas was the Launch of a change package supported by the Quality Improvement Team and a Stop the Pressure Day. This was also supported by the Chief Nurse, visiting wards and sharing this communication. Ward A9 were awarded certificates for achieving milestone dates without pressure ulcers.

Safety Alerts

WHH uses the daily safety brief to share learning on a wider scale, these are shared Trust wide via communications, and noted as pop-ups on computer screens and shared at daily staffing huddles. The below table provides examples of Safety Alerts issued by the Trust via the daily safety brief following incidents that occurred or were investigated in Quarter 3:

Subject	Detail	Date issued
Infection risk when using FFP3 respirators with valves or Powered Air Purifying Respirators	A National Patient Safety Alert was issued which highlighted that staff performing aerosol generating procedures were at risk of infection due to the FFP3 masks not providing sufficient protection. **Action:** The alert was shared via the daily safety huddle starting on 26 October 2021 and continued to be shared throughout November 2021. Posters were created and distributed across the Trust to highlight this to staff and this information was cascaded by the senior clinical staff among their teams. **Assurance:** We will know that this communication has had the desired impact by monitoring the number of incidents relating to this.	26/10/21
Importance of Fit testing	An anonymous concern was raised with the Health and Safety Team in regard to clinical staff using masks which they have not been fit tested for. **Action:** A communication has been issued to give staff instruction on what action they must take to ensure they are acting in line with Trust policy and to keep themselves, their colleagues, and patients safe. All Clinical Governance Leads, Clinical Leads, Consultants, Head of Nursing, Matrons, Ward Manager and Heads of Departments were asked to print off the Safety Alert and ensure this was communicated to staff within	20/12/21

	their areas of responsibility as part of all communication/health and safety briefings **Assurance:** We will know that this communication has had the desired impact by monitoring the number of incidents reported relating to this issue.	
Change to CSF sampling requirements	A change in process had occurred earlier in 2021 in regard to the collection bottles being used for samples. However, it was identified by the laboratory team that old kits were still in circulation, which meant that samples submitted using the old kits could not be accepted. **Action:** A communication was shared with all laboratory users to request them to return any old test kits and to explain the rationale behind this. Senior staff were asked to disseminate this information to their teams. **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.	23/12/21

Never Events

Never Events are incidents that are entirely preventable because guidance or safety recommendations providing strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers. The Never Event list (2018) is included for information as an Appendix (Appendix 3).

Never Events from this Quarter

There was 1 Never Event opened in Quarter 3 that was reported on 2nd November 2021. This is an increase from Q2, where there were no Never-Events opened or closed. Following the never event, an urgent Exec led debrief panel was arranged by the Director of Governance to ensure that actions were undertaken promptly.

The Patient underwent fixation of the right distal radius. On review of the patient at a planned follow-up appointment it was noted the screw guide for the wrist plate had been left in at the end of the operation.

Duty of Candour

Whilst the Trust maintains its position of 100% compliance with Duty of Candour, we continue to look at methods for improving our Duty of Candour processes to support patient experience. In Quarter 2, a standalone Duty of Candour policy was implemented. The Patient Safety Manager and Associate Director of Governance monitor and track Duty of Candour compliance as part of the Patient Safety Meeting that occurs weekly to provide assurance.

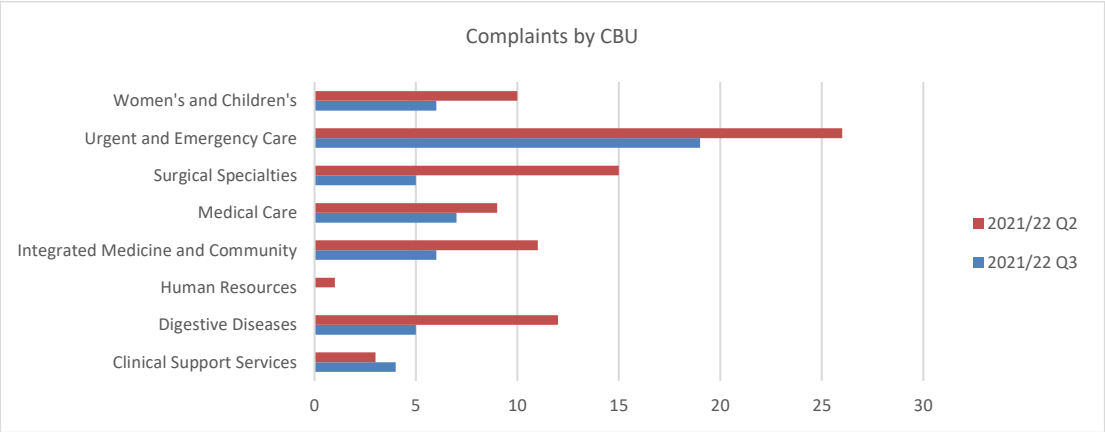
b. Learning from Complaints and PALS

Complaints

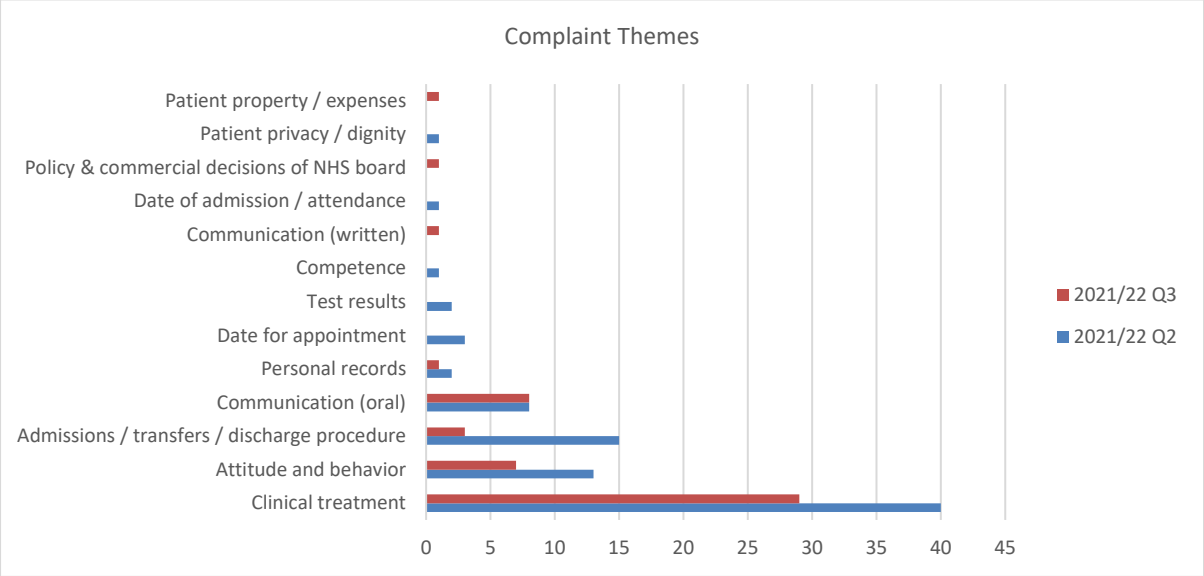
Complaints received

As per the below graph, there was a 40% positive decrease in complaints opened Trust-wide in Q3 (87 in Q2 versus 52 in Q3). This is a significant decrease from the same Quarter in 20/21, where 98

new complaints were received. The themes of these complaints are demonstrated in the graph further below. Clinical Support Services saw an increase in the complaints received. The remaining CBU's reported a decrease in their complaints.



The Themes of complaints received in Q2 vs. Q3 are outlined within the below chart. Clinical Treatment remains the most common theme of complaints received, however, the number of complaints relating to this theme have decreased significantly from 40 in Q2 to 29 in Q3. This is triangulated with the themes noted within incidents.

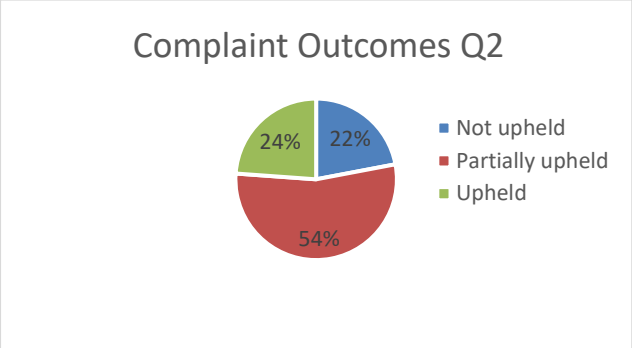


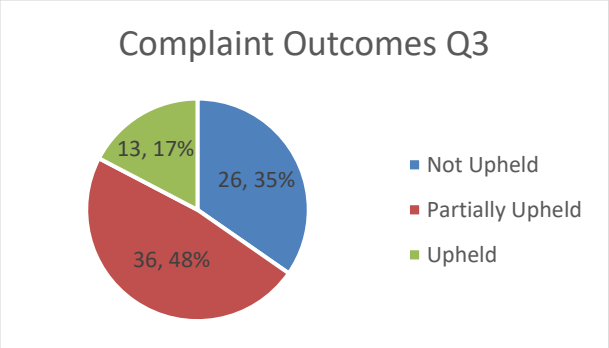
As previously reported the first impressions work is well underway which has begun to positively impact on the numbers of complaints received relating to attitude and behaviour as noted above (red line notes Q3).

The first impressions programme aims to use the 15 Step-challenge approach (methodology devised by NHSE/I in conjunction with patients and relatives) to improve how our hospitals look, sound and smell, to have a positive impact on how this makes our patients and relatives feel.

Complaints closed

There was a decrease in the number of complaints closed in the Trust in Q3 (90 in Q2 versus 75 in Q3). Clinical Support Services, Integrated Medicine and Community and Women's and Children's have increased the number of complaints closed in Q3. All of the other CBU's have decreased the number of complaints closed in Q3, this is a positive decrease as it is reflective of the reduction in number of complaints received. Urgent and Emergency Care has seen the highest decrease. The below pie charts demonstrate the outcomes for complaints closed in Q2 vs Q3. In Q3 a greater percentage of complaints were not upheld, indicating that complaint investigations are concluding that care and treatment provided has been appropriate despite concerns raised.





*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 Q3. The Trust had a target to respond to 90% of complaint on time and in Q3 the Trust continued to achieve 100%. The Trust currently has 0 breached complaints and there are no complaints over 6 months old. It is worthwhile noting that for the next reporting period, the Trust has the least number of complaints open in 4 years, at 35 open on the system (correct at time of reporting). This is a further reduction from 44 open complaints reported within the last LFE paper.

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

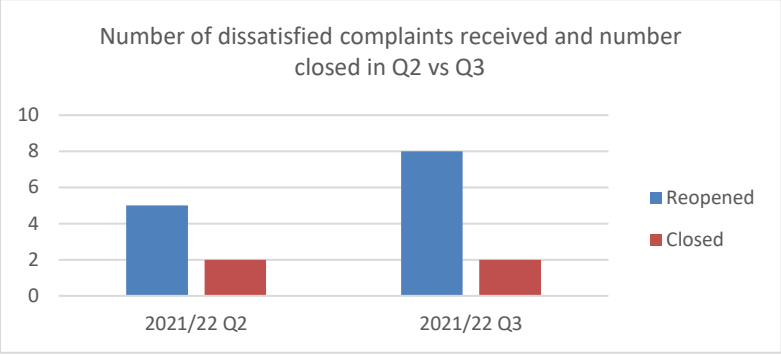
Actions resulting from Complaint investigations

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

You Said….	We Did….
Patients raised concerns in regard to not being kept up to date on ED waiting times.	ED have invested in a tannoy system, which includes an information board, that will provide patients in ED with important information, such as regular updates on current waiting times.
A complainant raised concerns that her father's diaphragmatic hernia had been identified on a CT scan in March 2020 but he had not been made aware of this or follow-up arranged.	The Trust acknowledged that hernias of this type are extremely rare and that hernias of this type if flagged may result in further monitoring or treatment being considered. A change in process has been implemented whereby if a hernia of this type is noted on a scan, an alert is sent to the reporting clinician to request a referral is made to the specialist team for assessment and management as appropriate.
A patient attended the ED following a sexual assault and the appropriate pathways were not correctly followed.	A summary guide was produced by the senior ED Team in December 2021 to give staff clearer direction on the steps to be followed when a patient presents with allegations of rape/sexual assault. Training around the bloodborne virus pathway (which forms part of the assessment that should be undertaken in these circumstances) has been added to the bespoke ED staff training package.

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.

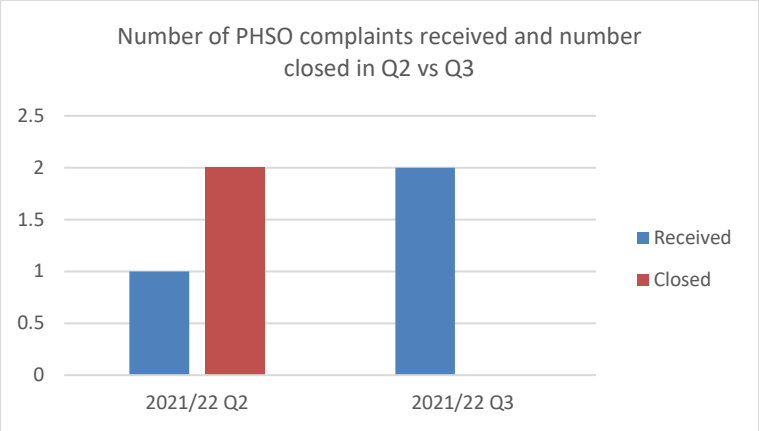


It is noted that whilst a higher number of dissatisfied complaints were received in Q3 than Q2, 6 of the 8 dissatisfied complaints were requests for meetings, where the complainant wished to discuss the answers previously given in written form. Each of the dissatisfied cases received had initially been offered a meeting but had declined. This further demonstrates that encouraging complainants to attend resolution meetings increases the likelihood of the complaint being resolved to the

satisfaction of the complainant without additional responses being required. The other 2 dissatisfied complaints were anticipated, due to the nature of the complaints and further responses have since been issued and the complaints closed.

PHSO Complaints

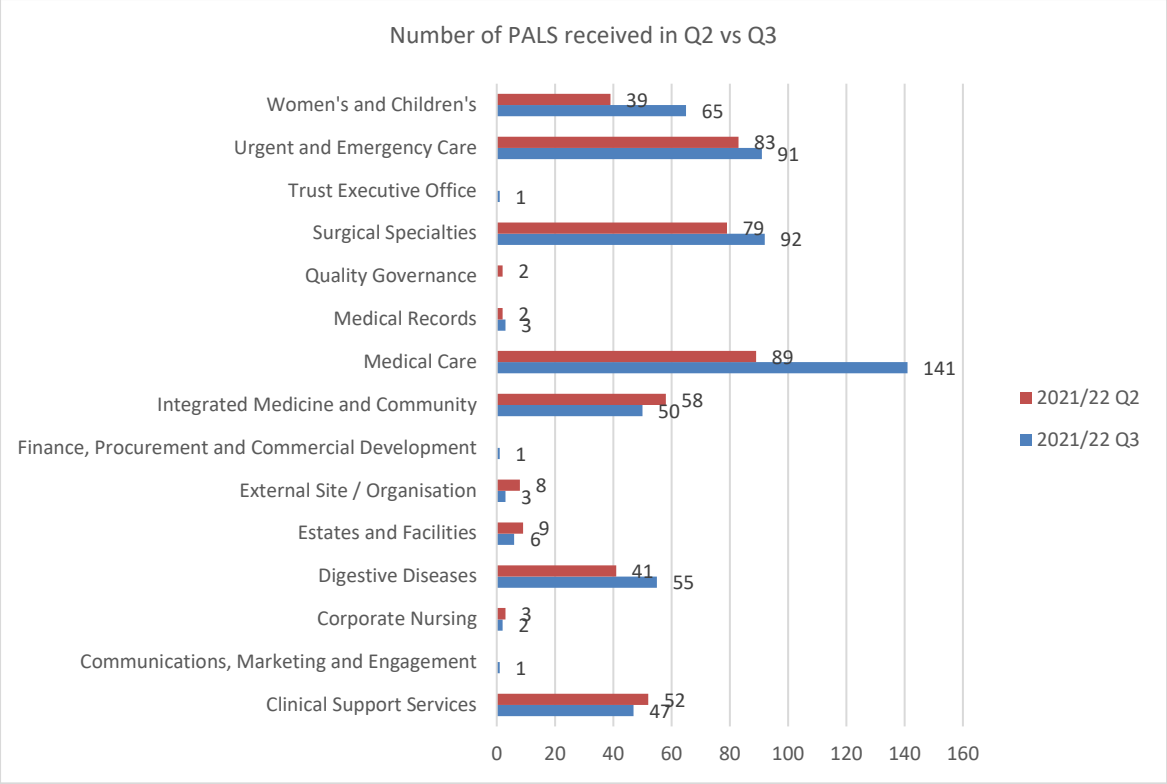
The number of PHSO complaints received within Q3 remained low. PHSO complaints continued to be dealt with in a timely manner. There have been no PHSO complaints closed within Q3 as the investigations being undertaken by the PHSO have not yet concluded.



PALS

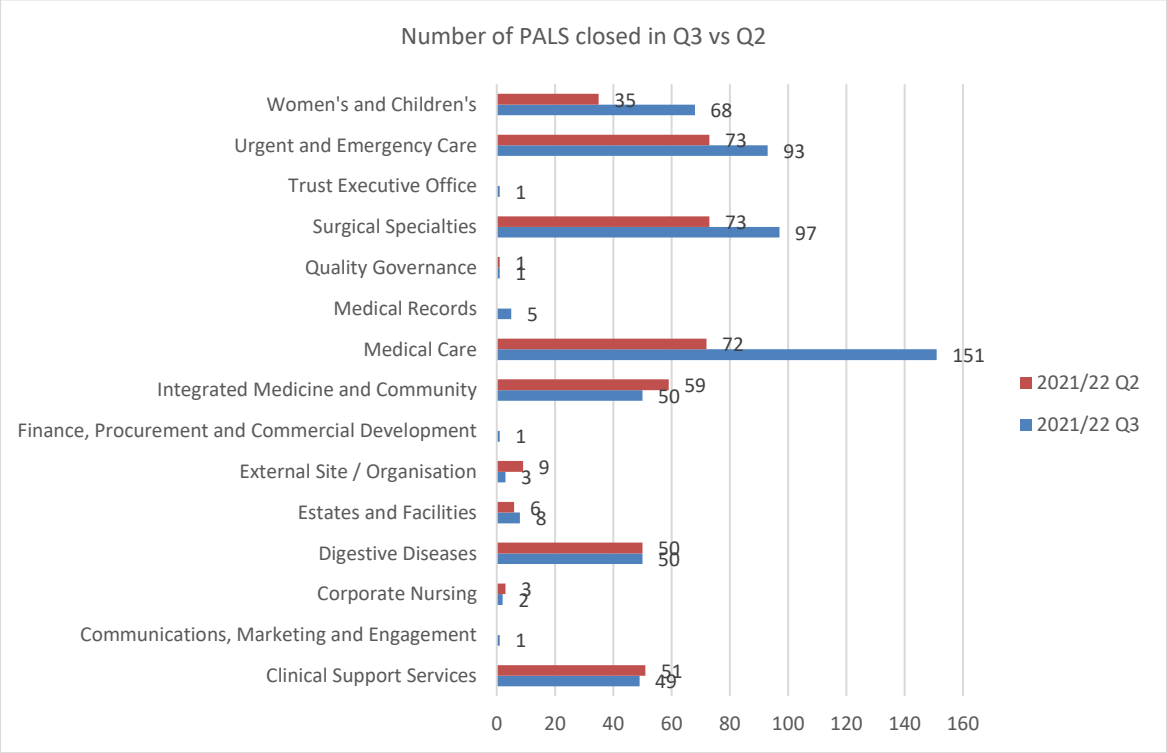
PALS received

There were 558 new PALS received in Q3, an increase from the 465 received in Q2. The below chart demonstrates the breakdown of PALS received for each service. Whilst the number of PALS has increased formal complaints have reduced indicating a positive improvement.



PALS closed

In Q3 we closed 580 PALS cases, compared with 432 closed in Q2. The below chart demonstrates the breakdown for PALS closed for each service.



PALS relating to the Medical Care CBU saw the biggest increase in cases closed in Q3, with 151 cases closed, compared with 72 closed in Q2. The increase is due to an increase in PALS received within

the quarter. Of the 151 closed in Q3, 22 of these were initially opened in Q2. Of the remainig 129 which were received in Q3, the most notable increases in themes for Medical Care were:

- 6 Admissions and Discharges informal concerns (compared with 0 closed in Q2)
- 6 Patient property (compared with 0 closed in Q2)
- 61 Communication (oral) (compared with 31 closed in Q2)

Of the 61 communication (oral) related PALS received and closed in Q3, 28 of these were relating to telephone communication. These cases related to relatives not being able to get through to wards for updates, patients struggling to get through to the appointment teams or secretaries or relatives not receiving update phone calls as previously agreed. For Women's and Children's, communication (oral) is also the biggest theme for cases closed in Q3 (19 an increase from 8 in Q2), with telephone communication being the most common sub-subject (9 compared to 3 in Q2). Communication (oral) was also the biggest theme for cases closed for Urgent and Emergency care in Q3 (34 compared to 21 in Q2) with telephone communication being the most common sub-subject (15 compared to 9 in Q2). As the theme of telephone communication is common across the Trust, the Head of Complaints, PALS and Legal Services has shared this data with the Patient Experience Team and a meeting is due to take place on 17th February 2022 to discuss targeted workstreams to be implemented to address this across the CBUs.

Actions resulting from PALS cases

You Said….	We Did….
A patient's family raised concerns in regard to visiting, as they had not been allowed to visit their mother who was receiving end of life care.	Discussions were held with the ward involved to reiterate that patients receiving end of life care are exempt from the visiting restrictions in place. A communication was also shared via the daily safety huddle to communicate to all staff what the latest restrictions and exemptions are. The case was also discussed at the Patient Experience Sub-Committee to highlight the concerns at a senior level and members of the committee further shared the learning with their teams.
A patient's daughter raised concerns in regard to the provision of wheelchairs at the front entrance.	The Patient Experience Team carried out a review of the accessibility of wheelchairs at the main entrance, to assess what measures can be introduced to improve the availability of wheelchairs out of hours. The Welcome Team are now in place at Warrington Hospital and one of their duties is to ensure wheelchairs are available at all patient entrances across the site.

c. Learning from Claims

Clinical Claims

Clinical Claims Received

There were 14 clinical claims received in Q3. This is a decrease from Q2, where 34 clinical claims were received.

Clinical Claims Closed

28 Claims were closed in Q3, 7 of which were with damages (totalling £340,905.77) (excluding the costs of instructing Trust solicitors). This is not a concerning feature as the number of claims remain stable. Damages were lower in Q3 than Q2 as fewer claims were closed and the values of the claims closed were lower on average than the previous quarter.

CBU/Speciality	Damages paid	No of Claims
Clinical Support Services	£7,000.00	1
Radiology	£7,000.00	1
Treatment, procedure	£7,000.00	1
Digestive Diseases	£25,500.00	2
Gastroenterology	£12,500.00	1
Accident/Incident that may result in in	£12,500.00	1
General Surgery	£13,000.00	1
Access, Appointment, Admission, Tran	£13,000.00	1
Urgent and Emergency Care	£308,405.77	4
Acute Medicine	£24,600.00	1
Diagnosis, failed or delayed	£24,600.00	1
Emergency Medicine	£33,805.77	2
Diagnosis, failed or delayed	£33,805.77	2
MIU	£250,000.00	1
Treatment, procedure	£250,000.00	1
Grand Total	£340,905.77	7

Non-Clinical Claims (Employee Liability/Public Liability)

Non-Clinical Claims Received

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

Non-Clinical Claims Closed

There were 2 employer Liability Claims closed in Quarter 3. One claim was successfully repudiated whilst the other was closed with damages totalling £3,600 (excluding costs).

CBU/Speciality	Damages Paid
Digestive Diseases	**3600**
Accident/Incident that may result in injury / harm	**3600**

Improvements and changes arising from Claims

Following claims investigations for claims closed in Quarter 3, 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.

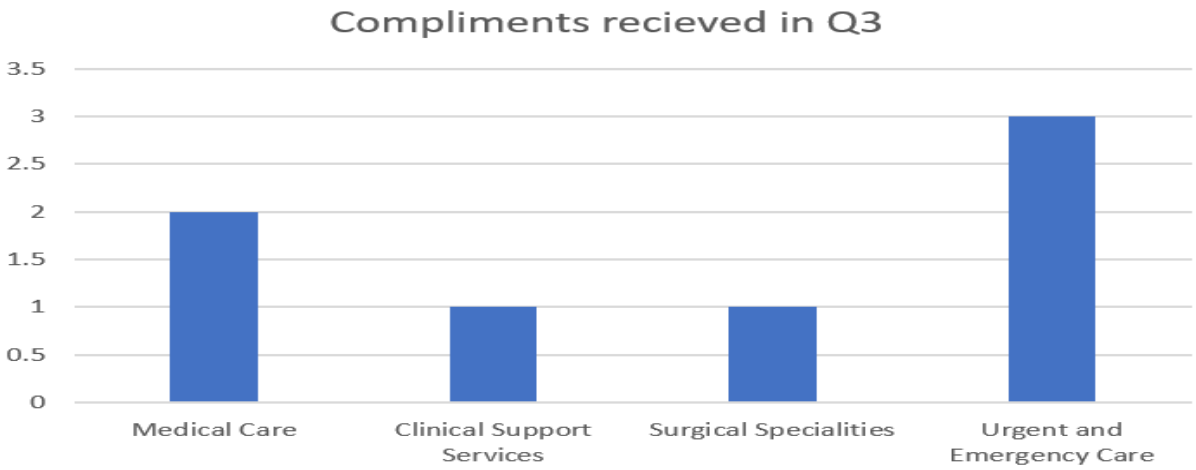
Failure to complete formal capacity assessment resulting in fall
Within Q3, a claim was closed where it was determined that the patient's capacity had not been assessed and was therefore not taken into account when assessing the patient's risk for falls. In response to this all of the nursing staff on the ward received re-training on the Enhanced Care Policy. It was also reiterated to the staff that completion of the Enhanced Care risk assessments documentation must be completed outside of the bay to ensure that whilst staff are in the bay, their focus is on the patients. The individual nurses involved also received updated training on Mental Capacity Assessments. The mental capacity training is a wider piece of work that is led by the Safeguarding Team. There has been no trend noted in terms of claims relating to capacity assessments.

Failure to diagnose appendicitis
A claim was settled where it was admitted that there had been a failure to diagnose a patient's appendicitis. In response to this, updated guidance was issued to the medical staff to inform them of the need to consider appendicitis as a differential diagnosis for abdominal pain in the elderly as it can be atypical in its presentation. Medical staff have been advised as part of the updated guidance that in elderly patients with abdominal pain and rising inflammatory markers who are not improving medical staff should consider early senior surgical review and consider ordering a CT abdomen and Pelvis. This was shared with all staff via the CBU governance meeting.

Failure to interpret scan images
The Trust settled a claim whereby there was a failure to identify metastases on a CT scan. Following this, the case was discussed at the Radiology Events and Learning Meeting (REALM) where the features of the scan were reviewed. As part of the REALM meeting, complaints, incidents and claims are discussed and plans are implemented for any themes arising, such as additional training sessions or a review of processes in place. Learning from the REALM meeting was disseminated to the wider team via the CBU governance meeting as to how the scan could have been interpreted so as to identify the presence of the metastases.

d. Learning from Compliments

A positive safety culture is one where compliments are fed back to staff in the same way that investigations are. Compliments are a really useful tool for the Trust to be able to identify what areas are working well. In Q3 the Trust received 7 compliments, this compares with 13 compliments which were received in Q2



It has been identified that Compliments are often received within letters of complaint, whereby the patient or relative will take the time to acknowledge the positive impact of staff members involved in their care. This positive feedback is also shared with the CQC. In order to ensure that these compliments are being captured and accurately recorded, the Head of Complaints is undertaking a deep dive review of complaints and the results of this will be available in the Q4 LFE report.

e. Learning from the CBUs

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

Medical Care

We found….

A patient was due to be prescribed an anticoagulant as an inpatient. The consultant arranged for the request to be put through on the electronic prescribing system. The medication was added to the prescribing system but the full prescription form hadn't been completed and so the patient did not receive the anticoagulant. The patient developed a Pulmonary Embolism.

We Acted….

- Clinicians have been advised to confirm all medications are correctly prescribed before finishing the electronic prescription.
- A daily pharmacist is now assigned to the wards to check and fulfil prescriptions in a timelier manner.
- The daily handover checklist has been updates so that all patient medications are checked.

Integrated Medicine & Community

We found….

A patient's blood glucose was not checked at bedtime or overnight. As a result, the patient's discharge was delayed as the medical team were unable to suggest any adjustments to the patient's insulin regime without the required readings. It was identified that the ward had been staffed by agency staff who reported not being trained around the processes in place to complete blood glucose tests.

We Acted….

- The incident was shared via the weekly safety brief for wider learning
- A Step-by-step guide was developed and made available to the agency and agency staff working on the ward of how to escalate any staffing issues or lack of appropriately trained staff.

Clinical Support Services

We found….

A sample was submitted with an ICE form that did not clearly indicate who had requested the test. The results were sent to the patient's GP advising that the carcinoembryonic antigen test (CEA)performed had come back as abnormal. The GP queried with the speciality whether the results had been sent for information only and the query from the GP was not picked up, resulting in a two-month delay to follow up.

We Acted….

- A communication was issued via a safety huddle to advise all staff of the issues possible with the manual blood forms and direct staff to appropriate training resources.
- As part of the safety alert staff were advised that blood request profiles can be created for each speciality to make using the ICE system easier.
- It was acknowledged that letters to the GP should be clearer to advise if the GP is expected to follow up. An on-going review is underway within the CBU to look at introducing 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….

- The process within the ED has now been changes so that all majors' patients and known diabetic patients have a blood sugar taken on admission.
- A Triage education programme is being developed to look 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….

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

Digestive Diseases

We found….

A patient had a delay of eight weeks in undergoing 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
- The CBU is exploring the possibility of introducing iron deficiency anaemia clinics.

Women's & Children's

We found….

A baby was born with hemolytic disease of the newborn and needed to be transferred to a specialist unit for treatment. Baby has since recovered. The mum was Rhesus negative blood group and had become sensitised during pregnancy (meaning that she had developed positive antibodies for the disease during pregnancy), which is a rare event.

We Acted….

- The process in the laboratory has been strengthened to ensure all women who have positive antibodies in pregnancy, require regular follow up; if there is a high level of antibodies, the laboratory will refer blood samples for more in-depth analysis.
- awareness has been raised with the Obstetricians and Midwives around the significance of women who have positive antibodies and the follow up that would be required.
- The laboratory reports have been updated to include the detail relating to the cause for the positive antibodies and the follow up required.

f. Learning from our Staff

Health & Wellbeing

One of the Trust's People objectives is to create conditions to promote wellbeing and enable an engaged workforce to improve patient and staff experience. The Trust's intranet's section "Supporting you – Mental Health & Burnout" offers staff support the different campaigns and workstreams on-going to ensure staff feel supported in looking after their mental health. These campaigns have been designed in response to feedback received from staff in regard to what matters to them. A section on self-care has been added to these pages, which provides staff with resources on how to practice self-care.

Staff Thank you Awards

The Thank you Awards ceremony was held at the end of Q3 and celebrated the achievements of Trust staff. The ceremony is an opportunity for the Trust's senior team to thank staff at all levels of the Trust for their hard work and dedication. The Awards also encourage staff engagement and help staff to feel recognised for their efforts.

Bright Spots

The Bright Spots section is within the daily Trust-wide Safety Brief and is an opportunity to recognise the efforts of our staff and thank them for their hard work. The table in Appendix 3 provides examples of some of the staff featured in the Bright Spots section in Q3.

g. Learning from Patient Experience

Continued focus on learning from patient experiences:

- Introduction of digital stories to drive quality improvement.
- Meetings with community partners and follow up complaint meetings with service users to continually learn and act on experience to improve outcomes.
- Service user and community engagement event with Healthwatch Warrington and the Warrington Deaf Centre to discuss improvements in access to British Sign Language (BSL). A deep dive into the Trust BSL provision will be undertaken in quarter 4.
- Enhancing 'Customer Service' training by utilising the lived experience of patients to inform content from PALS and Complaints meetings.

Friends & Family test Feedback

The Patient Experience Team continues to gather feedback via the friends and family test. Recent feedback provided in relation to Ward C20 has been largely positive and quotes from the feedback have been given as follows:

h. Learning from Clinical Audit

National Audits

National Joint Registry

Summary:

The National Joint Registry (NJR) collects information about hip, knee, ankle, elbow and shoulder joint replacement operations (arthroplasty) from all participating hospitals. The registry's purpose is to record patient information and provide data on the performance and longevity of replacement joint implants; the surgical outcomes for the hospitals where these operations are carried out; and on the performance outcomes of the surgeons who conduct the procedures. The data presented is in relation to clinical activity during the 2020 calendar year, the year that was audited.

Results:

Warrington performed 33 procedures during 2020.
All results are within or above the expected range.

Quality Measure		This Hospital	National Expected	Worse than Expected / EXPECTED RANGE / NATIONAL EXPECTED / Better than Expected
Compliance (for the Trust)	Better Than Expected	97.7%	95.0%	
Revision Compliance (for the Trust)	Better Than Expected	100.0%	95.0%	
Consent	As Expected	84.8%	90.0%	
Valid NHS number	Better Than Expected	100.0%	95.0%	
Time taken to enter data	As Expected	27 Days	30 Days	

Overall Warrington is performing well within the 'expected' range for hip, knee, elbow and shoulder replacement surgery. Warrington are also performing 'better than expected', in the majority of

quality measures. Consent and time taken to enter the data is within 'expected' range. This however is an improvement on the previous year's report where consent was 'worse than expected'

Data Quality:
The display also shows a result for data entry delay. This indicates whether the hospital is submitting their information in a timely way. This is important so that the NJR can report an accurate and full picture of performance to hospitals, the surgeons who work there as well as to patients and the public. Data for 1 April 2019 - 31 March 2020.

Future Trajectory and Recommendations
It is anticipated that in the next 5 years, the percentage of 6-month assessments carried out will be maintained above the national average at approximately 60% of applicable stroke patients if the rate of improvement continues from 2018-19 to 2019-20 for which plans are in place .

Local Audits

Re-audit of Yield of Adequate Microcalcification at Stereotactic Vacuum Biopsies (VABs) of the Breast

Summary:

Breast cancer is one of the most common cancers in the UK with 55,200 cases per year. Clustered suspicious microcalcifications found on imaging can be a sign of malignancy particularly typical for DCIS (ductal carcinoma in situ). Vacuum assisted biopsies (VABs) are an excellent alternative to surgical biopsies as it is usually performed under imaging guidance and can be performed upright, prone or supine. The standards recommended to ensure adequate calcification removal and sampling is for optimum number of 5 or more flecks of calcium per sample and for 3 or more cores containing calcium on a specimen radiograph:

An audit performed in 2019 showed that 50% of 1st VABs had less than 5 calcification flecks.

A retrospective study was completed auditing cases from January 2021- June 2021. Randomly selected 75 patients who were seen in breast screening clinic or those referred to symptomatic breast clinic were chosen.

Key Findings:

Findings in 2021

- 100% of patients had 3 cores taken
- 100% of patients had 2nd line VAB for B3 results
- 72 out of 74 VABs had 5 or more calcification flecks (97.30%)

The results show an improvement of number of calcification flecks obtained compared to 2019 Only 2 out of 74 sampled had <5 flecks.

Recommendation:

The importance of adequate sampling and the correlation of this with sensitivities/specificities of malignancies is reiterated at team meetings and the improvement is to be measured again in 2-3 years by undertaking a re-audit.

Assurance Rating*:

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

*The assurance rating is assessed by looking at the level of risk to the patient/service/department/Trust if action is not implemented; the measures put in place, and the likelihood of a consequence occurring given the measures that have been implemented.

i. Quarterly Learning Piece

Quality Priorities

Simon Constable, Chief Executive, shared a Good Morning message on 27th January 2022 from Layla Alani, Director of Integrated Governance and Quality. The message looked back on the challenges in 2021 and acknowledged the exceptional teamwork within the Trust that has allowed the Trust to deliver a high standard of care to patients. The message detailed the domains of quality and touched on some of the work undertaken in the previous year and requested staff input in helping the Trust to select meaningful quality priorities for the year ahead.

Last year areas of focus included improving the care of patients with Learning Disabilities for which a strategy was devised, implementation of the Serious Illness Care Programme, factors associated with DNA CPR and methods by which to strengthen CBU governance.

Staff were encouraged to complete the Stakeholder Consultation Survey via the following link:

https://www.surveymonkey.co.uk/r/S53KFQM

Through filling in this survey, all staff across the organisation could voice their views to direct the focus for the quality agenda for the coming year.

j. Workstreams for Quarter 3

Action Planning

On review of the actions arising from RCAs and complaints investigations in Quarters 2 and 3, the Head of Complaints, PALS and Legal Services and the Patient Safety Manager have identified that action planning across the CBUs is not consistently S.M.A.R.T (Specific Measurable Achievable Realistic Timed). In the next Quarter, the Complaints and Patient Safety Teams will work in collaboration with the Governance Managers to implement S.M.A.R.T action plan training and a toolkit, to help action planners and owners set and complete meaningful actions. This will be monitored via the Quality Assurance Committee. Initial discussions into what the training package and toolkit are expected to achieve have taken place in Quarter 3 and this workstream is progressing in Quarter 4.

Complaints Monitoring and Improvement

The Head of Complaints, PALS and Legal services is liaising with senior CBU leaders in order to set dates for complaints training. Initial dates for training are planned for March 2022, with the first session planned to be delivered to staff in Clinical Support Services. The aim of these will be give staff in the CBUs information around how to handle concerns at first contact to reduce the number of formal complaints, and to look at how formal complaints and PALS can be responded to, to give the best outcome for our patients and their families. This also facilitates learning in real time.

In order to support training sessions and to give staff information that they can quickly access around responding to complaints and concerns, the Complaints and PALS Teams are in the process of developing toolkits. There will be three toolkits, due to be finalised in Q4 focussing on:

- Resolving concerns locally
- PALS
- Formal complaints

The formal complaints toolkit has now been approved and this will begin to be shared with the CBUs in Quarter 4.

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

The Complaints Quality Assurance Committee (QAG) continues to meet monthly, focussing on a different CBU each time. These meetings are an opportunity for the Chairman to review the Trust's complaints position, and for CBUs to reflect and feedback upon the quality and detail included within their responses. The QAGs held in Quarter 3 focussed on Digestive Diseases and Urgent and Emergency Care.

Complaints Satisfaction Service Questionnaire

This workstream has progressed in Quarter 3 and the questions for the questionnaire are currently with the Director of Governance for approval. The Questionnaire will be available in both a physical and electronic format so that it is accessible to more service users. The Questionnaire is expected to go live in Quarter 4. The information gathered from this survey will enable the Trust to understand what works well, and what can be improved, to better support our patients and families through the Complaints process. A sample of the questionnaire findings will be available in the next reporting period with learning identified and included in reporting to the Quality Assurance Committee.

Welcome Booklet

The Patient Experience Team are in the process of redesigning the Trust's "Welcome to our Hospitals" booklet. This booklet provides information for patients, relatives and carers on what to

expect from their hospital stay, from admission to discharge. It provides key details around topics including mealtimes, visiting and infection control. The booklet is being redesigned in collaboration with the Digital Communications Team, Complaints & PALS Team and Clinical Teams from each of the CBUs and seeks to address questions commonly asked by patients and relatives. This workstream was paused due to the rise of the Omicron variant, however, is scheduled to recommence in Q1 of 2022/23. This will allow for directives such as visiting to be updated in relation to Covid-19.

Staff involved in incidents – Survey

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

Hotline Phone

In Quarter 4, the Director of Governance, the Associate Director of Governance, the Head of Complaints, PALS & Legal Services will establish a Hotline phone service, that will give patients and their families access to a senior member of staff to resolve concerns in real-time. This is intended to provide prompt resolution to concerns as they are occurring and reduce the number of PALS and formal complaints received thus enhancing patient experience and patient safety.

3. RECOMMENDATIONS

The Board of Directors is asked to note the report.

Appendix 1 -Colposcopy Standard Operating Procedure

1. Patient Access Officer (PAO) will log onto the Colposcopy Mailbox and print out all direct referrals from Manchester Cytology Centre (MCC). The PAO will email/receipt to MCC. This email/receipt will also acknowledge that the number of referrals received correlate with the number of referrals sent. This receipt process is completed before midday daily. (Email address: nch-tr.ColposRefer@nhs.net). MCC follows up with a telephone call to the PA Office if they do not receive the return email/receipt by midday.

2. PAO dates referrals according to the abnormality grading marked by Cytology. All high grades (Borderline in endocervials, moderate or severe dyskaryosis, CGIN? Invasive cancer), are dated within 2 weeks' (14 days) as per NHSCSP KPI targets. All low grades are dated within 6 weeks. If KPI dates cannot be accommodated, the PAO, and the Senior Nursing Team will review options for creating capacity. This may be clinically reviewing existing booked patients for potential to moved/rescheduled to create extra capacity. Or alternatively, the team will explore providing extra clinics to create extra capacity. If these options do not optimize capacity the PAO will escalate this to the CBU Management team.

3. Choose and Book colposcopy referrals are received by the main appointments department. These are triaged daily by the Colposcopy Advanced Practitioners. Referrals not meeting Colposcopy clinic criteria will be redirected to the appropriate clinic. The Choose & Book referrals are then collected and actioned by the main outpatients department. The C & B staff (Appointment team 4) will escalate and capacity/slot issues to the PAO.

4. Patient enquiries: Patient Access Office contact number is listed on all patient letters. This contact number is manned 8.30am to 5.00pm Monday to Friday. A voicemail is provided if the line is engaged. The voicemail provides instruction to leave contact details including hospital unit number and a short message. All voicemail messages are responded to throughout the day by the PAO. The Clinical Business Unit administrator provides cross cover in the absence of the P A O for access to the nch-tr.ColposRefer@nhs.net maillbox.

5. If a patient cancels their initial appointment more than once the PAO informs the Consultant Team/Nurse Colposcopists. The referral will be clinically reviewed and a further appointment is sent if required. If the Nurse Colposcopist decides not to request a further appointment they will write to the GP and discharge the patient. If a patient has been referred through the Cancer Fast Track pathway, the PAO will inform Cancer Services of the consultant decision to remove them from the CFT lists.

6. Any telephone queries received by the Patient Access Team, secretarial and administrative team that concern results or clinical questions, then the patient's details and a brief content of the request is taken. These queries are passed onto the clinical team for them to contact the patient. Patients are advised that their message will be passed on to the clinical team that day and they will be contacted following clinical sessions. The clerical team will deliver written telephone messages to the Clinical Colposcopy Team for action the same day.

7. The clinician completes an E-outcome at the time of the patient being seen in the clinic. The outpatient reception teams depart the patient on Lorenzo adhering to the instructions on the E-outcome. The colposcopy patients are added to the appropriate access plan for follow-up. Appointments Team 4 in the outpatient booking team ensures all follow ups are made within the specified timescale. Any appointments which cannot be made within the specified timescale are escalated to the PAO. Capacity options as per Step 2 above are followed.

8. Appointments Team 4 will follow instructions on E-outcomes for follow up appointments. Clinicians must ensure treatment follow up requests clearly state timescales (i.e. within 4 weeks (28 days) from date of E-Outcome. If there are any difficulties with booking appointments, Team 4 will escalate to PAO to action.

9. The majority of results from colposcopy related procedures require a telephone follow up appointment to discuss their results. This appointment will be booked with the patient in clinic with date and time agreed verbally. A confirmation letter is also sent to the patient and the GP confirming the results and discussion. Follow up appointment requests from theatre procedures will be emailed to PAO by the Gynaecology secretary typing the theatre discharge letter.

Appendix 2 – Never Event List

The Never Event list (2018) as defined by NHS England is as follows (note: this list is not exhaustive):

1. Wrong site surgery
2. Wrong implant/prosthesis
3. Retained foreign object post-procedure
4. Mis-selection of a strong potassium containing solution
5. Administration of medication by the wrong route
6. Overdose of insulin due to abbreviations or incorrect device
7. Overdose of methotrexate for non-cancer treatment
8. Mis–selection of high strength midazolam during conscious sedation
9. Failure to install functional collapsible shower or curtain rails
10. Falls from poorly restricted windows
11. Chest or neck entrapment in bedrails
12. Transfusion or transplantation of ABO-incompatible blood components or organs
13. Misplaced naso- or oro-gastric tubes
14. Scalding of patients
15. Unintentional connection of a patient requiring oxygen to an air flowmeter

Appendix 3 – Bright Spots

Bright Spots examples

Staff/Area	Feedback	Date
Thank you, Lisa White from the PEF team	"She very kindly came over from Halton last week to run an extra student nurse assessor workshop specifically for our ED staff so that we can help support more students on placement. The workshop is going brilliantly, and staff will benefit massively. Thank you, Lisa!"	01/11/2021
Halton Porters	"The porters at Halton hospital are fantastic. They provide an amazing service and go out of their way to help my disabled dad get to the right department; this often means they are pushing his wheelchair as I am unable to help him. Halton is such a friendly and easily accessible hospital, but the willingness to help from both porters and security really takes the stress out of what would otherwise be a very stressful appointment. Thank you!"	18/11/2021
Acute care team and Ward A4	"Thank you to the Acute Care Team for supporting Ward A4 on 29th Nov. We had a complex very sick patient who required level 2 support to enable her to be managed safely. Due to bed pressures this couldn't be facilitated in HDU until the afternoon. The infusions and drugs required were administered on the ward for a prolonged period supported namely by Suzanne and Claire who were fantastic and monitored the patient throughout. Whilst they were on the ward this obviously caused their team to also be depleted and everyone continued in a professional manner despite the difficulties this created. It was an extremely challenging shift with pressures and boarded patients also, so a big thankyou to all involved in the shift	01/12/2021

	Thanks to Suzanne and Claire 😊I know the ward team and acute care team were also busy with another 2 patients at the time also Amanda thank you. Sue, you managed the ward brilliantly also yesterday with all the different challenges along with all the ward team.”	

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/22/03/42**	
SUBJECT:	**Ockenden Progress Update: Maternity Self Assessment Tool Position Paper**	
DATE OF MEETING:	30th March 2022	
AUTHOR(S):	Catherine Owens, Director of Midwifery/Associate 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. 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)***	**#145** Influence within Cheshire & Merseyside a. Failure to deliver our strategic vision, including two new hospitals and vertical & horizontal collaboration, and influence sufficiently within the Cheshire & Merseyside Healthcare Partnership and beyond, may result in an inability to provide high quality sustainable services may result in an inability to provide the best outcome for our patient population and organisation, potential impact on patient care, reputation and financial position. b. Failure to fund two new hospitals may result in an inability to provide the best outcome for our patient population and organisation, potential impact on patient care, reputation and financial position.	
EXECUTIVE SUMMARY ***(KEY ISSUES):***	This paper has been presented at Quality Assurance Committee and noted assurance following discussion in relation to Warrington and Halton Teaching Hospital (WHH) Ockenden update and the position of WHH when benchmarked against the Materntiy Self Assessment Tool. NHS England and NHS Improvement wrote to all maternity providers on 25th January 2022 to evidence a discussion with their Trust Board of Directors by March 2022 an update of its implementation of all Ockenden 7 Essential Safety Actions and Revised Maternity Self-Assessment Tool and maternity service workforce plans. A position paper was presented to Executive Team in December 2021 to identify where Warrington and Halton Teachings Hospital NHS Foundation Trust (WHH) had implemented the 7 Essential Safety Actions recommended by the Ockenden Report (2020) following WHH receipt of the phase 2 Ockenden individual provider report.	

<table>
<tr><td></td><td colspan="4">This report to the Trust Board provides an update on WHH Ockenden position using the revised Maternity Self-Assessment Tool:

The revised Maternity Self-Assessment Tool is a national assurance tool introduced to maternity providers in response to the Kirk Up Report (2015) and Ockenden Report (2020) and findings of outstanding Care Quality Commissioners (CQC) reports to support trusts to benchmark their services against national standards and best practice guidance.

The WHH benchmarking update aligns to the key themes identified within the recommended tool:
• directorate infrastructure and leadership
• multidisciplinary team dynamics
• governance infrastructure and ward-to-board accountability
• application of national standards and guidance
• safety culture across the Care Group and Trust
• comprehension of business and impact on quality.
The Tool identifies 174 criteria to be evidenced of which WHH can provide the evidence for 63% of the criteria. A detailed action plan has been developed to comply with all criteria. A trajectory to be 100% is on tract to be completed by 30th September 2022.
Trusts were provided with additional funding to increase the midwifery and medical workforce to support the implementation of the Ockenden recommendations. This paper will identify where WHH has utilised the funding received in its workforce plans.
This paper is asked to be noted for information</td></tr>
<tr><td>PURPOSE: (please select as appropriate)</td><td>Information
x</td><td>Approval</td><td>To note
x</td><td>Decision</td></tr>
<tr><td>RECOMMENDATION:</td><td colspan="4"></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/01/03/2022</td></tr>
<tr><td></td><td colspan="2">Date of meeting</td><td colspan="2">1st March 2022</td></tr>
</table>

	Summary of Outcome	Noted for information
FREEDOM OF INFORMATION STATUS (FOIA):	Choose an item.	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	Choose an item.	

REPORT TO BOARD OF DIRECTORS

SUBJECT	**Ockenden Update: Maternity Self-assessment position paper**	**AGENDA REF:**	**BM/22/03/42**

1. BACKGROUND/CONTEXT

NHS England and NHS improvement (NHSEI) wrote to all maternity providers in England on 25th January 2022 (Appendix 1) to ask that all Trust Boards were updated in relation to the implementation of the 7 Essential Safety Actions of the Ockenden recommendation 12 months on from the Ockenden Report in 2020 utilising the Maternity Self-Assessment Tool (Appendix 2). Also included are the workforce plans to underpin Ockenden recommendations.

The Maternity Self-Assessment Tool has been developed in response to national maternity review findings, including the Kirkup Report (2015) and recommendations for good safety principles within maternity services. The current tool has been further influenced by the findings of the Ockenden review (2020), 7 features of safety culture and the emerging themes from services on the safety support programme and the trusts found to be outstanding following Care Quality Commissioners (CQC) reviews in other maternity services across England.

The Maternity Self-Assessment Tool has been been designed for NHS maternity services providers to self-assess whether their operational service delivery meets national standards, guidance, and regulatory requirements.

The tool is underpinned with a philosophy of promoting a positive leadership and safety culture and to inform the Trust Board and c Commissioners of the current maternity quality improvement and safety programme.

2. KEY ELEMENTS

2.1 The Maternity Self-Assessment Tool

In July 2021 WHH submitted its evidence to demonstrate how the 7 Essential Safety Actions recommendations of Ockenden were implemented. WHH received its provider report in

October 2021 where WHH triangulated submitted evidence against the provider report. The report identified WHH were fully compliant with 84/124 criterion. A position paper was shared with the Executive Team on 18th January 2022. The Quality Assurance Committee is updated monthly re Ockenden as part of the monthly Safety Champions update report.

The tool differs from the initial Ockenden evidence request. It has been structured according to the six key areas important for the leadership and quality of maternity services that emerged in the diagnostic phase (year 1) of the Maternity Safety Support Programme (2018). These were:

- directorate infrastructure and leadership
- multidisciplinary team dynamics
- governance infrastructure and ward-to-board accountability
- application of national standards and guidance
- safety culture across the division and trust
- comprehension of business and impact on quality.

2.2 Benchmarking

WHH has undertaken an extensive review of the key areas of improvements identified in the Tool and developed an action plan to become fully compliant by 30th September 2022 (Appendix 3).

The Tool identifies 174 criteria of which WHH is compliant with 110, which equates to 63%. An extensive action plan has been developed as can be reviewed in Appendix 3. This action plan will be monitored at Women's and Children's Governance meeting monthly, and a senior management team Task and Finish Group will meet weekly to review and support implementation of all actions. The remaining actions are on trajectory to be completed by 30th September 2022. The action plan has also been added to the Women's and Children's Moving to Outstanding action plan which will also be reported monthly via the Trust Moving to Outstanding meeting.

The completed criterion identified will provide Trusts with a significant and detailed level of assurance that their local maternity service is safe and underpinned with outstanding leadership, effectiveness and extensive engagement with women and families, the multi-disciplinary team and Trust Board.

2.21 Themes of focussed workstream:

The Maternity Tool has been reviewed and identified the following themes for WHH Maternity team to further focus activity to provide the required evidence:

- Engagement with Maternity Voices Partnerships

- Development of a Maternity specific Risk Management Strategy
- Development of a Maternity specific Quality Improvement Programme
- Development of a Maternity Safety Plan
- Development of a Maternity specific SWARTZ Round.

WHH Women's and Children' CBU are collaborating with Trust engagement, risk management, quality and safety leads to ensure specific maternity strategies and improvement programmes are identified and aligned with WHH Trust plans, processes and existing strategies.

2.3 Workforce planning

Pivotal to the implementation of the national Maternity Transformation Programme and safety recommendations has been the financial investment from NHSEI /Ockenden monies to support Trusts to implement the necessary uplift in midwifery and obstetric workforce.

WHH has been pledged to receive £457,961.00 which has been allocated in incremental instalments.

The allocation of funding is as follows:

Role	Assumptions	Band	WTE	Pas	2021/22 Cost £'s	Recurrent Cost £'s
Midwifery						
Fetal Surveillance		Band 7	0.60		19,852	34,034
Perinatal mental Health		Band 7	1.00		33,561	57,537
Antenatal screening	1.00 WTE post with 0.40 WTE from existing funding	Band 7	0.60		19,852	34,034
Triage AMP's		Band 8a	1.00		46,241	79,275
Triage AMP's		Band 8a	1.00		39,079	66,996
Band 3 MSW		Band 3	1.00		14,360	23,839
			5.20	**-**	**172,945**	**295,715**
Medical Staffing						
Fetal Surveillance and training	4 hours per week covering fetal surveillance and training			1.00	8,663	12,995

Evening Ward Round	11.25 hours per week, cover over 52 weeks. Resident extended from 19:00 to 21:15			3.75	41,725	62,587
ATTAIN Review	4 hours per week			1.00	8,663	12,995
PRMT - Obs	Attending meetings and bereavement			0.50	4,228	6,342
PRMT - Neonatal	Attending meetings and bereavement			0.50	4,228	6,342
Monthly Perinatal meeting - Obs	2 hours per month - 10 meetings per annum includes admin			0.125	1,057	1,586
Monthly Perinatal meeting - Neonatal	2 hours per month - 10 meetings per annum includes admin			0.125	1,057	1,586
Neonatal safety champion	0.50 PA			0.50	4,228	6,342
Anaesthetic Support	1 PA			0.50	4,228	6,342
Obstetric Governance	0.50 PA (to create 1.00 PA in total, 0.50 PA Trust funded)			0.50	4,757	6,342
MDT training - medical	Medical Staff MDT training backfill				11,637	11,637
			-	**8.50**	**94,471**	**135,096**
MDT Training	MDT other (capped) @£300 per MW establishment				**26,880**	**26,880**
	Total				**294,296**	**457,691**
	Ockenden Funding Allocation				**294,297**	**458,323**

2.31 Rationale for Ockenden funding allocation:

Midwifery

1 WTE lead midwife in mental health to support the development of perinatal mental health care pathways at WHH in response to increased national gaps in Peri Natal Mental Health

(NMH) services and increasing associated clinical outcomes as reported by Mothers and Babies Reducing Risk Through Audits and Confidential Enquiries (MRRACE) reports year on year.

1 WTE Ante Natal Screening midwife to support and implement the national screening standards throughout the pregnancy continuum.

2 WTE Advanced Midwife Practitioners - this is a new role and will underpin the national safety agenda by providing advanced midwifery skills to women and families, implement safety standards and support the medical rota, examples include acting as a lead practitioner in ante natal and maternity triage services.

1 Fetal Surveillance midwife an essential role as stipulated by Ockenden recommendations.

Band 3 Maternity Support Worker (MSW) to support administrative duties associated with Ockenden implementation.

Medical rationale for Ockenden funding allocation

Number of medical Planned Activities (PA's) in relation to Ockenden is 8.5; each PA is a time period of 4 hours.

Maternity and neonatal planned activities implemented to meet Ockenden Safety Action 1 Enhanced Safety recommendation:

- Named obstetric lead for Governance
- Named Obstetric lead for Fetal Surveillance as per Ockenden essential recommendation
- Facilitate twice daily Ockenden ward rounds on birth centre to ensure Consultant led ward rounds are undertaken to oversea patient safety and communication
- Perinatal Mortality Review obstetric and neonatal activity to undertake reviews and attending local and regional meetings
- Maternity and Neonatal Safety Champion Role.

The Director of Midwifery/Associate Chief Nurse and Senior Business Accountant for Women's and Children's met with NHSEI, as part of a routine assurance meeting, to discuss Ockenden funding on Wednesday 9th February and update NHSEI how we had allocated funding and current position. This meeting was also attended by the Regional Chief Midwife. WHH was commended on its workforce plans and how the money has been allocated and has been requested to be a case study.

2.4 Next steps

The next national update report for Ockenden Phase 2 is expected on 22nd March 2022 on receipt of this WHH will review and benchmark its findings and make the necessary amendments to its action plan.

The Women's and Children's CBU will meet weekly with the senior management and leadership team to monitor the Maternity Self Assessment Tool action plan. The action plan will also be monitored via Women's and Children's Governance Meeting and added to the Moving to Outstanding plan.

2.5 Conclusion

NHSEI have requested that each Trust Board is updated before March 2022 in relation to how their organisation has implemented the 7 Essential Safety Actions as recommended by Ockenden in December 2020, 12 months on from the original report, using the Maternity Self-Assessment Tool.

WHH has updated the Maternity Self-Assessment Tool and confirmed evidence in relation to 110/174 of the criteria which equates to 63% and developed an action plan which will enable full compliance. The action plan is on trajectory to be 100% completed by 30th September 2022 . Currently no challenges seen to complete this plan.

NHSEI has provided WHH national financial funding of £458,323,00 which has been invested to recruit specialist midwives and increased planned obstetric and neonatal activity to ensure all 7 Immediate Safety Actions recommendation are embedded in to practice, a safe and learning culture and improve outcomes.

NHSEI have commended WHH for its utilisation of Ockenden funding to improve safety and requested to provide a case study.

The action plan will be monitored via Women's and Children's Governance meeting and added to the Moving to Outstanding action plan.

3 ACTIONS REQUIRED/RESPONSIBLE OFFICER

4 IMPACT ON QPS?

5 MEASUREMENTS/EVALUATIONS

6 TRAJECTORIES/OBJECTIVES AGREED

7 MONITORING/REPORTING ROUTES

8 TIMELINES

9 ASSURANCE COMMITTEE

This paper has been presented to the Quality Assusrance Committee (QAC) on 1st March 2022 and will be monitored via Maternity and Neonatal Materntiy Safety Champions monthly update as per Ockenden requirements. The findings of the Materntiy Self Assessment Toool have been added to the Women's and Children's Moving to Outstanding (M20) action plan and will also be moniotored monthly via local governance and corporate M2O meeting

10 RECOMMENDATIONS

The Board of Directors are asked to note this paper

- The current position in relation to WHH implementing the 7 Essential Safety Actions as per Ockenden recommendations using the Maternity Self-Assessment Tool.

- The current position of how the funding allocated by NHSEI to implement the Ockenden 7 Safety Actions have been utilised to increase the maternity and medical workforce.

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/22/03/43**	
SUBJECT:	**Quarter 3 2021/22 current position of the Avoiding Term Admissions Into Neonatal Units Programme (ATAIN)**	
DATE OF MEETING:	30th March 2022	
AUTHOR(S):	Catherine Owens, Director of Midwifery/Associate 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. 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)***	**#1134** Failure to provide adequate staffing caused by absence relating to COVID-19 resulting in resource challenges and an increase within the temporary staffing domain	
EXECUTIVE SUMMARY *(KEY ISSUES):*	This paper has been discussed at the Quality Assurance Committee and provided the committee assurance around the ATAIN position at Warrington and Halton Teaching Hospital (WHH) in Quarter 3 and improving ATAIN rates and the work undertaken by the maternity and neonatal teams at (WHH) to reduce the number of term babies admitted to the Neonatal Unit. The Avoiding Term Admissions in Neonatal (ATAIN) programme of work aims to reduce the harm leading to unavoidable admission of a term infant over 37+0 weeks. A central aim of the work is to prevent harm leading to separation of the mother and baby. The report will update the Board of Directors on the current WHH Quarter 3 position of the ATAIN programme and consequent action plan as outlined in the NHS Resolution Year 4 2021/22 Maternity Incentive Scheme (MIS) as per Safety Action 3: Transitional Care Activities and ATAIN. The Maternity Incentive Scheme (MIS) safety standards require an ATAIN action plan to have been agreed at Trust Board level in response to findings from ATAIN reviews. The action plan once approved by the Trust Board will also be shared with the Local Maternity and Neonatal System as well as the Integrated Care System as part of the external monitoring and assurance programme. WHH Q3 ATAIN rate is 5.2% WHH Q1 -3 ATAIN rate is 5.9% National ATAIN rate is 6%	

	North West Neonatal Operational Delivery Network trajectory is 5.6% This paper is asked to be noted for information and action plan approved.			
PURPOSE: ***(please select as appropriate)***	Information x	Approval x	To note	Decision
RECOMMENDATION:				
PREVIOUSLY CONSIDERED BY:	**Committee**	Quality Assurance Committee		
	Agenda Ref.	QAC/1/03/2022		
	Date of meeting	1st March 2022		
	Summary of Outcome	Approved and shared with BoD		
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None			

REPORT TO BOARD OF DIRECTORS

SUBJECT	Quarter 3 2021/22 WHH current position of the Avoiding Term Admissions Into Neonatal Units Programme (ATAIN)	AGENDA REF:	BM/22/03/43

1. BACKGROUND/CONTEXT

NHS Resolution is operating a fourth year of the Clinical Negligence Scheme for Trusts (CNST) maternity incentive scheme (MIS) to continue to support the delivery of safer maternity care.

This paper describes the current position against Safety Action 3 which relates to having the required transitional care services to support the Avoiding Term Admissions into Neonatal units Programme (ATAIN). More specifically, the ATAIN action plan should be shared with Trust Board, Local Maternity and Neonatal System (LMNS), and Integrated Care System (ICS) quality surveillance meetings.

The action plan addresses local findings from the ATAIN reviews of term admissions to the Neonatal Unit and improvement actions which are aligned to each modifiable and avoidable reason for admission.

The ATAIN action plan is requested to be approved by the Board of Directors at the March 2022 meeting. Progress of the approved action plan should be submitted to the LMNS and ICS quality surveillance meeting each quarter. The Maternity Service has received a request to submit an updated ATAIN action plan to LMNS by 4th March 2022. The action plan is due to be reviewed at the March 2022 Quality, Safety & Surveillance Group (QSSG).

2. KEY ELEMENTS

Avoiding Term Admissions into Neonatal units Programme (ATAIN)

The ATAIN objective is to reduce the number of unexpected term admission of infants >37 weeks to the neonatal unit (NNU). The national ambition is to ensure that term admission rates are below 6%. North West Neonatal Operational Delivery Network (NWNODN) has set a target of 5.6% for term admissions to neonatal units. This initiative is to keep mothers and babies together as much as possible and avoids separating them at the crucial time after birth.

The number of unexpected term admissions to neonatal units is seen as an indicator that preventable harm may have been caused at some point along the maternity or neonatal pathway. Admission to a neonatal unit can lead to unnecessary separation of mother and baby. Evidence suggests that separating mother and baby at or soon after birth can affect the positive development of the mother-child attachment process and adversely affect maternal perinatal mental health. It is therefore an area of focus for quality improvement and has been incentivised as part of the MIS Safety Action 3 standard.

WHH Annual Term Admission to NNU Trend

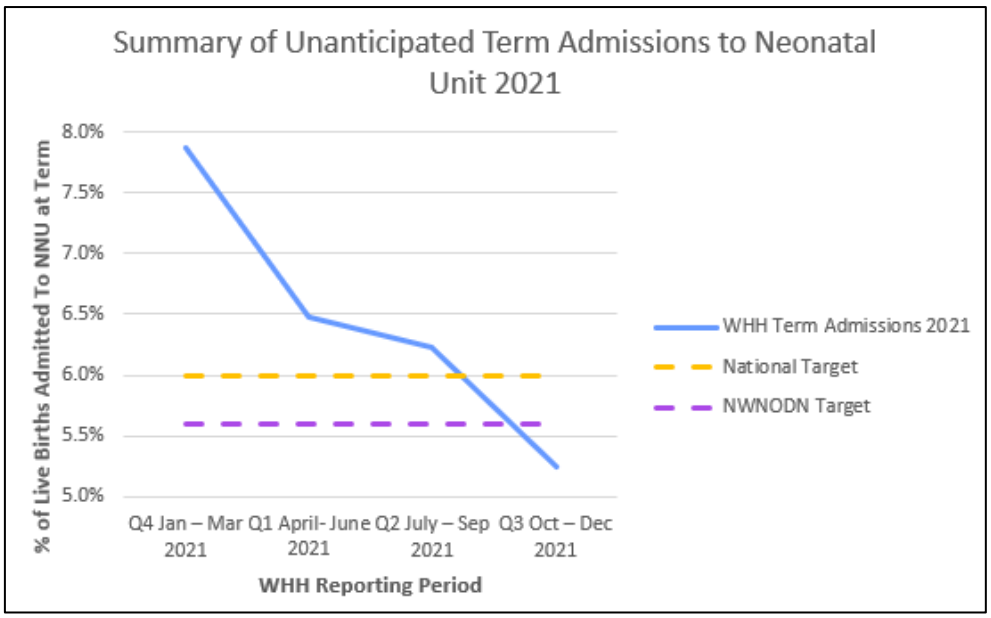
The following table represents the annual number of term babies admitted into the Neonatal Unit as a numerical value and as a percentage of total births during each year

	2017/18	2018/19	2019/20	2020/21	2021/22 (Quarters 1-3: Apr-Dec 2021)
Number of Term Admissions	253	190	159	148	119
Number of Live Births as a %	9.5%	7.1%	6.0%	5.9%	5.9%

Summary of unanticipated term admissions to Neonatal Unit 01/01/2020 – 31/12/2021

(Reporting quarters run from April to April)

WHH reporting period	Total Number of Live Births	Total Number of term admissions	Total Number of term admissions as a % of live births	National target 6%	NWNODN Target 5.6%
Q4 Jan – Mar 2021	597	47	7.9%		
Q1 April- June 2021	617	40	6.5%		
Q2 July – Sep 2021	706	44	6.2%		
Q3 Oct – Dec 2021	687	36	5.2%		
Totals	**2607**	**167**	**6.45%**		



Quarter 3 Admission Rates for Term Babies to WHH Neonatal Unit 01/01/2021 – 31/12/2021

Admission rates have consistently reduced year on year; however, the decrease has slowed this year. Quarter 4 (2020/21) showed a term admission rate of 7.9%, which is high and considered to have some correlation to the COVID-19 pandemic. However, during the first three quarters of this year, this rate has reduced to 5.2% in Q3.

The average rate of term admissions at WHH for quarters 1-3 of 2021/22 is 5.9%, which is below the national ATAIN target of 6%. It is not yet below the North West Neonatal Operational Delivery Network (NWNODN) target of 5.6% however the Q3 ATAIN rate of 5.2% was in line with the NWNODN target.

The Women's' and Children's Clinical Business Unit is monitoring the ATAIN Action Plan (Appendix 1) and will be participating in the Maternity and Neonatal Safety Improvement Programme (Mat Neo SIP) which is being relaunched in April 2022. The Mat Neo SIP programme aims to improve the early detection and management of deterioration of women and babies and to support the development of a national maternity early warning score which will standardise monitoring of women and babies. Early detection of maternal or fetal risk is associated with improved clinical outcomes.

Improvements in our electronic data capture and changes to transitional care service form a ward-based model to a virtual model have supported improvements in the quarterly admission rate of term babies to neonatal unit.

ATAIN Review Systems for Term Admissions to the Neonatal Unit

The National ATAIN scheme requires all Trusts to review unanticipated admissions of term babies into the neonatal unit. All unexpected admissions of term babies to neonatal unit are reviewed. Cases are identified through the Datix incident reporting system, Badgernet data collection tools and clinical review.

Multi professional meetings are held regularly with representation from maternity, neonatal, senior leadership and governance teams. Themes from reviews are collated and actions developed to support improvements in quality and safety of care provided. All cases of suspected Hypoxic Ischaemic Encephalopathy (HIE) that meet national reporting criteria are notified to the Hospital Safety Investigation Bureau (HSIB) by the Governance Manager.

There are five key clinical areas that represent a significant amount of potentially avoidable harm to babies:

- Respiratory symptoms
- Sepsis/Suspected Infection
- Hypoglycaemia
- Jaundice
- Asphyxia (perinatal hypoxia-ischaemia) is known as Hypoxic Ischaemic Encephalopathy (HIE) and is one of the top 5 reasons for a term baby to be admitted to the NNU due to reduced

cerebral blood flow as a result of fetal or neonatal insult or injury during the perinatal period. In Q3 no babies were admitted to the NNU as a result of HIE

Reasons for term admissions 01/01/2021 – 31/12/2021

Data Source: Badgernet data by ATAIN admission criteria

WHH Number Live Births 2020-2021		Term Admissions		Respiratory Symptoms		Sepsis/ Suspected Infection		Hypo-glycaemia		Jaundice		Suspected HIE	
		Number	% live births	Per 1000 live births	No of babies	Per 1000 live births	No of babies	Per 1000 live births	No of babies	Per 1000 live births	No of babies	Per 1000 live births	No of babies
Q4 Jan-Mar 2021	597	47	7.9%	41.9	25	8.4	5	6.7	4	1.7	1	0.0	0
Q1 Apr-Jun 2021	617	40	6.5%	34.0	21	4.9	3	4.9	3	1.6	1	0.0	0
Q2 Jul-Sep 2021	706	44	6.2%	32.6	23	4.2	3	0.0	0	4.2	3	0.0	0
Q3 Oct-Dec 2021	687	36	5.2%	18.9	13	8.7	6	2.9	2	2.9	2	0.0	0
Total	**2670**	**167**	**6.45%**	**31.7**	**82**	**26.2**	**17**	**14.5**	**9**	**10.4**	**6**	**0.0**	**0**

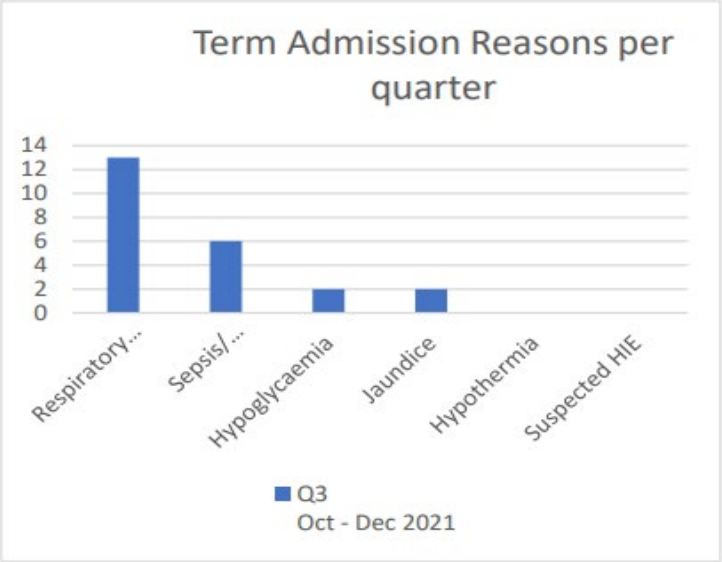
Themes and Learning WHH 2020/21 2021/2022 Term Admissions
Outcomes of ATAIN review

WHH 2020/21 2021/2022	Number of Term Admissions	Outcome of ATAIN review			
		Avoidable Admissions	Unavoidable Admissions	Data unavailable	Awaiting Review
Q4 Jan – Mar 2021	47	8	30	9	0
WHH 2021/22					
Q1 April- June 2021	40	6	17	17	0
Q2 July – Sep 2021	44	9	32	3	0
Q3 Oct – Dec 2021	36	9	25	0	2
Total *may not equal 100% due to rounding	167	32 (19%)	104 (62%)	29 (17%)	2 (1%)

All cases of term admission have been reviewed at the Women' and Children's CBU ATAIN meeting. Since July 2021, there has been consistent administrative support and data tracking, creating a robust system to record all of the outcomes and meeting discussions accurately. The rate of avoidable admissions has remained consistent through the year.

Over the last year, there has been a number of avoidable admissions relating to temperature management and control. Work is ongoing to improve the implementation of the Warm Care Bundle which includes the education of staff, skin-to-skin, monitoring birthing room temperature and management of baby whose temperature in low.

Reasons for Term Admission of Infants to Neonatal Unit



In Q3, 36% (13/36) of term admissions were related to respiratory conditions. Through the last four quarters, the rate has reduced from 41.9 per 1000 live births to 18.9 per 1000 live births. Six babies required ventilation in Q3, none of which required transfer to a level 3 unit. Two babies were transferred out for cardiac care, neither were ventilated. One of which had gastrointestinal surgery also. Both mothers had appropriate antenatal support with specialist fetal medicine input and were unavoidable admissions.

There were 6/36 infants (16%) admitted for monitoring with sepsis or suspected sepsis. Three cases of sepsis were deemed avoidable, i.e. the baby could have remained with the mother and offered transitional care however due to increased staffing challenges associated with COVID 19, which reduced the number of midwives on the maternity ward, the baby was admitted to the NNU. A Transitional Care task and finish group has been set up to monitor and develop the transitional care pathway in association with the Mat Neo SIP.

Learning Points/Themes from ATAIN Review

Documentation issues e.g. infant postnatal discharge summaries do not include details of care provided during the NNU admission. Failure to document care provided reduces the quality of information received by health professionals providing care in the community following discharge home.

Separation of mother and baby during infant resuscitation has been caused by the location of a resuscitaire outside of the birth room and theatre recovery area. Additional resuscitation equipment has been purchased to resolve the issue. Estimated delivery is 28th February 2022.

Temperature regulation in maternity theatre settings and on the postnatal ward have contributed to babies becoming hypothermic and requiring admission to neonatal unit. Action to improve environmental issues has been commenced with infant resuscitation equipment set warm prior to the birth of the baby. Parents have been advised on how to wrap babies safely and warmly to maintain their temperature. A national improvement 'Warm Care Bundle' is under review to identify further actions that may improve thermoregulation in newborn infants. Low reading thermometers have been purchased to ensure accuracy of temperature checking in newborns.

Transitional care: A small proportion of term infants have been admitted to NNU for feeding support and closer observation when the maternity service was unable to provide a transitional care service due to increased acuity or capacity issues. Sickness and absence of neonatal and maternity staff due to COVID infection or isolation requirements has also further impacted on the ability to deliver a consistent transitional care service. A Transitional Care Task and Finish group has been formed to review the current provision and where improvements can be made.

Learning and reflection opportunities have been offered to staff on an individual basis as required. Fetal Surveillance Lead Midwife, Infant Feeding Lead Midwife, Birth Suite Manager and Educational Supervisors have all provided individual support to staff and colleagues.

Progress with the ATAIN Action Plan

An ATAIN action plan is in progress to monitor service improvements aimed at reducing the number of avoidable term admissions to NNU. The action plan is on target and is reviewed as part of the ATAIN review meetings.

A process is in place to monitor the metrics for the admission of full-term babies as part of ATAIN review meetings and reported to Women's and Children's governance meetings. This report is also shared at the governance meeting. During Q3 11 ATAIN meetings were conducted.

Minimising Inappropriate Separation of Mother and Baby

Regional separation data shows that the average number of separation days per baby is 2.3, which is in the middle of the regional range.

NNU Designation	Unit of admission	Eligible Babies	Babies who received one or more eligible days in special or normal care	Babies who received one or more eligible days in special or normal care (%)	Eligible special care days	Eligible normal care days	Total eligible special and normal care days	Number of seperation days per baby
LNU	Countess of Chester	18	12	66.7	24	3	27	1.5
LNU	Leighton	24	20	83.3	69	0	69	2.8
LNU	Ormskirk	17	14	82.4	38	0	38	2.2
LNU	Warrington and Halton Hospitals NHS foundation Trust	30	24	80	72	0	72	2.3
LNU	Whiston	36	31	86.1	90	2	92	2.5
NICU	Arrowe Park, Wirral	18	16	88.9	63	1	64	3.5
NICU	Liverpool Womens	84	63	75	207	20	227	2.7

Data source: NNAP Maternal Separation for Term Admissions, data range 01.10.2021 – 31.12.2021.

An audit of transitional care is underway with findings to be presented as part of the Paediatric Audit Programme. The aim of the audit is to determine how may babies could have received transitional care from all term babies admitted to the NNU.

Babies admitted to the neonatal unit for ‘special care’ were reviewed to determine if care could have been completed on the postnatal ward as part of the transitional care service.

Data is being gathered from Badgernet, Lorenzo and the postnatal admission whiteboard to triangulate the information.

Recommendations

- To continue to monitor progress of the Action Plan 2021/22 at ATAIN meetings.
- To monitor progress of the actions through the CBU governance processes and present quarterly audit reports
- Focussed learning from ATAIN to continue to be included on the lessons learned to be shared and discussed with all midwifery and obstetric staff. To be shared via the Maternity Safety Champions newsletter and maternity safety briefs

2.1 Next steps

- The action plan was approved by the Quality Assurance Committee on the 1st March 2022; the action plan was shared with Cheshire and Mersey Local Maternity and Neonatal System as well as the Integrated Care System on 4th March 2022 where the action plan was reviewed as part of the LMNS monitoring and assurance functions.

- The action plan progress will be monitored as a standard agenda item at the Women's and Children's CBU monthly Governance meetings.

- The ATAIN clinical review meetings will continue as scheduled. The scheduling of this meeting is weekly however if no babies admitted a meeting will be stepped down.

- Participate in the Mat Neo SIP which will be relaunched in April 2022.

2.2 Summary

The rate of admission of term babies to the neonatal unit for Q1-3 is 5.9% which is below the national target of 6% but above the regional NWNODN target of 5.6%. The figures demonstrate an improving trend each quarter and it is anticipated that the Maternity and Neonatal Services will achieve the national target of 6% in the financial year 2021/22 when Q4 figures are published. The development of the action plan in response to the ATAIN review findings will further support a reduction in term admissions and achievement of the NWNDON target of 5.6%.

3. ACTIONS REQUIRED/RESPONSIBLE OFFICER

To note and approve the ATAIN action plan

4. IMPACT ON QPS?

5. MEASUREMENTS/EVALUATIONS

National ATAIN rate is 6%
NWNODN 5.6%
WHH Q3 ATAIN Rate 5.9%

6. TRAJECTORIES/OBJECTIVES AGREED

Action plan to be 100% completed by 30th June 2022

7. MONITORING/REPORTING ROUTES

ATAIN is monitored as part of MIS Safety Action 3 which is monitored across multiple platforms including monthly QAC Materntiy Safety Champions update, Women's and Children's Governance Committee and MIS Year 4 action plan which has also been added to the Trust Moving to Outstanding action Plan.

8. TIMELINES

MIS timelines have currently been suspended until 31st March 2022 and all providers are awaiting further timeline of year 4 schedule.

9. ASSURANCE COMMITTEE

ATAIN Quarter 3 findings and trajectory has been presented to QAC on 1st March 2022.

10. RECOMMENDATIONS

MIS Safety Action 3 recommends Trusts must demonstrate they can minimise the separation of mothers and babies by implementing the recommendations made in the ATAIN Programme.

The Board of Directors are asked to note this paper and approve the action plan Appendix 1

Appendix 1 ATAIN Action Plan

Item No	Link to ATAIN admission criteria (i.e. Respiratory, Jaundice, Hypoglycaemia, HIE, Observation, Poor feeding)	Recommendation identified following case review	Action plan to achieve compliance with recommendation (SMART)	Lead Responsible	Expected date for completion	RAG rating	Progress/comments	Date completed
1	Governance of ATAIN process	Outlier for high term admissions to neonatal unit in North West Neonatal ODN network. Quarterly dashboard monitoring reports admission rate above 6% national target and 5.6% ODN target	Continue to monitor term admission rates to neonatal unit and monitor progress in reducing this rate. Present ODN dashboards at Departmental governance meetings to ensure robust monitoring and scrutiny of admission rates.	Delyth Webb Consultant Paediatrician	May-22		Audit of term admissions to neonatal in progress. Q3 2021/22 TC results to be presented at Paediatric Departmental Audit Meeting in March 2022. NNU currently unit showing reducing rate of term admissions- 5.2% Q3 2021/2. The aim is to achieve a reduction to 6% by April 2022 and ongoing monitoring until NWNODN target of 5.6% is achieved. Updated 15/02/2022	
2	Governance of ATAIN process	Review ATAIN administrative process to ensure MDT attendance at weekly meetings.	Review TOR, identify admin support for ATAIN review meetings. Schedule dates and send meeting invitations.	Emma Bentham, CBU Personal Assistant	Nov-21		Admin and clerical support identified to gather case notes, record meeting minutes, prepare agendas and send out invitations. TOR reviewed and updated.	01/11 /2021
3	Governance of ATAIN process	Establish regular review meetings by a multidisciplinary team to discuss cases and identify avoidable factors for term admissions To ensure that all term	ATAIN proforma to be updated to ensure all information is captured effectively. And allow for auditing and collation of themes.	Chris Bentham, Obstetric Governance Lead	Oct-21		Electronic proforma developed to allow for capture of essential information.	01/11 /2021

		admissions to NNU are reviewed using a standardised template to identify areas for improvement.						
4	Governance of ATAIN process	To ensure Safety Champions receive updates on learning ad improvement identified from ATAIN reviews.	Sharing of meeting minutes and action log as part of Safety Champions monthly meeting.	Catherine Owens, DoM	May-22		Safety Champions to be included in distribution of meeting minutes from March 2022 onwards. Updated 15/02/2022	
5	Governance of ATAIN process	Ensure the Board have oversight of the ATAIN programme and progression of action plans.	Quarterly HLBP to Board describing learning from reviews and progress of action plans. Development of Board reporting work plan to schedule dates for quarterly reporting.	Catherine Owens, DoM	Feb-22		Q3 ATAIN report to be presented to QAC 01/03/2022.	
6	Governance of ATAIN process	Develop action log to record learning and improvement identified for each case.	Development of ATAIN cases for review. Development of action log in response to learning identified.	Emma Bentham, CBU Personal Assistant	Nov-21		Case review log completed. CBU Personal Assistant is able to identify new cases for review and monitor any backlog of case reviews. Action log also completed which is tracked to specific case review and learning.	01/11 /2021
7	Governance of ATAIN process	Ensure staff receive feedback from teams and earning identified at case reviews.	Learning for individuals ad groups to be identified and supported by specialist midwives and obstetric supervisors. Information on themes identified to be shared incidence newsletters and ward-based safety briefs.	Lorraine Millward Governance Manager	Jan-22		OWL newsletter included learning from ATAIN revies. Safety Champions newsletter contained details of CTG Fresh Eyes approach. SPL circulated to staff. Individual learning opportunities offered to staff as required.	31/01 /2022

8	Education and Training	Outlier for high term admissions to neonatal unit. ATAIN e-learning courses is not mandatory.	Inclusion of ATAIN e-learning as part of the maternity TNA programme.	Jeanette Carter PDM	Feb-22		Email to all staff advising ATAIN e-learning has been included in the Trust maternity training requirements. E-learning can now be monitored on ESR for levels of compliance. Action deadline to be extended util June 2022, to allow for monitoring of compliance. Updated 15/02/2022	
9	Provision of Transitional Care	Outlier for high term admissions to neonatal unit. Ward based TC model is not effective due to staffing requirements within the unit.	Establish Transitional Virtual Model of Care to support management of term eligible babies close to mother and avoid neonatal unit admission.	Women's Health Matron for Inpatient Services	30/09/2021		Transitional Care guideline has been updated to describe virtual model of transitional care. Babies requiring a higher level of care will remain om the postnatal ward. Babies eligible for TC will be care for in a virtual location with support from NNU nursery nurse and professional oversite from NNU nurses.	30/09/2021
10	Provision of Transitional Care	On occasions reduced staffing levels in maternity and neonatal teams has reduced the provision of a virtual TC service and some babies eligible for TC have been admitted to NNU.	To audit the number of babies admitted for "special care" who may have been able to receive TC care if the service was available. To review maternity and neonatal staffing levels to support provision of TC in the longer term.	Paediatric Nurse Consultant	31/05/2022		Review of NNU staffing is underway and will be presented to the Workforce Committee in May 2022. Red Flag reporting system under development for TC babies who are admired to NNU due to staff shortages. Updated 15/02/2022	
11	Provision of Transitional Care	Q2 TC audit has highlighted gaps in compliance with the TC pathway and guideline.	Task and finish group to be established to review recording and monitoring of TC babies on the postnatal ward.	Paediatric Nurse Consultant	14/01/2022		Task and finish group has been established with representation from Matrons, Ward managers, neonatal and maternity staff.	14/01/2022

12	Hypothermia	Reduce number of babies admitted to NNU from theatre recovery area with hypothermia due to environmental factors in the maternity theatre setting.	Posters to be developed to raise awareness of keeping baby warm and well wrapped. Staff to be informed to set Resuscitaire temperature to "full and not pre warm". Environmental temperature to be monitored daily.	Birth Suite Manager	31/03/2022		Posters have been developed for the recovery area to advise who to warp a baby and maintain temperature. Staff have increased temperature of resuscitaire. Low temperature thermometers have been ordered to accurately monitor babies' temperature. Updated 15/02/2022	
13	Respiratory and Poor Feeding Admission Criteria	Reduction the number of term neonatal admissions admitted due to hypoglycaemia and respiratory conditions caused by hypothermia	Education of staff on the warm care bundle. Re launch the warm care bundle with updated guidelines and QI initiatives as part of the MatNeoSIP improvement programme	Birth Suite Manager	1st June 2022		Guidelines from other trusts have bene received along with supporting information on the Warm Care Bundle. Midwifery and Neonatal champions to be identified to support the relaunch of the project. Improved baby blankets to be purchased for birth Suite as current blankets considered not to be effective in keeping baby warm. Updated 15/02/2022	
14	Respiratory Conditions	Increase in term admission to NNU for respiratory support following elective caesarean section.	Audit of infants born by caesarean section to identify areas for further improvement.	NNU Manager	Jul-22			
15	Respiratory Conditions	Increase in admission to NNU for respiratory support associated with obsolete or broken resuscitation equipment.	5 new resuscitaires to be ordered as part of the capital planning process and emergency equipment funding.	Birth Suite Manager	Jul-22		Current resuscitaires are in working order and have been inspected and maintained by Medical Devices Team. Bid for 5 resuscitaires successful and equipment ordered. Awaiting delivery of new equipment. Updated 15/02/2022	

16	Respiratory Conditions.	Action required to support staff with earlier identification of neonates at risk of respiratory distress and early interventions	Support for staff. SOP required. Jayne Wright will be asked to lead on this. Kim Wilcock has started writing a SOP on supporting new-borns with Respiratory Distress for midwives on Birth Suite, C23 and the NEST. First DRAFT embedded. Requested neonatal staff input.	Jayne Wright, Kim Wilcock and Delyth Webb	28/05/2022		Several mothers and babies have benefited from this method of avoiding separation.	
17	Suspected HIE	Identifying fetal monitoring errors and omission of fresh eyes review as a contributory factor in NNU admissions	To review CTG training compliance for all staff who give an opinion on a trace. To complete Fresh Eyes QI project to improve hourly review of CTG trace.	Sarah David, Lead Midwife for fetal monitoring	30/11/2021		Current work stream in progress to complete fetal monitoring training with all midwives. Additional dates added to Bank staff training to ensure training is complete.	30/11/2021
18	Suspected HIE	Intrapartum CTG concerns were a contributory factor to NNU admission.	Fetal monitoring midwife to share CTG for learning at C-Shop. Staff involved in the incident to be offered the opportunity to reflect and learn from the case review findings. Focus on K2 training for all staff who give an opinion on a trace.	Chris Bentham, Obstetric Governance Lead	30th June 2021		Quarterly monitoring of Fetal monitoring training compliance at Departmental Governance Meetings. Individuals have met with Fetal Surveillance Midwife and Obstetric Supervisor. Case has been presented at C-Shop for wider learning.	30/11/2021
19	Suspected HIE	Admission of babies to NNU for observation of borderline cord pH	Guidance in progress – to identify babies at risk of later compromise and	Laura Iley, Marisa Owen and	30/06/2022			

		and neonates admitted with low cord pH and risk of HIE	ensure safe postnatal transition.	Narayana Vayyeti				
20	COVID-19 Review. Observation Admission Criteria	Care of neonates born to suspected/ confirmed COVID-19 mothers and who require additional care	Guidance from Royal College of Paediatrics and Child Health and British Association of Perinatal Medicine (BAPM)	Delyth Webb Consultant Paediatrician	30/05/2020		These babies should be assessed in the birth suite and a decision made as to whether additional care can safely be provided at the mother's bedside – using the same criteria as used for additional care and observations with COVID negative mothers. If so, baby and mother remain together in appropriate isolation cubicle on delivery suite. If a prolonged stay for the baby is required, consideration of transfer of mother and baby to paediatric ward is required on an individual basis. Several mothers and babies have benefited from this method of avoiding separation. Babies of COVID positive mothers requiring admission to the NNU are assessed in a designated area in the NNU – an isolation cubicle is set up for this purpose. Infants who require respiratory support via ventilation or high flow will have a designated nurse with full AGP level PPE caring 1:1 for that baby. All equipment in the isolation room is cleaned as per Trust COVID-19 cleaning policy. A register must be kept of all staff entering the room. BAPM COVID-19 guidance is followed regarding these infants including parental support and use of breastmilk. As soon as practicable when the baby is suitable for care next to the mother, they will be transferred to a suitable cubicle with mother either on the maternity or paediatric unit. This allows her to stay with her baby whilst minimising infection risk to other parents and staff.	30/08 /2020

21	COVID-19 Review. Observation Admission Criteria	Increase in new-borns admitted to NNU with hypothermia which may be linked to birth rooms / theatres being colder than normal due to COVID-19 room ventilation advice	Reintroduce warm care bundle. Audit number of infants and reasons for admission.	Jayne Wright and Kim Wilcock	28/05/2021		Recent trend of incidents where neonates are admitted to NNU with hypothermia. ATAIN reviews identify reduced compliance with documentation of warm care bundle documentation. Jayne Wright is birth suite champion for the warm care bundle. Kim Wilcock has contacted the theatres manager regarding the temperature in maternity theatre as this is an area identified as being cool. The maternity team are asking for a temperature of 23C but this is often around 20C. It has recently been noted that the delivery unit temperature is cold, particularly at night. New window blinds that have been installed have helped. Updated 06/05/21: Action completed. Thermometers in all rooms on Birth Suite (rooms ideally to be monitored to ensure temp 23 degrees). There is ongoing discussion pertaining to theatres and ideal temperature. Delyth Webb discussed the perinatal optimisation toolkit (for preterm infants – however delivery room temperature relevant) and WHO guidance and will send this information to the group. https://www.bapm.org/pages/105-normothermia-toolkit http://apps.who.int/iris/bitstream/handle/10665/63986/WHO_RHT_MSM_97.2.pdf;jsessionid=C3F1622917CA237E50691F8018DAD37F?sequence=1	06/06/2021
22	Governance of ATAIN process	Monitor actions recommended in ATAIN reviews (i.e. individual learning/guideline review etc) as part of an action log.	Action log to be completed as part of ATAIN meeting process and regularly reviewed and updated.	Chris Bentham, Obstetric Governance Lead	Nov-21		Action log reviewed and updated at ATAIN meetings.	Nov-21

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/22/03/44**	
SUBJECT:	**Volunteer Report – April 2020 – March 2022**	
DATE OF MEETING:	March 2022	
AUTHOR(S):	Jennifer McCartney, Head of Patient Experience & Inclusion	
EXECUTIVE DIRECTOR SPONSOR:	Kimberley Salmon-Jamieson, Chief Nurse & Deputy Chief Executive	
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	**SO1 We will.. Always put our patients first delivering safe and effective care and an excellent patient experience.**	*
	SO2 We will.. Be the best place to work with a diverse and engaged workforce that is fit for now and the future	
	SO3 We will ..Work in partnership with others to achieve social and economic wellbeing in our communities.	
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): **(*Please DELETE as appropriate)***	**#1215** Failure to deliver the capacity required caused by the ongoing COVID-19 pandemic and potential environmental constraints resulting in delayed appointments, treatments and potential harm	
EXECUTIVE SUMMARY *(KEY ISSUES):*	The Volunteer Report details activity and achievements within the period of April 2020 to March 2022 and was noted for assurance at the Strategic People Committee. The report details: ▪ the impact of the COVID-19 pandemic on the WHH Volunteer service and its recovery processes ▪ key statistics on recruitment ▪ highlights of the programmes and opportunities where Volunteers have impacted the work of staff at WHH. Through engaging Volunteers, the Trust has enhanced the experience for patients, staff and visitor's and complimented health care delivery at Warrington and Halton Teaching Hospitals (WHH).	

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

RECOMMENDATION:	The Board of Directors are asked to receive and note the contents of this paper.	
PREVIOUSLY CONSIDERED BY:	**Committee**	Strategic People Committee
	Agenda Ref.	**SPC/22/03/38**
	Date of meeting	23/03/2022
	Summary of Outcome	
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED: *(if relevant)*	Choose an item.	

REPORT TO BOARD OF DIRECTORS

SUBJECT	Volunteer Report – April 2020 – March 2022	AGENDA REF:	BM/22/03/44

1. BACKGROUND/CONTEXT

Volunteers at Warrington and Halton Hospitals (WHH) provide a valuable supplementary service, enhancing the experience of patients, visitors and supporting staff.

Over the past two years the COVID-19 pandemic has had a detrimental impact on volunteering services and significant impact on the NHS overall. In response to the COVID-19 pandemic and in line with receipt of the "NHS Volunteer Guidance Version 1.0" from NHS England (NHSEI), all patient facing volunteer roles at Warrington and Halton Teaching Hospitals (WHH) were suspended in March 2020 until July 2020 when a recovery plan was initiated. The recovery plan is monitored on a bi-monthly basis via the Patient Experience Sub Committee.

Since July 2020 several roles have been adopted by the WHH Volunteer service in a staged approach to support the overall priorities of patient safety, improving quality reducing demand on staff and improving patient flow and wellbeing. This has resulted in:

- 137 existing Volunteers returning to support the Trust
- 5413 hours of support provided to the Trust by Volunteers
- 265 new Volunteers recruited to support the Trust

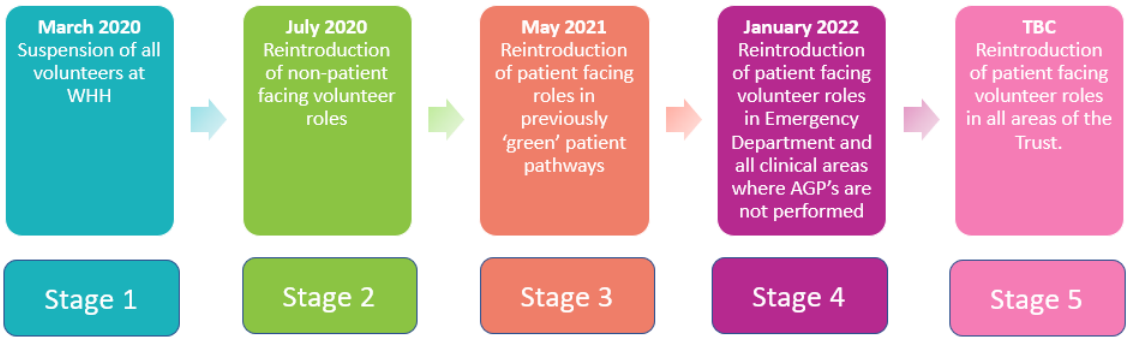
This paper details the impact of the COVID-19 pandemic on the volunteer service, its recovery process and the successes achieved between the period April 2020 and March 2022.

2. Impact of COVID-19 and recovery

In March 2020, as a result of the COVID 19 pandemic and in receipt of guidance from NHS England (NHSE/I) NHS Volunteer Guidance Version 1.0", the WHH Volunteer service was temporarily suspended until July 2020 where recovery processes were initiated.

The recovery plan for the service has been adopted via a 5-stage approach to ensure the safety of the Volunteers.

Details of the recovery plan is detailed in the infographic below. The service is currently working to stage four of the five staged approach.



It is noted that approximately 55% of existing Volunteers were over the age of 60 and / or clinically vulnerable therefore it was necessary to adopt the same risk assessment process as Trust staff to ensure the safety of the Volunteers supporting the Trust.

As part of the recovery process all existing Volunteers have received updated Infection Prevention and Control training and Occupational Health clearance prior to reinstating their volunteer status. Volunteers have also undertaken a mandatory training programme in line with Health Education England Guidance. This process has been adopted as part of business-as-usual processes and is followed in the recruitment of new Volunteers who wish to support the Trust.

3. Volunteer Activity

Since the initiation of the recovery plan for the Volunteer service in July 2020, the WHH Volunteer team have worked in collaboration with staff at WHH to develop a range of opportunities to support the overall priorities of patient safety, patient experience, improving quality reducing demand on staff and improving patient flow and wellbeing. These opportunities have included but not limited to the following:

- Support provided to the Trust Personal Protective Equipment (PPE) Safety Team ensuring mask stations where 'manned' ensuring all visitors to the Trust supported to follow Trust Infection Prevention and Control Guidelines
- Patient Information Reader Panel – ensuring a proof-reading service for all patient facing material.
- Support to the Vaccination Hub / Outpatient service supporting wayfinding and the wellbeing of patients whilst in the waiting rooms
- Wingman Lounge support
- Forget Me Not Ward Gardening –to ensure the garden is tidy and accessible for patients in the Forget Me Not Ward and surrounding wards
- Discharge Lounge – wellbeing support for patients during their time in the Discharge Lounge.
- Wayfinding support – to ensure visitors to the Trust are able to navigate their way to the relevant ward or department.

In addition to the above the WHH Volunteer team have provided support to external voluntary organisations and internal teams / departments to restart roles in line with guidance from Infection Prevention and Control team including Halton Hospital Radio, Friends of Halton Hospital, Warrington General Hospital Radio; Warrington League of Friends and Delamere CANtreat Volunteers.

The WHH Volunteer Team continue to reach out to teams within the Trust to identify Volunteer opportunities and provide valuable support.

4. Success Stories

In October 2021 NHS England and NHS Improvement Volunteering Services Fund 2021 awarded the WHH Volunteer team an amount of 14k as a result of a successful bid application, thus ensuring adequate monies to support in the recovery process and infrastructure of the service and provision of support during winter pressures. As a result of the successful bid the team were able to procure additional equipment to support role delivery, enable the provision of additional staffing hours to support the management of volunteers and to further support the recovery of the WHH volunteer service.
The WHH Volunteer team have mobilised 1200 hours of volunteer support into the Discharge Lounge to provide assistance in general tasks to ensure optimal patient flow and support for the experience of patients whilst in the department.

The WHH Volunteer team has also provided much needed support to the Trust Vaccination Team with the recruitment of 34 Volunteers providing 1600 hours of much valued assistance to our patients and staff utilising the service.

Finally, as part of the COVID-19 recovery process the WHH Volunteer team have conducted reviews of existing systems and processes to ensure effective onboarding and support for volunteers giving up their time to support the Trust. This has included the introduction of the National Volunteer Certificate Training Programme provided by e-learning for Health which has been very well received by all volunteers.

5. Volunteer Feedback

To ensure continuous improvement in the support of the Volunteer service to the Trust regular feedback is collected from staff and Volunteers.

Staff feedback is consistently positive regarding the value the Volunteer team brings to the services we provide. Having support from Volunteers enhances opportunities to ensure a positive experience for our patients when receiving care in our hospitals.

A snapshot of the feedback from our volunteers includes**:**

Wellbeing Vaccination Volunteer

- “I enjoyed it and it was very helpful for me to gain experience with dealing with different people and challenges” – Erin – new Volunteer

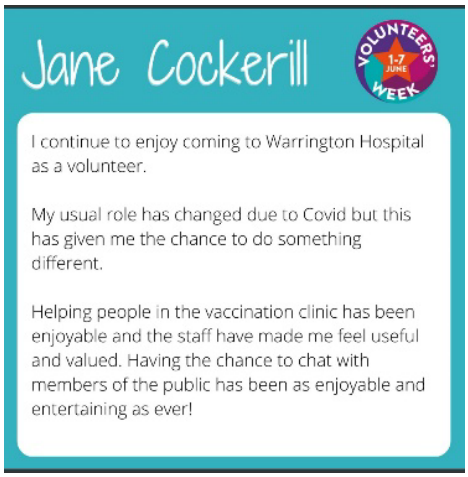
- “This is a very nice way to Volunteer, it allows you to meet many people and talk to a diverse community. it allows you to clean and wipe down chairs but also directing people on where to get their vaccination” - Rhea – new Volunteer

Wayfinders

- "This was a great opportunity that gave me a chance to learn the hospital's layout whilst assisting visitors find their way round. I enjoyed chatting to visitors and guiding them to where they needed to be. Most were thankful and grateful for the service. A great walking exercise too." – Thandi – New Volunteer

Discharge Hospitality Volunteer

- "Enjoyed helping people waiting for discharge felt really useful and part of a team" – John – returning Volunteer



6. Next Steps

The WHH Volunteer team continue to engage with teams to scope new opportunities within the Trust. Some of the plans in place include:

- The introduction of 'Litter Heroes' across the site in support of the Trust First Impression Programme.
- The introduction of 'Response Volunteer's' to support the wards and departments with tasks to support patient flow / patient experience.
- Reintroduction of Dining Companions for patients on inpatient wards.
- Widening access to roles for ward areas – ensuring support roles in the evening and weekends to enable those who want to volunteer but have commitments to study or work.
- Explore new and innovative ways to recognise the contribution of our Volunteers throughout the year and via key celebration events.

7. RECOMMENDATIONS

The Board of Directors are asked to receive and note the contents of this paper.

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/22/03/45**			
SUBJECT:	Learning from Deaths and Mortality Report Q3 2021-22			
DATE OF MEETING:				
AUTHOR(S):	Eshita Hasan, Associate Medical Director, Patient Safety and Trust-wide Lead for Mortality Alison Talbot, Associate Director of Governance			
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.	X		
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF):	No associated risks			
EXECUTIVE SUMMARY *(KEY ISSUES):*	This paper summarises 'Learning from Deaths' for Q32021/2022, for noting and scrutiny, in compliance with National Guidance requirements on Learning from Deaths. **Key points to note are:** • During Q3 2021/22, 319 deaths occurred within the Trust. • Of these, 99 met the criteria to be subject to a Structured Judgement Review (SJR). • SJRs have been completed on 44 out of 92 assigned. Which is a 3.2% increase from Quarter 2. • 2 cases were escalated to a Serious Incident investigation following an SJR. • SHMI (Hospital Standardised Mortality Ratio) based on 12 months data is 100.38 and is slightly lower than the expected SHMI range for peer organisations • HSMR (Summary Hospital-level Mortality Indicator based on Hospital Episode Statistics) for the 12-month period up is 84.23. This HSMR is markedly lower than the expected range for peer organisations. Further validation to understand this variation is underway. • Changes in coding due to COVID may mean that HSMR and SHMI may be less representative and more volatile at present and as such it is particularly important that the Learning from Deaths and Medical Examiner Mortality Review process are robust to provide assurance around mortality. • Attached as appendices are the MRG themes of the month **(Appendix 1,2,3),** the Anaemia focussed review report **(Appendix 4)** Serious Incident Newsletter **(Appendix B)** for learning.			
PURPOSE: *(please select as appropriate)*	Information	Approval	To note X	Decision

RECOMMENDATION:	The Board is asked to note the contents of this report and Receive assurance that the Trust has robust processes in place for the review of case level mortality through the LFD and Medical Examiner systems. - Receive assurance that effective thematic analysis and learning is gleaned and shared from the LFD process - Note that SHMI shows an improving trend and is in the lower expected range - Note that HSMR is lower than expected when compared to peer organisations - Note that further validation of the low (positive) HSMR statistic is underway	
PREVIOUSLY CONSIDERED BY:	**Committee**	Quality Assurance Committee
	Agenda Ref.	QAC/22/03/69
	Date of meeting	1ST March 2022
	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	Learning from Deaths and Mortality Report Q3 2021-22	AGENDA REF:	BM/22/03/45

1. BACKGROUND/CONTEXT

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

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

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

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

2. KEY ELEMENTS

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

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

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

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

3. MEASUREMENTS/EVALUATIONS

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

- All deaths of patients subject to care interventions with elective procedures. These are identified using the electronic patient record which provides a daily update as to patients that have died.
- Patients undergoing an emergency laparotomy.
- SHMI/HSMR outliers identified using the HED system.
- Deaths where learning will inform existing or planned improvement work, for example if work is planned on improving sepsis care, relevant deaths should be reviewed, as determined by the Trust.

- Death of a patient with severe mental health needs
- Death of a patient who had a DoLs in place during their admission.

- Trauma deaths will be reviewed and presented at MRG on a quarterly basis.
- Patients who have died aged between 18 and 55 years.
- Patients who have died with no DNACPR in place.
- Once a quarter, a further sample of other deaths will be selected that do not fit the above identified categories, to ensure we take an overview of where learning and improvement is needed most overall.
- All Coroners' reports received post-inquest will be triangulated with the SJR to enhance the learning.
- Any concern that a member of staff may have in relation to a patient death will be reviewed through the mortality process.
- At the request of the Medical Director or Chief Nurse.

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

3.1 Mortality Review Data Q3 2021/22

Fig. 1 – Key Mortality Data

Total deaths in quarter	Total LD Deaths	Total deaths that were an SI	Those meeting SJR criteria	Number of SJR reviews completed in Q3	Number of SJR Reviews that were allocated in Q3 and completed compared to Q2.	
319	5	2	99	77	Q2 – SJRs were completed on 33 out of 74 assigned. 44.6%	Q3 – SJRs were completed on 44 out of 92 assigned. 47.8%

- During Quarter 3, 99 deaths met the criteria to be subject to a Structured Judgement Review (SJR).
- 77 SJRs have been completed in Q3.
- Of the 77 SJRs completed, 44 were allocated in Q3 and 35 were allocated in previous quarters.
- An additional 18 SJRs were allocated in Q3 compared to Q2, however the completed percentage has still risen by 3.2% in Q3 when compared to Q2.
- To address the backlog from Q2 the Deputy Chair of MRG has requested that those from Q2 are completed within 1 month. It is worthwhile noting that the delays to completion are due to significant operational demand on the services.
- In addition, the new SJR that are sent will have a one-month deadline for completion.

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

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

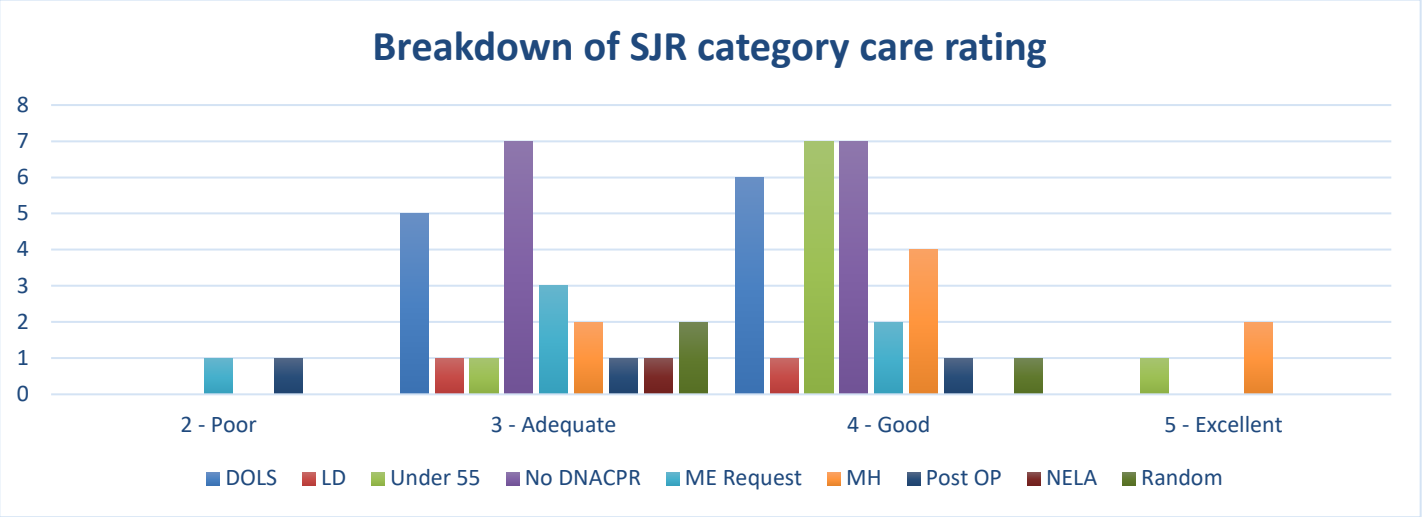
A sample of cases rated as *3:* ***Adequate*** are referred to MRG for further discussion to identify themes for learning and improvement.

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

Phase of care *	N/A	Very poor	Poor	Adequate	Good	Excellent
First 24hours/ admission	0	0	0	9	32	3
Ongoing care	7	0	1	15	20	1
Care during procedure	40	0	1	2	1	0
End of life Care	20	0	1	6	16	1
Patient records/ documentation	0	0	0	15	27	1
Overall care	**1**	**0**	**1**	**15**	**25**	**2**

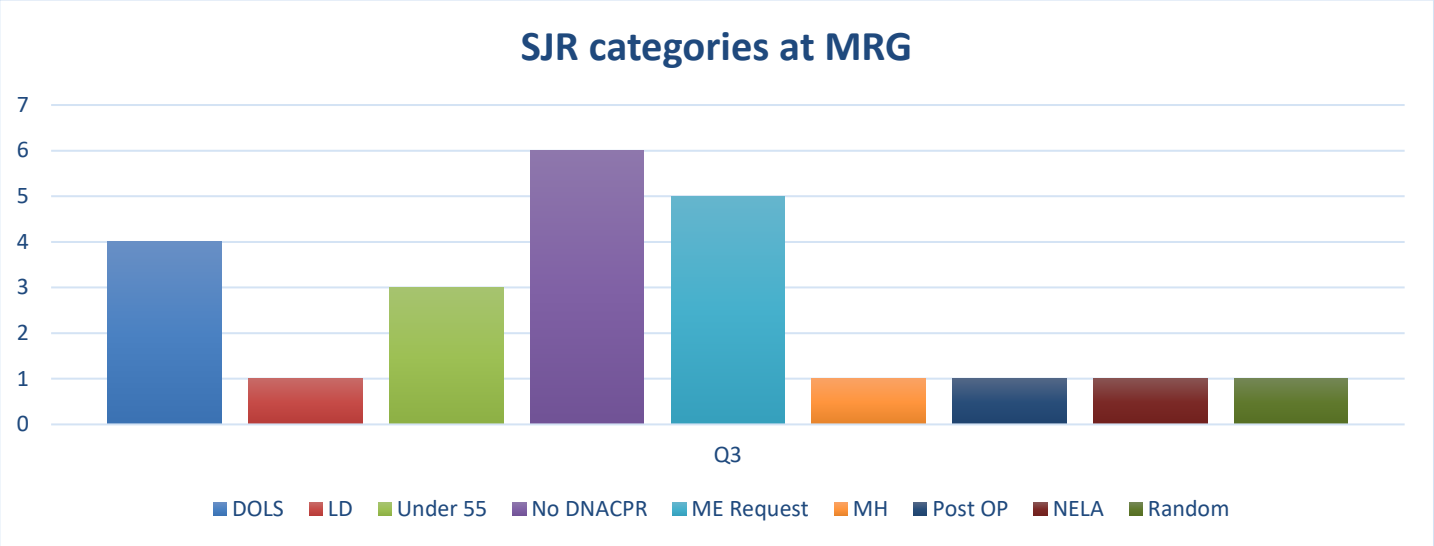
- In SJRs completed within Quarter 3, there have been no instances of very poor care at any stage of admission.
- There has been one SJR with an overall care rating of poor. A Serious Incident Investigation has been completed. The details of that are in the learning from incidents section.
- The highest number of 'excellent' care ratings happened during the first 24 hours of admission.
- Care during a procedure has more 'adequate' ratings of care than 'good'.
- All other phases of care have more 'good' ratings of care than 'adequate'.

Fig 3 - Shows the overall care rating within each SJR category in Quarter 3.



- People who have died aged 55 or under are predominantly receiving good care.
- No DNACPR remains a key focus of reviews.
- Patients who have died with a severe mental health disorder are receiving good and excellent care compared to adequate and poor care.
- The ME service is identifying more cases that are found to be adequate and poor than good or excellent which shows good triangulation between the service and wider governance structures.

Fig 4 - Shows the frequency of each SJR category presented at MRG in Quarter 3.



- The category with the highest number of SJR's requiring further discussion at MRG is No DNACPR. This is a quality priority for 2021/22 and the MRG provides the SJR findings as learning to feed into the ongoing DNACPR workstream.
- For Quarter 3, six ME requested reviews were brought to MRG. This is positive as it shows that the ME service can identify those deaths that do not fit into the criteria for SJR but may require an SJR.
- Four patients who died with a DoLS in place were discussed at MRG. Safeguarding attendance at MRG allows the triangulation of this learning.

3.2 Learning from deaths:

The below describes the learning following recent deaths and the actions taken.

A key focus for Q4 will be translating learning from MRG into SMART actions.

Learning	**Action**
ID:5526 - There was a lack of senior oversight and early recognition of the need to commence end of life care. A more bespoke service which is responsive to individual needs should be offered.	Learning sent to trainee doctors, MRG learning bulletin produced (Appendix 1) to go on CBU Governance agendas.
ID:6600 – Patients with severe heart failure should have CoC discussions in advance.	Case referred into DNACPR workstream to triangulate learning.
ID:7298 – Transfer of patients at night is poor practice and whilst sometimes unavoidable it can jeopardise patient care.	Case referred to the patient flow workstream.
ID:7582 – Patient needed a more senior review in the first week of care.	Learning referred to the relevant Governance lead to be disseminated into the CBU.
ID:7304 – No real medical assessment or specialty input sought to assess reversible causes for deterioration.	Case and RCA sent to the relevant specialty lead for the learning to be presented at their Governance meeting.
ID:7085 – More housekeeping needs to be observed when completing a legal document like DOLS to avoid mistakes.	MRG learning bulletin developed with safeguarding input (Appendix 3) to be included in CBU Governance and Specialty agendas.

Themes

- Increased frequency of consultant reviews offers the benefit of senior medical input that is required for making decisions on commencing end of life care.
- Appendices 1,2 and 3 identify the themes and learning that have arisen in the MRG meetings for Q3. These newsletters are then included on CBU and Specialty Governance agendas each month. The key themes focussed on in Q3 are palliative/end of life care, AKI/Renal Injury, and Mental Capacity Act learning.

Anaemia focussed review

A focussed review into 13 patients who died with anaemia took place after a spike in SHMI data and findings were reported into the October MRG meeting. (Appendix 4).

The main learning points identified were:

- Earlier palliative team input required/resus discussions to happen sooner
- Appropriateness for cystoscopy in frail patients
- Poor admission/clerking for elective procedures
- Unclear documentation for CoC

The main action points were:

- Case 6 sent to Digestive Disease CBU with learning and feedback.
- Case 7 sent to relevant lead for further review with regards to continuing attempts at resuscitation.
- Positive feedback sent to ED team regarding Case 10 and promptness in end-of-life care.
- All palliative/end of life care learning sent to Palliative care lead to triangulate with their ongoing workstream.

There were no significant coding issues identified and SJR overall care ratings were either 'good' or 'adequate'.
It is noted that there are no longer alerts within this SHMI group.

3.3 Learning from Serious Incident investigations:

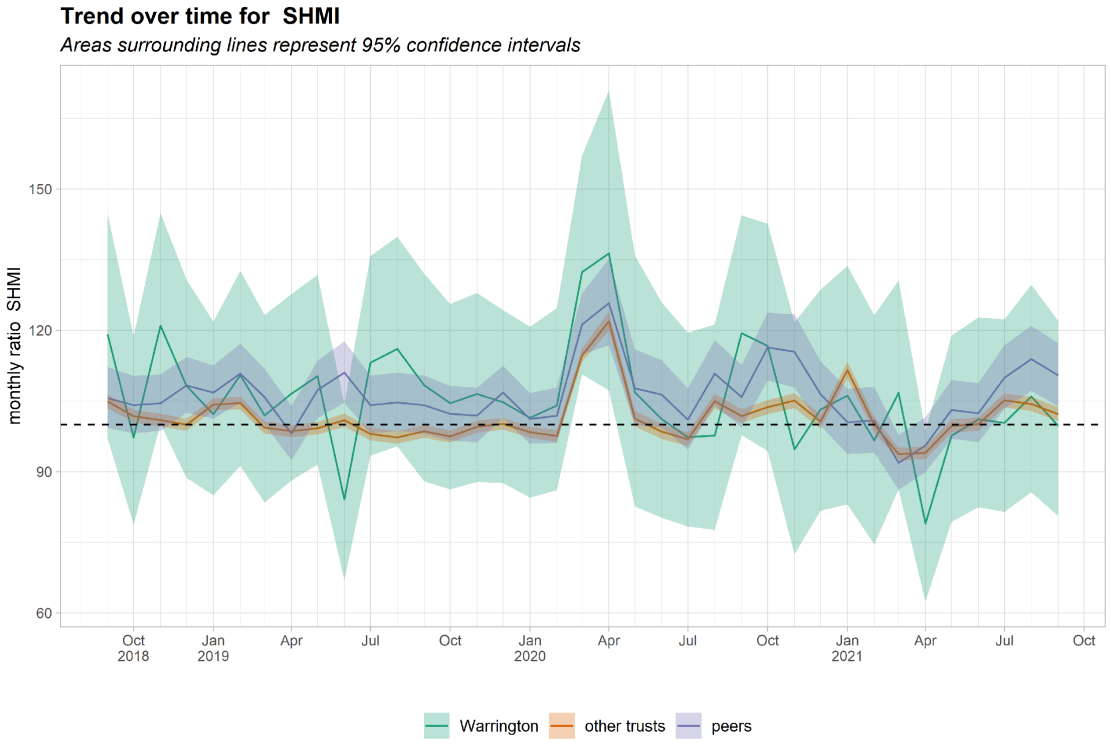
Incident: Patient sadly died following surgical intervention. Whilst this was sadly unavoidable an RCA was conducted for any learning.	• A clear and succinct Standard Operating Procedure has been created for escalation when emergencies occur in theatre including low threshold for contacting specialities. • Operation notes to include methods of managing bleeding during procedures**.** These will be audited by the Theatre Manager to ensure compliance

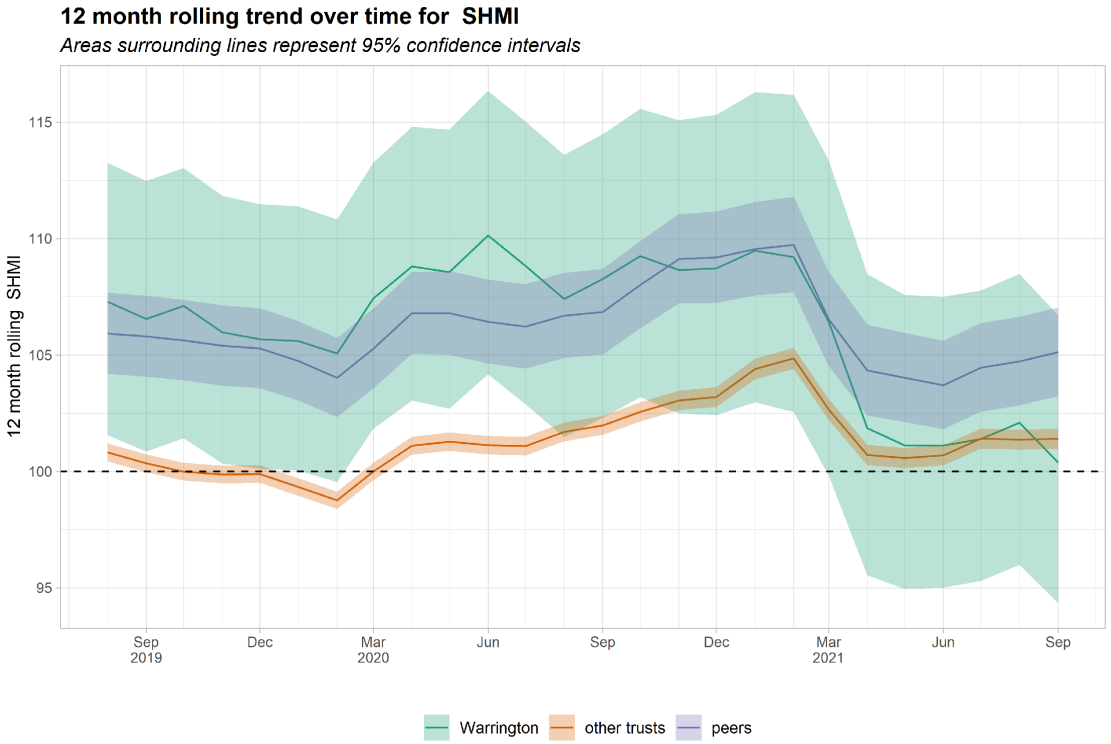
4. **Mortality Indicators**

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

To have a red flag means the HSMR is above 100 and the lower confidence interval is above 100 which signifies the variation is unlikely to be due to random or chance variation and other issues may be causing the variation. HSMR should be closely monitored alongside SHMI mortality indices with intelligence from HED and internal intelligence from risks, incidents, and complaints data.

4.1 HSMR and SHMI indicators



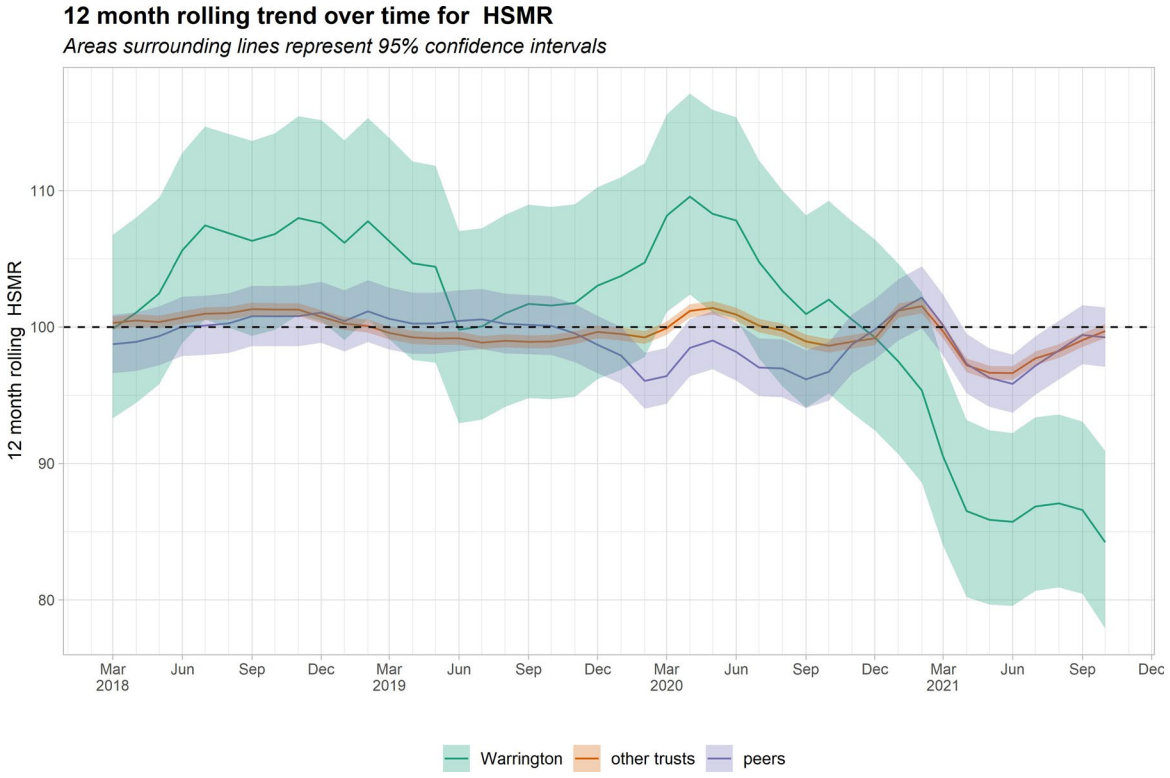


SHMI is **100.38** and is not considered an outlier. The 12-month rolling trend shows a positive lower position month on month and is in line with peers are noted below.

HSMR is 84.23 and is a low (positive) outlier, compared to peers as noted below HSMR has seen a steady positive decrease month on month and is the lowest HSMR compared to peers as below.

Further validation to understand this variation in underway.

Changes in coding due to COVID may mean that HSMR and SHMI are less representative and more volatile at present and as such it is particularly important at present that the Learning from Deaths and Medical Examiner Mortality Review process are robust to provide assurance around mortality.



4.2 Outliers

The below are noted as potential outliers within HSMR and SHMI; however, it is worthwhile noting that these trends are compared with other key indicators within Governance such as complaints, incidents, SJRS and are not showing an emerging trend. To review the areas that are flagging, the Trust wide Lead for Mortality supported by MRG completes case studies including a review of coding into deaths in diagnostic groups that continue to show an outlier trend on the monthly HED report. Each review is presented at the MRG and any known data errors are flagged via the HED system. In addition, a learning report is produced to feedback on areas for improve.

Key Diagnosis groups showing as outliers for SHMI using a Poisson funnel plot are:

- Cancer of colon
- Disorders of lipid metabolism, Nutritional deficiencies, other nutritional; endocrine; and metabolic disorder
- Anal and recal conditions, Diverticulosis, and diverticulitis
- Other gastrointestinal disorders
- Superficial injury; contusion
- Non-Hodgkin`s lymphoma

Key Diagnosis groups showing as outliers HSMR;

- Coronary atherosclerosis and other heart disease

5. MONITORING/REPORTING ROUTES

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

6. TIMELINES

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

7. RECOMMENDATIONS

The Board is asked to note the contents of this report and

- Receive assurance that the Trust has robust processes in place for the review of case level mortality through the LFD and Medical Examiner systems.
- Receive assurance that effective thematic analysis and learning is gleaned and shared from the LFD process
- Note that SHMI shows an improving trend and is in the lower expected range
- Note that HSMR is lower than expected when compared to peer organisations
- Note that further validation of the low (positive) HSMR statistic is underway

Appendix 1

NHS
Warrington and Halton Teaching Hospitals
NHS Foundation Trust

We are WHH

MRG Theme of the Month | October – 2021

CASE STUDY – PALLIATIVE/END OF LIFE CARE

Background

Frail 87-year-old with dementia (but lucid and fully communicative) under Section 3 MHA in Hollins Park. Also, IHD, OA, and possible asbestos which wasn't explored. Had several short attendances to ED with falls and minor HI. There was already a DNAR from the Community. Final attendance was a 6-week admission which started with increased SOB over several days. Initial thoughts of Covid based upon symptoms (and other residents of HP had Covid). Lymphocyte count low, however working diagnosis following timely Consultant PTWR review was decomp HF. Raised BNP. After treatment patient was making progress, but then had further infection. This sequence repeated a further 3 times in the 6 weeks. Further deterioration was noted on day 20 - ATSP hypothermic, NEWS 4, drowsy. Bloods OK, but continued high NEWS, 5 the next day. BP low. Sepsis screening inconclusive at that time, but then MSU grew Klebsiella. Inevitable outcome from this point as the patient's severe heart failure meant that fluid resuscitation was not possible. Once there was a final episode of sepsis and it was clear that he would not survive, palliative care was offered, and active care was withdrawn, and he passed away peacefully.

Points Identified

- Unnecessary procedures on an already frail patient; Had an episode of reactive arthritis in the wrist which was over-investigated, and CT contrast scan when an US scan showed a bladder lesion which had changed in appearance and some renal cysts.
- No recognition of trend when patient was dying.
- Patients who are under MHA when they die must be reviewed by the Coroner. By rescinding the MHA (provided it's not a forensic section) avoids unnecessary delays for the bereaved family when death is inevitable. This needs to be clearly documented in patient notes.
- Cut and paste notes in Lorenzo apparent in this SJR.

Learning

- Questions were raised over tests and why do we do this. Lack of senior oversight was queried, and are we doing these tests on a can or should basis.
- It was thought we should be recognising EOL and offering a more bespoke service which is responsive to a patient's individual needs.
- Juniors do a lot of the decision making and are keen to do the right thing. It was suggested that at least once a week the consultant (mainly on integrated care wards) to look at the bigger picture and predominant direction of patient and feedback to team.
- By creating a prompt to whether we are doing the right thing in regards to a patients end of life care we can set an example for the rest of the trust.

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

Appendix 2

NHS
Warrington and Halton Teaching Hospitals
NHS Foundation Trust

We are WHH

MRG Theme of the Month | November – 2021

CASE STUDY – AKI/RENAL INJURY

Background:

This 77 year old woman was admitted after being found in a confused state, wandering naked around her own home. She had diarrhoea and poor oral intake for 24-48 hours, and her main issue was pain in her bottom. On examination her abdomen was distended with compressible masses, semi-hard faeces were felt in the rectal canal, and patient had a tense and tender anal sphincter. She had a one week h/o dysuria and had taken antibiotics for 3/7 for a UTI. She also had a h/o bipolar affective disorder (on Lithium and Quetiapine), CKD Stage 3 and Vit D deficiency. She lived alone with carers attending twice daily and was mobile with a zimmer. Her working diagnosis was constipation with impaction, Urosepsis, AKI stage 3, and possible hypoactive delirium. She was reviewed by a Urology SHO and Consultant Nephrologist who felt patient to be in a diuresis phase of renal injury, advice was given regarding fluid replacement and stool chart for strict monitoring. However, 6 days after admittance the patient still had a negative fluid balance and was not a candidate for dialysis. There was a request for monitoring in a HDU environment which was declined, but regular blood monitoring and close monitoring of input/ output was advised instead. The Acute Care Team was then involved and an NG with bridle was inserted - patient was estimated water deficit by 8L. The plan was to cont. IV fluids plasmalyte alternating with 4% glucose 4 hourly and 2L water flushes via NG tube. In the days that followed a repeat CT abdo showed persistent gross distention of rectum with faeces with some resolution of right hydronephrosis and bibasal consolidation. Patient deterioated with increasing requirements of oxygen despite optimisation of medical management. After discussions with NOK it was felt the patient would be for best supportive care and with Palliative Care Team involvement. CoC was revised, anticipatory meds prescribed, patient was not for MET calls and kept comfortable.

Points Identified:

- It was identified that the patient was in a diuresis phase of renal injury, mainly due to bladder outlet obstruction. The patient was on lithium, which may have exacerbated the situation, but also they developed loose stools whilst on treatment for faecal impaction
- HDU transfer was declined but appropriate close monitoring and optimisation of fluid balance in ward was substandard.

Learning:

- Patient became hypernatraemic due to a combination of inadequate volume replacement when polyuric and the incorrect persistent use of sodium rich fluids which also drive the polyuria. Polyuria is always a risk when patients are recovering from AKI and is a common reason for recovery to stall if volume loss is not corrected for. As such monitoring fluid balance is crucial even when the creatinine is improving to ensure we are not missing polyuria. If fluid replacement is needed, appropriate fluids should be used as per trust guidance which is up to date.
- More widespread use and accurate completion of fluid balance charts in those with AKI by the nursing staff.

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

Appendix 3

Anaemia focussed review findings

This review was undertaken following HED data trigger reporting increased observed death in SHMI group (cc59)- acute post haemorrhagic anaemia, deficiency, and other anaemia. 12-month data including Dec /2020 was looked into. Observed death was 22 against expected death of 12 and gender analysis suggested predominantly female deaths (16 observed vs 5.37 expected).

13 patients' clinical data was analysed. Review encompassed an initial detailed **coding review** by senior coding manager with key findings as outlined below

1) All 13 deaths had their initial diagnosis coded correctly

2) 6 of the 13 (46%) were GP referral with known anaemia predominantly for transfusion as acute admissions (multi factorial causes including chronic anaemia on background of known malignancy, anaemia from bone marrow failure, recent chemo)

3) 3 of the 13 had high Charlson co-morbidity score over 15. Of the remaining 11, 6 had a score between 10 to15 meaning most of these patients had multiple co-morbidities with expected high mortality.

4) Based upon coding review 4 patients were identified as needing a full SJR due to variable reasons including re-admissions

3 of the 13 already had an SJR review through MRG

Indication for SJR	Care rating	Any learning identified?	Action taken
1) Elective admission- endoscopy	Good	Nil	Nil
2) Elective admission- Gastroenterology ward	Adequate	Poor documentation/ admission handover	Discussed in specialty governance meeting for learning from death & changes implemented
3) Death under 50	Good	Discussed in MRG meeting & satisfactory clinical care including ITU input	Nil

4 new SJR's undertaken by internal MRG assessor with key findings as below

Admission info/ SJR indication	Care rating	Any learning identified?	Action taken
1) Recent diagnosis of colon CA/low hb	Adequate	Pro-active resus discussions/ early palliative care team input	Referral to DNACPR work stream
2)Recent diagnosis of urology malignancy- readmission	Good	Nil concerns	Nil
3)Re-admission post ERCP with bleed	Good	Nil concerns	Nil
4) New pancytopenia- death within 24 hrs of admission	Good	Death certificate accuracy	Team fed-back

6/13 remaining patients care reviewed and discussed in MRG- nil major clinical concerns identified. Excellent clinical care was feedback to ED when a patient who presented end of life was pro-actively palliated in ED.

Outcomes of anaemia focussed review

1) Majority of patients (46%) admitted via the acute route had chronic anaemia and measures to avoid such admissions should be explored. Anaemia pathway is currently being developed by gastroenterology department which will also include a pathway for primary care to refer these patients for urgent elective day ward transfusions/ ferrinject infusions as appropriate via liaising with gastro team thereby reducing such admissions.

2) No poor clinical care identified in this focussed review. Some recurring themes including pro-active resus decisions/ discussions, death certificate accuracy have been flagged to relevant work-stream for ongoing measures to address.

3) Nil coding issues identified in this review.

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/22/03/46**	
SUBJECT:	**Report from Digital Board**	
DATE OF MEETING:	30th March 2022	
AUTHOR(S):	Tom Poulter, CIO Su Caisley, Deputy Chief Information Officer Alison Jordan, Associate Director of Information	
EXECUTIVE DIRECTOR SPONSOR:	Paul Fitzsimmons, Executive Medical Director	
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	SO1 We will.. Always put our patients first delivering safe and effective care and an excellent patient experience.	**X**
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): **(*Please DELETE as appropriate)***	**#1114** Failure to provide essential and effective Digital Services CAUSED BY increasing demands upon resources (e.g. cyber defences), new technology skillsets (e.g. Cloud), unfit solutions (e.g. Maternity), end-of-life solutions (e.g. Telephony), poor performance (e.g. Lorenzo EPR)RESULTING in a potentially reduced quality of care, data quality, a potential failure to meet statutory obligations (e.g. Civil Contingency measures) and subsequent reputational damage. **#1372** Failure to deliver the future Electronic Patient Record solution through the Strategic Procurement project in line with the Trust's time, budget and quality requirements CAUSED BY an un-affordable business case due to baseline costs, strong existing benefits & lack of new cash releasing benefits, plus delayed and diluted access to stakeholder support due to operational pressures RESULTING IN continuation of the Trust's challenges with the incumbent EPR, Lorenzo, which were identified in the Strategic Outline Case.	
EXECUTIVE SUMMARY ***(KEY ISSUES):***	The Digital Board met on the 23rd March, the meeting was postponed for 1 week, this was due to EPCMS commitments and the procurement programme. Below is a summary of papers received from key stakeholders and the minutes of the meeting are attached to this report for reference. The following assurance status for key delivery areas was noted: **Digital Board and Feeder Group Terms of Reference** A session will be held to discuss content and proposal for change in membership and reporting arrangement to improve scope and consistency of assurance. **Digital Programme.** **Good Assurance** End of tranche 2 31/03/22, 4 go lives • Ward round CDC form relaunch. • Removal of printing and postage of consultation letters for outpatients. • ICE functionality enhancements for 'Acknowledgement & Filing Results'.	

- Removal of paper diaries for Paediatrics ward attenders.

DOG met on 15th Feb, focus on prioritisation for 22/23, 8 approved for Elective Recovery Programme; 9 prioritised as projects for 22/23; 2 are unprioritized.

Dedalus (formerly DXC) Vendor management.
Good Assurance

- Vendor management meeting was cancelled this month, this was due to EPCMS commitments.

Information and business intelligence.
Good Assurance
Statutory reporting remains a challenge due to frequent new and changing requirements from NHS Digital, CIPHA and other external agencies.
The latest Corporate Information and BI deployments/developments include:

- Postcodes – reporting updates
- 2022/23 HRG Grouper Consultation Support
- VTE - Identification of patients for RCA
- ePCMS Video and OBS evaluation
- Medical Take List report
- 2022/23 Planning – Supporting datasets for RTT, Outpatient and Discharges

IT Services Update.
Substantial Assurance.

- 12 projects Completed since last Digital board**.**
- Change Control Activity all of January's change requests have been completed.
- IT received a total of 2125 Service Desk calls. The first time fix rate of the calls that were taken and resolved by the Service Desk staff is at 68**%.**
- Data centre application up time 100%
- Network availability up time 100%
- 3 outstanding devices on the Trust network to migrate to Windows 10 to be fully compliant. IT are working with thedepartments to resolve.

Digital Compliance and Risk.

Substantial Assurance

- The National Cyber Security Centre (NCSC) has urged organisations in the UK to bolster their cyber security resilience in response to malicious cyber incidents as a result of the ongoing situation in the Ukraine.

- Microsoft Advanced Threat Protection a significant drop of the Advanced Threat Score to just above the target of 29 (low) Trust score is 30.
- CareCERTs There was 1 High CareCERT reported last month by NHS Digital, this did not affect the Trust as we do not use affected version of VMWare.

Strategic Electronic Patient Record
Good Assurance

Concluding stages, almost in position to confirm and communicate outcome. Core team are meeting over the next week to work through validation and risk assessments. EPR board approval on 5th April. Acknowledged Dedalus plans complicating matters, actions around tactical Lorenzo contract. And impact assessment is to be completed.

Clinical safety and risk review.
No clinical PANs (Lorenzo) reported this month

Digital Diagnostics Programme
Good Assurance

- All schemes on target for spend in this financial year. Resource via DDCP funding should see the resolution of site-specific issues around digital pathology.
- Collect on" option for ICE requesting introduced in preparation for removing Pathology paper requesting/Phlebotomy App.
- Working with AMU to introduce a process change in ICE requesting to allow for the roll out of the Phlebotomy app to the bedside.

Digital Maternity.
Good Assurance.
The phased go-live is scheduled for 3 May (antenatal) and 16 May (intrapartum).

- Project timeline: activity remains predominantly testing and training.
- Interfaces: interface work completed, and testing commenced
- Training: Staff feedback positive, DNAs due to operational pressures manageable but close monitoring needed.

RIS Procurement

- Contract awarded as using CORE CRIS and moving CRIS EVO. This will be a centrally managed.
- CCN to be signed by 1st April, most trusts still to sign.
- CRIS EVOs functions will be available for use in the next 12-18 months.

eRostering Tactical Update
Good Assurance

	Level of Attainment (LoA) – We have achieved 94% of substantive clinical workforce using e-rostering for medics so far, NHSE/I confirmed that it is not a requirement to include locums in this % (please note there is in excess for 200 locums working in the Trust). We are still working towards 5 AHP areas. Clinical Workforce Group (Allied Health Professionals (AHPs)) – 5 areas have been identified to on board at this stage – Radiography, Orthoptics, Physiotherapy, Dietetics and Therapy. **Regional "place" Digital Programme** **Deferred until April Meeting.** **Items to escalate to FSC (for information only):** • Dedalus announcement that Lorenzo EPR will be replaced by ORBIS U – a comprehensive impact assessment to be completed asap, with regards to the implications for BAU and strategic EPR plans • Paperless care programme discussion about "switching off" paper-format Pathology requesting and results – actions to assess operational SOPs and clinical safety issues for a timetable to be confirmation for phased removal of paper • IT Services to commence SLA reporting against KPIs for incident resolution and request fulfilment from April 2022 • Enhanced cyber security assurance and plan for business continuity exercises • EPCMS procurement in final stages, outcome to be recommended to EPR Board on 5th April 2022 • Badgernet Maternity EPR on track for planned go live in March 2022 (focus on training required)

PURPOSE: ***(please select as appropriate)***	Information x	Approval	To note	Decision
RECOMMENDATION:	The Trust Board is asked to note the report.			
PREVIOUSLY CONSIDERED BY:	**Committee**	Circulated to FSC Members for information 24/03/2022		
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	Section 43 – prejudice to commercial interests			

REPORT TO BOARD OF DIRECTORS

SUBJECT	Digital Board Update	AGENDA REF:	BM/22/03/46

1. BACKGROUND/CONTEXT

This report provides an update on the programmes of work in Digital Services and Digital Analytics, with the latest assurance assessment, this report does not include minutes of February Digital Board the meeting was cancelled due to EPCMS commitments.

2. KEY ELEMENTS

1.1 Digital Programme

Good Assurance

An update on progress for the Paperless Care Programme. 4 projects completed since last Digital Board update. The Digital Optimisation Group met on 15th February the main focus of the meeting to prioritise Paperless Care 22/23 programme. 5 projects on Track to be delivered in Tranche 1 and 9 projects at risk but with moderate mitigation plans in place. On the 3rd March Global Director of External Relations Will Smart emailed the Trust to announce; the change to Orbis_U, A meeting is being arranged with Dedalus to discuss next steps

1.2 Dedalus (formerly DXC) Vendor management

Good Assurance

March meeting cancelled due to EPCMS commitments.

1.3 Information and business intelligence.

Good Assurance

Statutory reporting remains a challenge due to frequent new and changing requirements from NHS Digital, CIPHA and other external agencies.
The team have suffered significant team losses due to recent staff departures – this has caused some slippage in projects and proving very difficult to recruit against these vacancies.
The latest Corporate Information and BI deployments/developments include:

- Postcodes – reporting updates
- 2022/23 HRG Grouper Consultation Support
- VTE - Identification of patients for RCA
- ePCMS Video and OBS evaluation
- Medical Take List report
- 2022/23 Planning – Supporting datasets for RTT, Outpatient and Discharges

1.4 IT Services Update.

Substantial Assurance

12 projects completed since last Digital board**.** IT received a total of **2125** Service Desk calls. First time fix via telephone handled activity 68%. To ensure we have full Infrastructure compliancy and

protection against Cyber attacks we are required to patch all network Infrastructure. We will be providing SLA metrics from April 2022 on the Trust network activity. All of January's change requests have been completed, except for 1 pending CAB approval in February.

1.5 Digital Compliance and Risk.

Substantial Assurance

The National Cyber Security Centre (NCSC) has urged organisations in the UK to bolster their cyber security resilience in response to malicious cyber incidents as a result of the ongoing situation in the Ukraine.

Microsoft Advanced Threat Protection a significant drop of the Advanced Threat Score to just above the target of 29 (low) Trust score is 30.
There was 1 High CareCERT reported last month by NHS Digital, this did not affect the Trust as we do not use affected version of VMWare.

1.6 Strategic Electronic Patient Care Management System (including tactical solution).

Good Assurance

Concluding stages of EPCMS, almost in position to confirm and communicate outcome. Core team are meeting over the next week to work through validation and risk assessments. EPR board approval on 5th April. Acknowledged Dedalus plans complicating matters, actions around tactical Lorenzo contract. And impact assessment is to be completed.

1.7 Clinical safety and risk review.

Good Assurance (for Lorenzo).

No clinical PANs (Lorenzo) reported this month.

1.8 Digital Diagnostics Programme

Good Assurance

All CMPN DDCP workstreams are on Track, 1 is off track which is Digital Pathology, DDCP funding ringfenced to support resource requirements as necessary. Conversations ongoing as to whether Philips can provide the long-term solution for Digital Pathology in C&M.

All schemes on target for spend in this financial year. Resource via DDCP funding should see the resolution of site-specific issues around digital pathology.

Collect on" option for ICE requesting introduced in preparation for removing Pathology paper requesting/Phlebotomy App.

Working with AMU to introduce a process change in ICE requesting to allow for the roll out of the Phlebotomy app to the bedside.

1.9 Digital Maternity.

Good Assurance

Progress against key risks discussed at the February Project Group meeting.
Reporting: collaborative working to define the reporting solution.
Interfaces: interface work completed, and testing commenced
Training: Staff feedback positive, DNAs due to operational pressures manageable but close monitoring needed.

1.10 Radiology Information System (RIS) Procurement.

Kick off engagement meeting to take place 5th April with Trust's representatives from IT and Radiology department. Brian Rigby IT Infrastructure Manager & Darren Owens Diagnostic Systems Manager will represent WHH.

Work to start on integrating Mid Cheshire's radiology data on to the existing C&M infrastructure by Aug 2022, after that all Trusts will be migrated to the new centrally hosted solution by Oct 2022.

Contract awarded as using CORE CRIS, and moving CRIS EVO. This will be a centrally managed.
CCN to be signed by 1st April, most trusts still to sign.
CRIS EVOs functions will be available for use in the next 12-18 months.

1.11 eRostering Tactical Update

Good Assurance

The objective of workforce development Medical e-Rostering Level of Attainment (LoA) 1 is to achieve 90% utilisation across all clinical workforce by 31 March 2022.

Level of Attainment (LoA) – We have achieved 94% of substantive clinical workforce using e-rostering for medics so far, NHSE/I confirmed that it is not a requirement to include locums in this % (please note there is in excess for 200 locums working in the Trust). We are still working towards 5 AHP areas.

Clinical Workforce Group (Allied Health Professionals (AHPs)) – 5 areas have been identified to on board at this stage – Radiography, Orthoptics, Physiotherapy, Dietetics and Therapy.

3. ACTIONS REQUIRED/RESPONSIBLE OFFICER

Actions from the Digital Board meeting are identified within the attached minutes and managed via an Action log that is reviewed at the start of each meeting.

The following items are highlight for attention of Finance & Sustainability (for information only, required actions assigned and being managed appropriately)

4. RECOMMENDATIONS

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

Appendix 1 ATAIN Action Plan

Item No	Link to ATAIN admission criteria (i.e. Respiratory, Jaundice, Hypoglycaemia, HIE, Observation, Poor feeding)	Recommendation identified following case review	Action plan to achieve compliance with recommendation (SMART)	Lead Responsible	Expected date for completion	RAG rating	Progress/comments	Date completed
1	Governance of ATAIN process	Outlier for high term admissions to neonatal unit in North West Neonatal ODN network. Quarterly dashboard monitoring reports admission rate above 6% national target and 5.6% ODN target	Continue to monitor term admission rates to neonatal unit and monitor progress in reducing this rate. Present ODN dashboards at Departmental governance meetings to ensure robust monitoring and scrutiny of admission rates.	Delyth Webb Consultant Paediatrician	May-22		Audit of term admissions to neonatal in progress. Q3 2021/22 TC results to be presented at Paediatric Departmental Audit Meeting in March 2022. NNU currently unit showing reducing rate of term admissions- 5.2% Q3 2021/2. The aim is to achieve a reduction to 6% by April 2022 and ongoing monitoring until NWNODN target of 5.6% is achieved. Updated 15/02/2022	
2	Governance of ATAIN process	Review ATAIN administrative process to ensure MDT attendance at weekly meetings.	Review TOR, identify admin support for ATAIN review meetings. Schedule dates and send meeting invitations.	Emma Bentham, CBU Personal Assistant	Nov-21		Admin and clerical support identified to gather case notes, record meeting minutes, prepare agendas and send out invitations. TOR reviewed and updated.	01/11 /2021
3	Governance of ATAIN process	Establish regular review meetings by a multidisciplinary team to discuss cases and identify avoidable factors for term admissions To ensure	ATAIN proforma to be updated to ensure all information is captured effectively. And allow for auditing and collation of themes.	Chris Bentham, Obstetric Governance Lead	Oct-21		Electronic proforma developed to allow for capture of essential information.	01/11 /2021

		that all term admissions to NNU are reviewed using a standardised template to identify areas for improvement.						
4	Governance of ATAIN process	To ensure Safety Champions receive updates on learning ad improvement identified from ATAIN reviews.	Sharing of meeting minutes and action log as part of Safety Champions monthly meeting.	Catherine Owens, DoM	May-22		Safety Champions to be included in distribution of meeting minutes from March 2022 onwards. Updated 15/02/2022	
5	Governance of ATAIN process	Ensure the Board have oversight of the ATAIN programme and progression of action plans.	Quarterly HLBP to Board describing learning from reviews and progress of action plans. Development of Board reporting work plan to schedule dates for quarterly reporting.	Catherine Owens, DoM	Feb-22		Q3 ATAIN report to be presented to QAC 01/03/2022.	
6	Governance of ATAIN process	Develop action log to record learning and improvement identified for each case.	Development of ATAIN cases for review. Development of action log in response to learning identified.	Emma Bentham, CBU Personal Assistant	Nov-21		Case review log completed. CBU Personal Assistant is able to identify new cases for review and monitor any backlog of case reviews. Action log also completed which is tracked to specific case review and learning.	01/11 /2021
7	Governance of ATAIN process	Ensure staff receive feedback from teams and earning identified at case reviews.	Learning for individuals ad groups to be identified and supported by specialist midwives and obstetric supervisors. Information on themes identified to be shared incidence	Lorraine Millward Governance Manager	Jan-22		OWL newsletter included learning from ATAIN revies. Safety Champions newsletter contained details of CTG Fresh Eyes approach. SPL circulated to staff. Individual learning opportunities offered to staff as required.	31/01 /2022

			newsletters and ward-based safety briefs.					
8	Education and Training	Outlier for high term admissions to neonatal unit. ATAIN e-learning courses is not mandatory.	Inclusion of ATAIN e-learning as part of the maternity TNA programme.	Jeanette Carter PDM	Feb-22		Email to all staff advising ATAIN e-learning has been included in the Trust maternity training requirements. E-learning can now be monitored on ESR for levels of compliance. Action deadline to be extended util June 2022, to allow for monitoring of compliance. Updated 15/02/2022	
9	Provision of Transitional Care	Outlier for high term admissions to neonatal unit. Ward based TC model is not effective due to staffing requirements within the unit.	Establish Transitional Virtual Model of Care to support management of term eligible babies close to mother and avoid neonatal unit admission.	Women's Health Matron for Inpatient Services	30/09/2021		Transitional Care guideline has been updated to describe virtual model of transitional care. Babies requiring a higher level of care will remain om the postnatal ward. Babies eligible for TC will be care for in a virtual location with support from NNU nursery nurse and professional oversite from NNU nurses.	30/09/2021
10	Provision of Transitional Care	On occasions reduced staffing levels in maternity and neonatal teams has reduced the provision of a virtual TC service and some babies eligible for TC have been admitted to NNU.	To audit the number of babies admitted for "special care" who may have been able to receive TC care if the service was available. To review maternity and neonatal staffing levels to support provision of TC in the longer term.	Paediatric Nurse Consultant	31/05/2022		Review of NNU staffing is underway and will be presented to the Workforce Committee in May 2022. Red Flag reporting system under development for TC babies who are admired to NNU due to staff shortages. Updated 15/02/2022	

11	Provision of Transitional Care	Q2 TC audit has highlighted gaps in compliance with the TC pathway and guideline.	Task and finish group to be established to review recording and monitoring of TC babies on the postnatal ward.	Paediatric Nurse Consultant	14/01/2022		Task and finish group has been established with representation from Matrons, Ward managers, neonatal and maternity staff.	14/01/2022
12	Hypothermia	Reduce number of babies admitted to NNU from theatre recovery area with hypothermia due to environmental factors in the maternity theatre setting.	Posters to be developed to raise awareness of keeping baby warm and well wrapped. Staff to be informed to set Resuscitaire temperature to "full and not pre warm". Environmental temperature to be monitored daily.	Birth Suite Manager	31/03/2022		Posters have been developed for the recovery area to advise who to warp a baby and maintain temperature. Staff have increased temperature of resuscitaire. Low temperature thermometers have been ordered to accurately monitor babies' temperature. Updated 15/02/2022	
13	Respiratory and Poor Feeding Admission Criteria	Reduction the number of term neonatal admissions admitted due to hypoglycaemia and respiratory conditions caused by hypothermia	Education of staff on the warm care bundle. Re launch the warm care bundle with updated guidelines and QI initiatives as part of the MatNeoSIP improvement programme	Birth Suite Manager	1st June 2022		Guidelines from other trusts have bene received along with supporting information on the Warm Care Bundle. Midwifery and Neonatal champions to be identified to support the relaunch of the project. Improved baby blankets to be purchased for birth Suite as current blankets considered not to be effective in keeping baby warm. Updated 15/02/2022	
14	Respiratory Conditions	Increase in term admission to NNU for respiratory support following elective caesarean section.	Audit of infants born by caesarean section to identify areas for further improvement.	NNU Manager	Jul-22			

15	Respiratory Conditions	Increase in admission to NNU for respiratory support associated with obsolete or broken resuscitation equipment.	5 new resuscitaires to be ordered as part of the capital planning process and emergency equipment funding.	Birth Suite Manager	Jul-22		Current resuscitaires are in working order and have been inspected and maintained by Medical Devices Team. Bid for 5 resuscitaires successful and equipment ordered. Awaiting delivery of new equipment. Updated 15/02/2022	
16	Respiratory Conditions.	Action required to support staff with earlier identification of neonates at risk of respiratory distress and early interventions	Support for staff. SOP required. Jayne Wright will be asked to lead on this. Kim Wilcock has started writing a SOP on supporting new-borns with Respiratory Distress for midwives on Birth Suite, C23 and the NEST. First DRAFT embedded. Requested neonatal staff input.	Jayne Wright, Kim Wilcock and Delyth Webb	28/05/2022		Several mothers and babies have benefited from this method of avoiding separation.	
17	Suspected HIE	Identifying fetal monitoring errors and omission of fresh eyes review as a contributory factor in NNU admissions	To review CTG training compliance for all staff who give an opinion on a trace. To complete Fresh Eyes QI project to improve hourly review of CTG trace.	Sarah David, Lead Midwife for fetal monitoring	30/11/2021		Current work stream in progress to complete fetal monitoring training with all midwives. Additional dates added to Bank staff training to ensure training is complete.	30/11/2021
18	Suspected HIE	Intrapartum CTG concerns were a contributory factor to NNU admission.	Fetal monitoring midwife to share CTG for learning at C-Shop. Staff involved in the incident to be offered the opportunity to reflect and learn from the case review findings. Focus on K2	Chris Bentham, Obstetric Governance Lead	30th June 2021		Quarterly monitoring of Fetal monitoring training compliance at Departmental Governance Meetings. Individuals have met with Fetal Surveillance Midwife and Obstetric Supervisor. Case has been presented at C-Shop for wider learning.	30/11/2021

			training for all staff who give an opinion on a trace.					
19	Suspected HIE	Admission of babies to NNU for observation of borderline cord pH and neonates admitted with low cord pH and risk of HIE	Guidance in progress – to identify babies at risk of later compromise and ensure safe postnatal transition.	Laura Iley, Marisa Owen and Narayana Vayyeti	30/06/2022			

20	COVID-19 Review. Observation Admission Criteria	Care of neonates born to suspected/ confirmed COVID-19 mothers and who require additional care	Guidance from Royal College of Paediatrics and Child Health and British Association of Perinatal Medicine (BAPM)	Delyth Webb Consultant Paediatrician	30/05/2020		These babies should be assessed in the birth suite and a decision made as to whether additional care can safely be provided at the mother's bedside – using the same criteria as used for additional care and observations with COVID negative mothers. If so, baby and mother remain together in appropriate isolation cubicle on delivery suite. If a prolonged stay for the baby is required, consideration of transfer of mother and baby to paediatric ward is required on an individual basis. Several mothers and babies have benefited from this method of avoiding separation. Babies of COVID positive mothers requiring admission to the NNU are assessed in a designated area in the NNU – an isolation cubicle is set up for this purpose. Infants who require respiratory support via ventilation or high flow will have a designated nurse with full AGP level PPE caring 1:1 for that baby. All equipment in the isolation room is cleaned as per Trust COVID-19 cleaning policy. A register must be kept of all staff entering the room. BAPM COVID-19 guidance is followed regarding these infants including parental support and use of breastmilk. As soon as practicable when the baby is suitable for care next to the mother, they will be transferred to a suitable cubicle with mother either on the maternity or paediatric unit. This allows her to stay with her baby whilst minimising infection risk to other parents and staff.	30/08 /2020

21	COVID-19 Review. Observation Admission Criteria	Increase in new-borns admitted to NNU with hypothermia which may be linked to birth rooms / theatres being colder than normal due to COVID-19 room ventilation advice	Reintroduce warm care bundle. Audit number of infants and reasons for admission.	Jayne Wright and Kim Wilcock	28/05/2021		Recent trend of incidents where neonates are admitted to NNU with hypothermia. ATAIN reviews identify reduced compliance with documentation of warm care bundle documentation. Jayne Wright is birth suite champion for the warm care bundle. Kim Wilcock has contacted the theatres manager regarding the temperature in maternity theatre as this is an area identified as being cool. The maternity team are asking for a temperature of 23C but this is often around 20C. It has recently been noted that the delivery unit temperature is cold, particularly at night. New window blinds that have been installed have helped. Updated 06/05/21: Action completed. Thermometers in all rooms on Birth Suite (rooms ideally to be monitored to ensure temp 23 degrees). There is ongoing discussion pertaining to theatres and ideal temperature. Delyth Webb discussed the perinatal optimisation toolkit (for preterm infants – however delivery room temperature relevant) and WHO guidance and will send this information to the group. https://www.bapm.org/pages/105-normothermia-toolkit http://apps.who.int/iris/bitstream/handle/10665/63986/WHO_RHT_MSM_97.2.pdf;jsessionid=C3F1622917CA237E50691F8018DAD37F?sequence=1	06/06/2021
22	Governance of ATAIN process	Monitor actions recommended in ATAIN reviews (i.e. individual learning/guideline review etc) as part of an action log.	Action log to be completed as part of ATAIN meeting process and regularly reviewed and updated.	Chris Bentham, Obstetric Governance Lead	Nov-21		Action log reviewed and updated at ATAIN meetings.	Nov-21

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Equality Duty Assurance Report (EDAR) 2021-2022

disability confident EMPLOYER

Contents

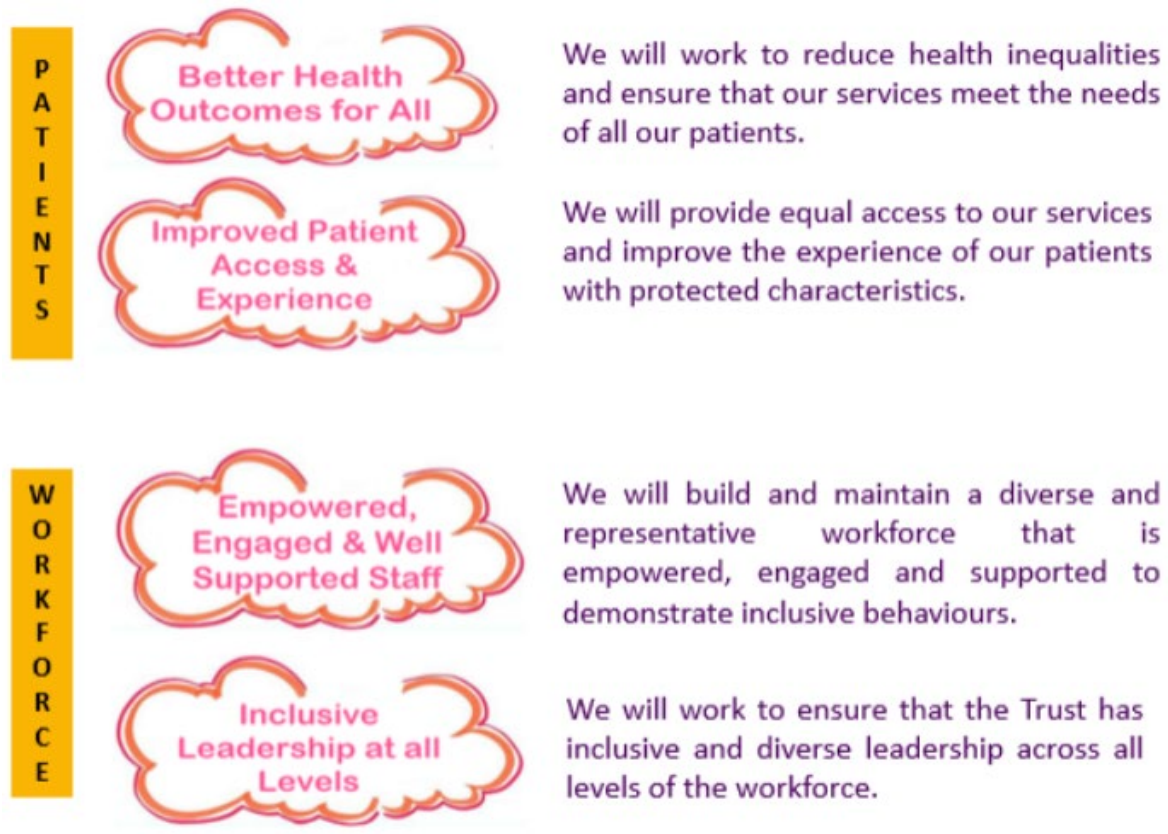
1. Introduction

1.1 Background

Public Sector organisations have been required to demonstrate how they are actively working to reduce health inequalities by promoting equality and working to eliminate discrimination, whilst maintaining a commitment to respect human rights. Moreover, they need to demonstrate the outcomes of this work, in particular, showing how they have assessed the impact of policies, strategies and action plans on the local population and its workforce.

The Trust's Equality, Diversity and Inclusion Strategy's objectives which provide an approach to delivering the organisation's Public Sector Equality Duty expectations is outlined in **diagram one.** The objectives cover both our equality, diversity and inclusion objectives from a patient and workforce perspective**:**

Diagram One: Equality, Diversity and Inclusion Strategy Objectives 2019 - 2022



1.2 Aims of the Equality Duty Assurance Report (EDAR)

In formulating this Equality Duty Assurance Report (EDAR), Warrington and Halton Teaching Hospitals NHS Foundation Trust (WHH) is not only aiming to ensure that it is meeting the legal duties to promote equality and challenge unlawful discrimination, but also to ensure that consideration of equality and human rights issues is incorporated into day-to-day practice across the organisation. Intended outcomes will be equal access to services for all groups and reduced health inequalities and improved health outcomes for patients. Safeguarding employees across the protected characteristics and a commitment to advance equality of opportunity across the organisation are also key components.

This document aims to provide reassurance that the strategic direction of WHH for promoting equality and eliminating discrimination since April 2011 underpins its adherence to the general duty of the Equality Act (2010) and binding specific duties of the equality duty. Moreover, it may serve as a stepping stone towards formulating strategies and actions that build upon the previous achievements made under Equality Delivery System (EDS2) and related equality action plans.

1.3 Scope of the Equality Duty Assurance Report (EDAR)

This Equality Duty Assurance Report sets out the commitment of Warrington and Halton Hospitals NHS Foundation Trust (WHH) in how it will endeavour to adhere to statutory obligations, building upon progress achieved under previous equality schemes and directives.

2 The Public Sector Equality Duty

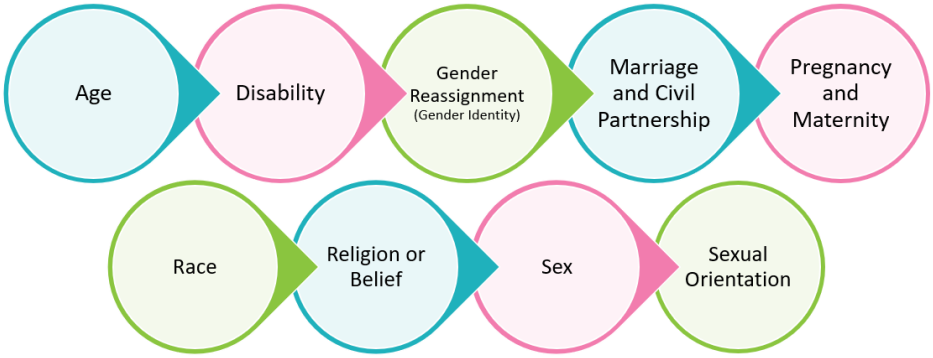
2.1 Legislation Overview

In April 2010, the Equality Act received Royal assent. The act identified the phased implementation of legislative requirements, to bring into effect measures to promote equality and eliminate discrimination, which were built upon nine previous pieces of equality law. The initial phase came into force in October 2010. The second phase came into effect from 5th of April 2011. This took the form of the creation of a single equality duty for public sector bodies. The third phase came forward from 1st of October 2012 and this extended *Age equality* from only employment protection to include the duty with regard to the provision of goods and services

This single equality duty replaces the three previous duties which applied to only race, disability and gender. The duty now includes other protected characteristics, although the part of the general duty that applies to *civil partnership and marriage* is the responsibility to eliminate discrimination and prohibited conduct.

The full list of protected characteristics as outlined in the Equality Act (2010) are illustrated in **diagram two**.

Diagram Two: Protected Characteristics in the Equality Act (2010)



Warrington and Halton Hospitals Teaching Hospitals NHS Foundation Trust (WHH) has been working towards eliminating discrimination across many of these protected characteristics for some time, which is reflected in the organisation's Equality, Diversity and Inclusion strategy and its objectives as outlined in section 1. In addition, the Trust also ensures that due regard is given to other vulnerable groups, such as, but not limited to:

- Carers
- Deprived Communities
- Asylum Seekers and Refugees
- Military Veterans and the Armed Forces Community.

To support the EDAR, the organisation also provides a profile of its workforce by protected characteristic through the Workforce Equality Analysis Report which is published on the organisation's website. From a patient perspective, an analysis of each protected characteristic by patient profile is available in **appendix one**.

2.1.1 What are the Equality Duties?

The single equality duty requires public organisations to show how they will adhere to the new ***general duty***. This is underpinned by a set of actions and assurances termed the ***specific duties***. These serve as guidance on how the general duty can be met, through a range of actions and the provision of evidence in varied formats. The framework is based upon the

inaugural creation of a public sector equality duty for race, which came into force in 2002, following the race relations (amendment) Act (2000).

The **general duty** is illustrated below:

- **Eliminate** unlawful discrimination, harassment and victimisation and other conduct prohibited by the Act.
- **Advance** equality of opportunity between people who share a protected characteristic and those who do not.
- **Foster** good relations between people who share a protected characteristic and those who do not.

Public Sector bodies, such as Warrington and Halton Teaching Hospitals NHS Foundation Trust should adhere to the **public sector specific** duties which came into force on 10th September 2011 and state that public sector bodies should:

- **publish information** to demonstrate compliance with the general duty by 31st January each year.
- **publish one or more specific and measurable equality objectives** which will help to further the three aims of the Equality Duty by 6th April 2012 (annual thereafter).

Adherence to the public sector specific equality duties are through the production of the Workforce Equality Analysis Report (WEAR) and the Equality Duty Assurance Report (EDAR). All information published will need to ensure that it is accessible to the public and available in various formats upon request.

2.2 Amendments to previous obligations

There is no longer a requirement to produce a single equality scheme (SES) and the Warrington and Halton Teaching Hospitals NHS Foundation Trust's SES ended on 31st March 2014.

WHH introduced equality impact assessments, with regard to assessing potential differential impacts against protected characteristics and Human Rights Articles.

The emphasis of equality, diversity and inclusion now focuses on equality outcomes and productivity rather then process. To help NHS Trusts to demonstrate equality assurance and performance, NHS England introduced the NHS Equality Delivery System.

WHH will continue its commitment to adhere to the revised equality duties and build upon the significant progress of work already undertaken with regard to race, disability and gender

and all other protected characteristics. This equality duty assurance report is clear and provides the means to demonstrate adherence to the general duty.

Since the onset of the Specific duties of the single equality duty, WHH has met its obligation to "Publish Information outlining how they (WHH) will comply with the general duty", through annually published Equality Duty Assurance Reports and Workforce Equality Analysis Reports, and the Workforce Race Equality Standard, within the designated Time frames and will subsequently meet the requirements laid out for the Workforce Disability Standard in 2019.

The assessment of the 18 individual EDS2 outcomes can only be assessed by internal and external stakeholders, who reflect the spectrum of the protected characteristics and represent their respective interests and collective insight. So the grades provide robust assurance that the Trust's functions, services, policies and strategies are working towards reducing inequality and health inequalities across the whole organisation.

3. Meeting the Equality Duties

3.1 Providing evidence on meeting the "Duty"

Through this EDAR and the Workforce Equality Analysis Report (WEAR) (2021) which will also be published by 31st of January 2022, WHH aims to demonstrate how it is paying due regard to the general duty.

The EDAR outlines the equality governance framework of the organisation, which underpins equality and human rights activity across all functions, policies and services within the organisation.

The Workforce Equality, Diversity and Inclusion Sub Committee (WEDISC) and Patient Equality, Diversity and Inclusion Sub Committee (PEDISC) are chaired by the Chief People Officer and Chief Nurse and Deputy Chief Executive, respectively, who will in turn ensure reports go to the Board of Directors. The EDI Sub Committees have internal and external stakeholder membership, with active involvement from patient representatives and members of third sector bodies.

The Trust's four Staff Equality Networks representing Race, Disability, Sexual Orientation & Gender Identity, and Armed Forces, all have representatives who attend the Workforce EDI Sub Committee. The aim of this is to help ensure the voice of our workforce is fed in at this level and that commitments can be made to ensure the Trust is eliminating any potential for discrimination within its Workforce.

The EDI Sub Committees link in with the following groups within the governance structure in Trust:

- Patient Experience Sub-committee
- Operational People Committee
- Strategic People Committee
- Quality Assurance Committee
- Trust Board

The Trust's Workforce EDI Sub-Committee has membership of the Chairs from the following Staff Networks:

- LGBTQA+ Staff Network
- Disability Awareness Network
- BAME (Building A Multicultural Environment) Staff Network
- Armed Forces Staff Network

In addition, the organisation's Staff Networks have a standing agenda item on the Workforce EDI Sub-Committee and the work of the Workforce EDI Sub-Committee is also supported by additional staff engagement mechanisms such as the Freedom To Speak Up Champions and Mental Health First Aiders where appropriate.

As in previous years, WHH can provide its strategic documents in varied formats. Although it is not a legal requirement to publish equality analysis and engagement undertakings, WHH will continue to be transparent and inclusive, in demonstrating how it is meeting its equality duty and working in partnership with others.

3.2 Consultation and involvement of staff and service users

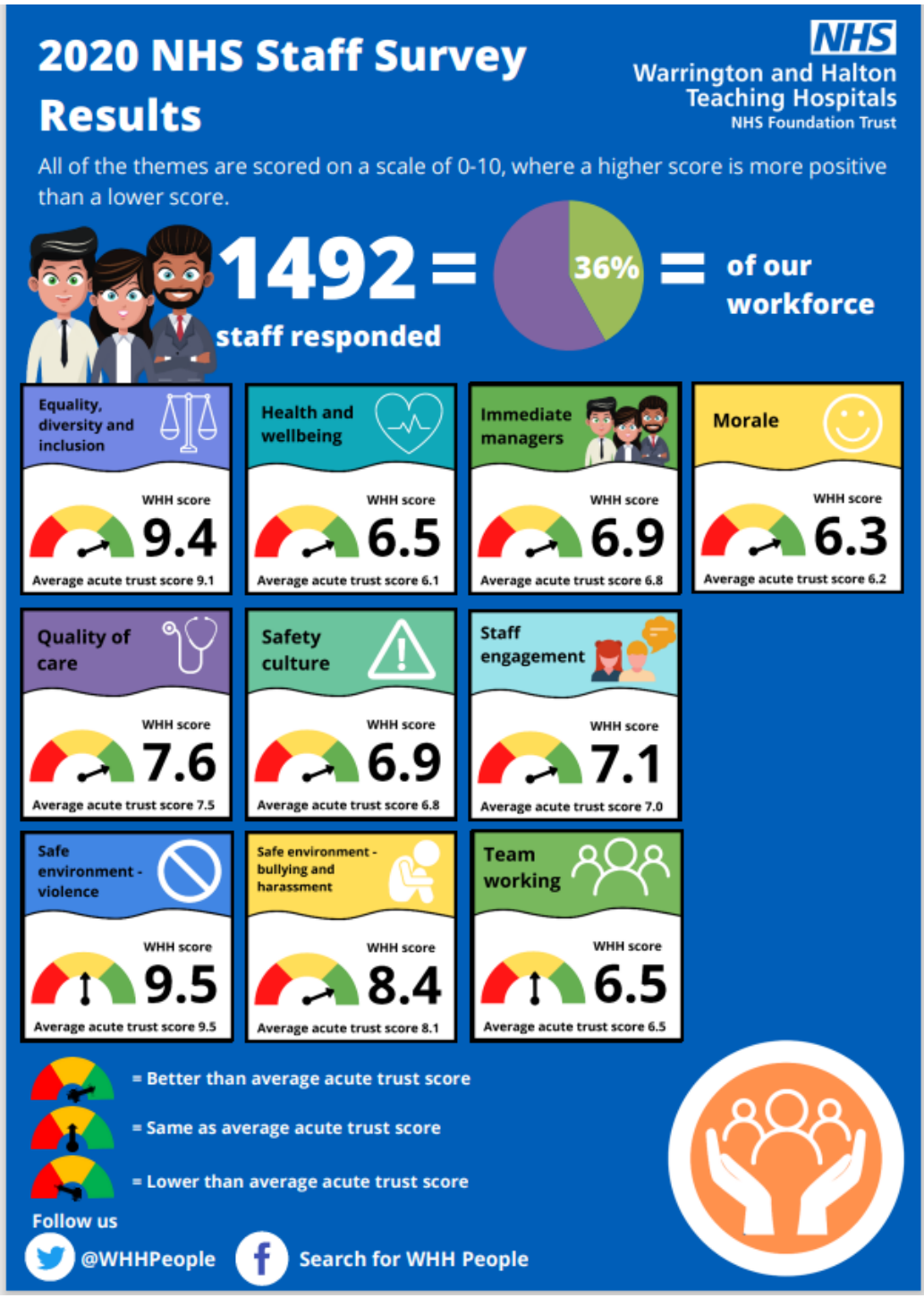
WHH is committed to ensuring that staff and service users are involved in shaping the equality, diversity and inclusion work streams and have opportunities to influence health service planning and delivery. The Trust's approach is supported by a Head of OD, Learning and Culture which supports the staff engagement and wellbeing portfolio and ensures that staff voice is integral to improving the experiences of the workforce at WHH. The Trust also has workforce and patient Equality, Diversity and Inclusion Sub-Committees made up of staff and external stakeholders, which directs its associated EDI action plans and work plans for 2019-2022. Both staff engagement & well-being, and equality, diversity and inclusion agendas are reported through the Operation People Committee and the Strategic People Committee.

From a workforce perspective the Trust utilises analysis from the annual staff survey and recently implemented quarterly NHS People Pulse survey[1] which is able to be broken down into protected characteristics to understand the experiences of our staff. The Trust's 2020 staff survey data, illustrated in **diagram three** illustrates that the organisation is doing better than the Acute Trust average across England in 8 areas with the same as the Acute Trust average score in two areas, focusing on safe environment in relation to violence and team working.

[1] NHS People Pulse Survey: www.england.nhs.uk/nhs-people-pulse

These results are shared with the Staff Networks who contribute to an organisational staff survey action plan based on the experiences of their networks and illustrating how the organisation are paying due regard to the experiences of individuals who have protected characteristics as outlined in the Equality Act (2010) and diagram two.

Diagram Three: NHS Staff Survey 2020 Results



From a patient perspective the Trust works in partnership with a variety of external partners and advocacy groups. This allows for a greater understanding of the local population, health needs and barriers to accessing health care which leads to addressing potential health inequalities.

The Trust complies with the Equality Delivery System reporting which is in place for both patients and service users and workforce. Grading is completed on an annual basis for the 9 outcomes for patients and service users and this is graded in collaboration with community partners, key stakeholders and the wider public. A copy of the latest EDS2 grading can be found on the Trust website.

The Trust is confident in securing the views of patients and their families and this is evidenced by the following:

- Trust Friends and Family Test Scores - Inpatient, Emergency Department, Maternity and Outpatients
- National Patient Survey Results
- NHS Choices – Online comments
- Patient feedback reported through Patient Experience and Inclusion Team and local Community Partners and Healthwatch
- Patient and public engagement events

Scores and data collated from the Friends and Family Test, survey results and subsequent action plans and key themes identified through engagement with the public and community partners are reported monthly through the Patient Experience Sub-Committee.

Table one highlights available data for the Trust Friends and Family Test in 2021/22 with the Cheshire and Merseyside average for local Emergency Departments.

Table One: Patient Friends and Family Test Data

Month	Internal Target	Emergency Department	Cheshire and Merseyside Average	Inpatient Areas	Outpatient Areas
April 2021	87%	79%	84%	98%	93%
May 2021	87%	78%	83%	98%	93%
June 2021	87%	77%	76%	98%	93%
July 2021	87%	73%	71%	96%	92%
August 2021	87%	70%	73%	96%	93%
September 2021	87%	72%	71%	97%	92%
October 2021	87%	68%	70%	96%	93%
November 2021	87%	73%	74%	98%	93%
December 2021	87%	75%	*No data*	97%	93%
January 2022	87%	75%	*No data*	98%	93%

The Trust is able to breakdown feedback results by protected characteristic to highlight if there are any disproportionate impact on patient's experience. Learnings from patient feedback and results are utilised in patient stories which allows for continued learning across the Trust and improvements in the Customer Service training.

WHH has a strong emphasis on engagement in its equality action plans, in order to facilitate '*autonomy, accountability and democratic legitimacy*' with regard to how it discharges undertakings under the general duty of the equality Act (2010). Only by working in partnership with service users and our staff can we develop services that meet local need and are utilised effectively.

3.3 Equality Monitoring

Good quality data underpins all equality and diversity work from identifying priorities to measuring the effectiveness of our actions. The quality of data collection and analysis needs to be improved in order that we may effectively understand our local population and who is using local services. Continuing to improve the capture and quality of equality data is a key element of the existing EDI strategy and is reflected within the workplans and action plans of the workforce and patient EDI teams.

3.4 Equality Impact Assessments

A commitment to undertaking equality analysis ensures that our policies, strategies, functions and any services we deliver endeavour not to lead to an unfavourable effects on different people and help to identify any positive action we can take to promote equality of opportunity and access.

An Equality Impact Assessment is a tool that is used to ensure due regard is recorded in respect of decision making, policies, procedures, and strategic and operational decisions so they are inclusive and don't disadvantage individuals or groups protected under the Equality Act 2010. Equality Impact Assessments are an evidence-based tool to enable a demonstrated compliance with the public sector equality duty, it helps to support good decision-making through methodical assessment of likely or actual impact and analysis for people relating to the 9 protected characteristics.

In 2021/22 the Trust progressed a development programme to have a more effective equality analysis process to inform and improve health outcomes for all. This is being achieved through a three-step process:

1. Implementation of a quality review process which is completed by the Patient Experience and Inclusion Manager and Workforce Equality, Diversity and Inclusion Manager. This enables potential and/or actual impacts which have not been identified, recorded, analysed or judgement made to be addressed with steps taken to address this.

2. Bi-monthly quality assurance process which reviews EIAs completed in the previous period for approval. Following assurance this is presented to both Patient and Workforce Equality, Diversity and Inclusion Sub-Committee for comments and learning.

3. Training commissioned by Jagtar Singh Associates to deliver a suite of EIA knowledge and skills improvement modules to clinical and non-clinical stakeholders in the organisation.

To enable transparent analysis the Trust in 2022 will proceed to implement new and effective ways of recording EIAs, this will include a digital approach which will allow for direct support to be provided to people completing EIAs by Equality, Diversity and Inclusion Teams.

3.5 Creating accessible information

Barriers to information can prevent people from effectively accessing health services and may affect health outcomes for some people. It is important that local people are involved in helping us to identify these needs and agree solutions. This is an important element of how WHH actively works with its internal and external stakeholders.

The Trust has a range of focus groups and committees that include internal and external membership from advocate groups, patients, carers and 3rd sector organisations. Included in these groups are the Trust's Council of Governors, Patient Experience Committee, EDISC, Dementia Steering Group, the Learning Disabilities Steering Group and the Disability Focus Group. These groups continue to collaborate to try to make improvements to the experiences of disabled patients and to work on solutions to surmount any barriers they may face, including communications and related matters. WHH is working to enhance the range and format of communications to ensure equality of access and to provide additional support to those accessing our services. We are undertaking a new assessment under the Accessible Information Standard specifications in 2018-19 to ensure that information is fully accessible including greater use of new technologies to assist with this.

The Trust is also in review of its Translation Services to ensure that we are providing the best care for all our service users.

3.6 Improving patient experience and quality

WHH builds upon what it has learned from assessments undertaken as part of the Equality Delivery System (EDS2) and previously the Single Equality Scheme (SES) with a view to improving services and patient experience.

The Trust works toward engaging with local people from all communities and the Health Watch teams from Halton and Warrington. It also collaborates with partner organisations in the statutory sector, in order to gain greater understanding of the local picture and work to address potential health inequalities.

3.6.1 Foreign Language Interpretation

The Big Word has been the primary provider at WHH since May 2018, providing translation and interpretation services for foreign languages both by telephone and face to face. The Deafness Resource Centre (DRC) provides British Sign Language (BSL) services, this has been in place with consistently satisfactory service experience for some years.

Data provided by the Big Word for utilisation in 2019-2020 found that:

- Face to Face (F2F) bookings (<24 hours' notice) had a 43.75% fulfilment rate set against a KPI of 80%
- Face to Face (F2F) bookings (>24 hours' notice) had an 89.95% fulfilment rate set against a KPI of 95%

Due to the lack of consistency provided by The Big Word during the contract term a trial with Language Line Solutions® (LLS) was completed as part of the initial review in March 2020 across four areas of the Trust: Breast Screening, Ophthalmology, Outpatients and Emergency Department. This was received with positive reviews from staff with regards to the easy application, the speed to access an interpreter and the standards of interpretation and translation.

In 2021 the Trust introduced Language Line Solutions as an additional supplier for foreign language interpretation and translation services, this was supported by a robust procurement process.

The COVID-19 pandemic brought many challenges in the way that interpreting services were provided, this was continued into 2021/22 with additional waves of the pandemic and subsequent national lockdowns. As a result, the addition of Language Line Solutions allowed for a virtual interpreter to be present via video or audio connection through tablets and other electronic devices available on wards, in outpatient departments and at the Emergency Department.

Figure One illustrates the usage for Language Line Solutions following on from the introduction of the supplier across all clinical areas in 2021:

Figure One: Language Line Solutions Usage 2021/22

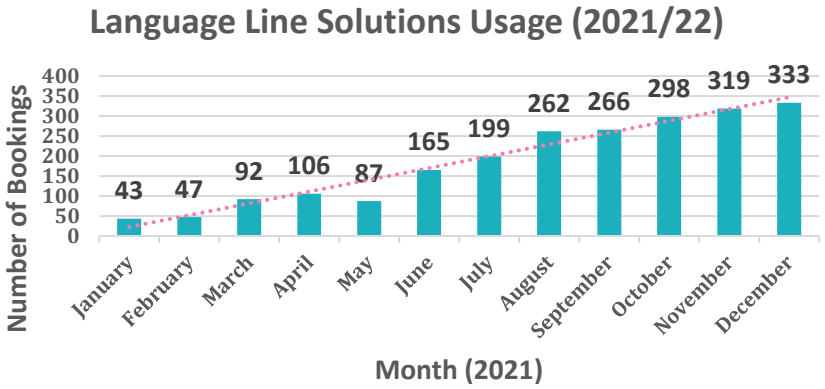


Figure One demonstrates a 214% increase in Language Line usage from April 2021 to December 2021 where a full calendar months data can be analysed. The average usage of interpreter services remains consistently between 265 and 320 bookings per month. The increase in usage for interpretation and translation has resulted in a reduced request for the Warrington and Halton Teaching Hospitals workforce to act in the position of an interpreter. This ensures that the Trust meets its quality standards and that patients are supported by bilingually competent, neutral, independent and professionally trained interpreters.

In addition to usage, it is important to understand the most frequently requested languages which is highlighted in **table two.** The final column in **table two** highlights the number of requests for face-to-face (F2F) serviced bookings for The Big Word:

Table two: Most commonly requested languages

Language	Language Line Total	The Big Word (F2F)
Romanian	269	17
Arabic	229	39
Polish	217	68
Sorani	216	14
Farsi	105	6
Cantonese	103	11
Turkish	47	12
Tigrigna	35	0
Spanish	34	2
Bulgarian	33	10
Hungarian	33	9
Portuguese	29	5
Slovak	29	8
Mandarin	26	6
Bahdini	24	4

3.6.2 British Sign Language (BSL) Interpretation

Throughout the pandemic British Sign Language interpreters have continued to visit site in a safe and controlled manner to support patients who require a BSL interpreter. In the event that a BSL interpreter is unable to visit the hospital site, a virtual BSL interpreter could be connected through Language Line Solutions.

Table Three provides an update on usage for the Deafness Resource Centre in 2021/22 (up to the end of January 2022).

Table Three: British Sign Language Usage

Dates	Number of bookings
April 2021 – June 2021	**43 active bookings**
July 2021 – September 2021	**28 active bookings**
October 2021 – December 2021	**31 active bookings**
January 2022	**16 active bookings**
Total	**118 active bookings**

Data demonstrates a consistent delivery of BSL interpretations across the Trust with data reviewed on a regular basis at the Trust Patient Equality, Diversity and Inclusion Sub-Committee to ensure there are no known barriers to accessing the hospital by a BSL patient or service user.

To promote awareness of BSL in the Trust, the Patient Experience and Inclusion Team with support from the Deafness Resource Centre celebrated 'Deaf Awareness Week' in May 2021 enabling on-going improvement and awareness for staff on how to support patients, service users and their families. In addition, the Trust commissioned a 6-week non-accredited BSL training programme for 12 clinical and non-clinical staff across the Trust. The aim of this programme was to:

- understand and use a limited range of simple health related words and sentences in BSL
- take part in simple, everyday conversations in BSL
- give and follow simple directions or instructions in BSL
- give and follow simple familiar healthcare statements or descriptions in BSL.

3.6.3 Tools to enable interpretation and translation

The Patient Experience and Inclusion Team in response to patient feedback produced an Interpretation and Translation 'Hot Topic' in August 2021 focused on:

- Improving awareness of how to access an interpreter.
- Recording alerts on patients' records if an interpreter is required.
- The different types of interpretation and translation.
- Seeking additional support in the event an interpreter has not been booked.

Following the success and feedback collated during the hot topic the Trust launched an 'Interpretation, Translation and Accessible Information' Staff Guide to simplify the

interpretation and translation process and enable appropriate continuous learning. The guide has information on:

- Foreign language interpretation
- British Sign Language
- Accessible Information Standards
- Safeguarding and consent
- Easy read documentation
- Makaton
- Language identifiers

To support the rollout of the staff guide, drop in training was provided to wards and departments as required to promote usage of the guide. Due to the positive comments received of the staff guide, the Trust will proceed to create a digital version for patients to access in different formats in 2022. This will support pre-admission, outpatient appointments and inpatient stays at WHH.

3.7 Health Inequalities

The Trust will continue to collaborate with partner agencies in both statutory and third sector, to work on improving accessibility to services and the patient experience of patients from seldom heard groups in the community, who have been shown in Joint Strategic Needs Assessments and epidemiology studies to be disproportionately prevalent in poor health outcomes, morbidity and low access to both primary and secondary care services and resources.

3.8 Promoting equality among the workforce

WHH aims to have a workforce that reflects the demographic make-up of the local population. It will do this through positive and targeted recruitment policies and procedures. In addition it will ensure that the workforce is supported to promote equality of opportunity and challenge discrimination. WHH will maintain an annual commitment to produce a full workforce equality analysis, in order to support future planning and development options.

The Trust has also complied with reporting requirements for the Workforce Race Equality Standard, with the development of appropriate action plans, and has successfully implemented the Workforce Disability Equality Standard in partnership with the organisation's Disability Staff Network. The Trust also regularly reviews Staff Survey results by protected characteristic with the organisation's Staff Networks ensuring subsequent action plans and recommendations are collaboratively developed to ensure that equality is promoted and no potential discrimination exists.

Our policies and Strategies are also equality assessed to ensure no employee is at a detriment due to any protected characteristics and these are regularly reviewed. In addition, there is a programme of activity led by the Equality, Diversity and Inclusion team in partnership with the Staff Networks to develop a calendar of events across the organisation to promote equality within the workplace.

In addition to this, the Trust also has a Freedom to Speak Up Guardian and Champions who are available to support any member of staff who may wish to raise any concerns.

3.9 Action planning

The organisation's approach to action planning to promote equality and meet our Equality Duties is one of collaboration utilising the organisation's growing engagement network and externally with 3rd sector organisations. This approach enables the organisation to gain the perspectives and ascertain the needs of both its workforce and the public that the Trust serves.

3.10 The Trust's objectives

The Trust's objectives focus on Quality, People and Sustainability as illustrated in **diagram four**.

Diagram Four: Organisational Objectives

3.11 Organisational mission, vision and values

Our Mission is that ***"We will be outstanding for our patients, our communities and each other"*** . The organisational vision is ***"We will be a great place to receive healthcare, work and learn"***.

To support the organisation's mission and vision, the values of the organisation demonstrate the commitment of the organisation to create a culture which promotes equality and advancing of opportunity and challenging discrimination in all its forms. The values of the organisation are illustrated below:

- Working Together
- Excellence
- Inclusive
- Kind
- Embracing Change

Effective application of the mission, vision and values relating to the equality duty will complement and support the organisation's strategic vision. An increase in knowledge and understanding of the Workforce, patients, local communities and their needs will enable more effective and efficient use of resources and as a consequence, help improve patient and staff experience, quality and minimise potential for inequalities or discrimination.

4. Progress and Achievements

The equality governance framework serves to not only ensure that WHH remains compliant with legislation and that equality issues are considered as part of mainstream functions but that improvements are made and innovations realised in partnership with equality and health inequality stakeholder groups.

4.1 Summary of key equality achievements

Some of the key equality achievements of the organisation are illustrated below:

- Continue to publish Workforce Equality Analysis Report (WEAR) on an annual basis from 31st March 2013.
- Continued implementation of Gender Pay Gap reporting on an annual basis, including development of associated action plans collaboratively developed in partnership with the workforce.
- Attained an achieving grade in 16 and 2 of excelling of 18 EDS2 outcomes in 2018 assessments.

- Development and implementation of Staff Networks which have thrived during the pandemic and now include the following:
    - Armed Forces Network
    - B.A.M.E – Building a Multi-cultural Environment
    - D.A.N – Disability Awareness Network
    - LGBTQA+ - Lesbian, Gay, Bisexual, Transgender, Questioning, Ally Network
- Development of bespoke risk assessments to support individuals with protected characteristics at risk from COVID-19 at the beginning and during the pandemic, which continues to ensure that the workforce are kept safe within the organisation.
- Published the updated Equality, Diversity and Inclusion strategy for 2019-2022.
- All policies, procedures and service changes are equality impact assessed against protected characteristics.
- Formulated the Carers Strategy in partnership with the two borough Carer organisations *WIRED* and *Halton Carers Centre* and have initiated Carers Cafes, to raise staff awareness and promote Carer inclusivity at all stages of the care pathway
- In collaboration with Warrington Disability Partnership we established an Independent Living Centre in our Outpatients department to support Patients, Staff and Carers in accessing advice and support.
- Enhancing interpretation and translation service to support minority and disabled communities.
- Annual sponsorship of the international Disability Awareness Day event in Warrington.
- Increased investment and implementation of Mental Health First Aiders across the organisation to increase awareness of mental health and offer the workforce additional support as required.
- Introduction of a dedicated quiet waiting area and treatment space in A&E to support patients with mental health issues or other additional needs
- Implementation of equality, diversity and inclusion calendar across the organisation to support awareness of campaigns supporting protected characteristics and significant events to support our communities focusing on Human Rights.
- Implementation of Blue-badge hidden disabilities signage across the organisation developed by the Disability Awareness Network
- Implementation of a reciprocal mentoring scheme with members of the organisation's Staff Networks and senior members of staff.
- Development of tailored career conversation support for members of Staff Networks and across the organisation to support talent management across all protected characteristics.
- Increasing diversity of Freedom To Speak Up Champions across the organisation.

- Retained Disability Confident Employer Status and securing support to increase Disability Confident Level to level two for organisation in partnership with the Shaw Trust and NHSE/I

5. Accountability

5.1 Responsibilities and Accountability

The Board of Directors have overall responsibility to ensure that the organisation adheres to the statutory obligations contained within section 149 of the Equality Act (2010) known as the Public Sector Equality Duty (PSED).

From a workforce perspective, the Chief People Officer chairs the bi-monthly Workforce EDI Sub-Committee which reports into the Strategic People Committee and subsequently to Trust Board.

From a patient perspective, the monthly Patient EDI Sub-Committee is chaired by the Chief Nurse and Deputy Chief Executive and the committee reports into the Quality Assurance Committee and subsequently to Trust Board.

6. Conclusion

Warrington and Halton Teaching Hospital NHS Foundation Trust continues to work together through the delivery of its values of “inclusive”, the governance routes in place and the enabling of workforce and patient voice through engagement networks and mechanisms to build upon the significant progress that has been made in meeting the equality duties of embedding equality analysis and engagement in its functions, services, strategies and operational approach.

6. Further Details

Further details about the organisation’s equality, diversity and inclusion approach can be found via our website below:

www.whh.nhs.uk/about-us/corporate-publications-and-statutory-information/equality-diversity-and-human-rights

APPENDIX ONE – Patient Equality Profile

To provide a local population benchmark to patient equality data the Trust utilises available population data for Warrington and Halton. The local population of Warrington is published in the Warrington Borough Council Joint Strategic Needs Assessment (JSNA) and Halton Borough Council JSNA retrospectively. This assessment collates information from the Office of National Statistics as well as estimates of data driven by the Census 2011, gathered by Public Health England. Data in the demographics below are numbers used to determine estimates and therefore are not intended as definitive.

Age Profile – Warrington and Halton

Warrington

18.9% of the population in Warrington were aged under-16 which is similar to 19.2% in England and Wales and 19% in the North West. 62.2% in Warrington were aged 16-64, similar to 62.4% in England and Wales, and 62.5% in the North West. 18.9% of the population in Warrington were aged 65 and over, similar to 18.4% in England and Wales and 18.4% in the North West.

Although the population of Warrington is comparable to that of England and the North West, Warrington has a higher proportion of people aged 50-64 at 20.6% in comparison to 19%. In contrast Warrington has a lower proportion of people aged 20-24, 25-29 and 30-34.

Halton

20% of the population in Halton were aged under-16 which is similar to 19.2% in England and Wales and 19% in the North West. 61.5% in Halton were aged 16-64, slightly less in comparison to 62.4% in England and Wales, and 62.5% in the North West. 18.4% of the population in Halton were aged 65 and over, similar to 18.4% in England and Wales and 18.4% in the North West.

Public Health England. Public Health Profiles. [29th July 2021] https://fingertips.phe.org.uk © Crown copyright [2021]

Gender Profile – Warrington and Halton

Warrington

The mid-year estimate for Warrington's population as of 2020 stands at 209,397, this is made up of 103,843 males (49.59%) and 105,554 females (50.41%).

Halton

The mid-year estimate for Halton's population as of 2020 stands at 129,759, this is made up of 63,295 males (48.78%) and 66,464 females (51.22%).

Office for National Statistics (ONS) [2020]

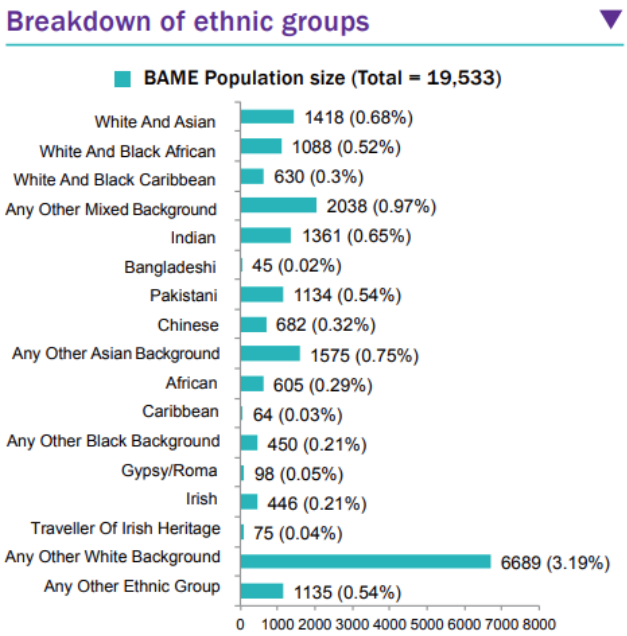
Ethnicity Profile – Warrington and Halton

Warrington

The Census in 2011 detailed that 95.9% of the population of Warrington were from White ethnic groups (White British, Irish, Gypsy or Irish Traveller, Other White and White Non-British). In comparable to the Census undertaken in 2001, this was a decrease of 1.1%. 2.4% of Warrington were from Asian/Asian British ethic groups with 1.1% from Mixed/Multiple ethic groups, just over 0.6% were from other ethnic groups.

It is noted in the Cheshire and Merseyside Health Partnership 'Ethnicity Profiles in Cheshire and Merseyside' report (2020) that the total Black, Asian and Minority Ethnic population size in Warrington is 9.31%. The below infographic provides a breakdown of ethnic groups.

Diagram Five: Warrington Ethnic Groups Demographic



Source: UK Office for National Statistics/Schools Census records 2020

The Census in 2011, found that 1.9% of Warrington households have no people with English as a main language in comparison to 4.4% in England and 2.9% in the North West. 7.4% of households in Bewsey and Whitecross have no people where English is their main language, this is followed by Fairfield and Howley at 5.1%. It is noted, not having English as a main

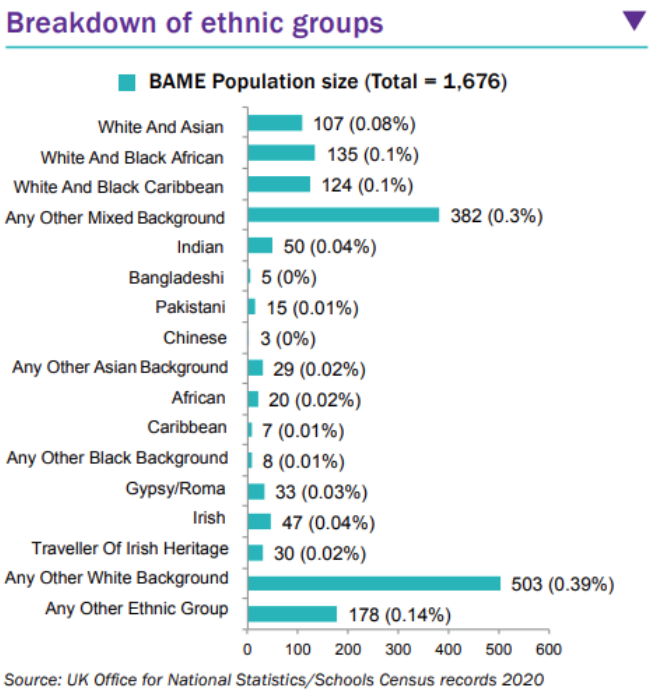
language does not mean that someone cannot communicate in English. [Office for National Statistics, Census 2011]

Halton

The Census in 2011 found that 97.8% of the population of Halton were from White ethnic groups, with 2.2% from non-white ethnic groups. In comparable to Warrington it was found that 0.6% of the Halton population have no people with English as a first language.

It is noted in the Cheshire and Merseyside Health Partnership 'Ethnicity Profiles in Cheshire and Merseyside' report (2020) that the total Black, Asian and Minority Ethnic (BAME) population size in Halton is 1.31%. Analysis shows that proportionally to other areas in Cheshire and Merseyside and the North West this percentage is lower in comparison. The below infographic provides a breakdown of ethnic groups.

Diagram Five: Halton Ethnic Groups Demographic



Source: UK Office for National Statistics/Schools Census records 2020

N.B. It is noted in the report that although Census (2011) data does provide detailed ethnicity and resident location of people, this information is almost 10 years out of data at the time of producing the 'Ethnicity Profiles in Cheshire and Merseyside' report. For this project authors used publicly available data sourced from the Office for National Statistics (ONS) and Department for Education (DfE).

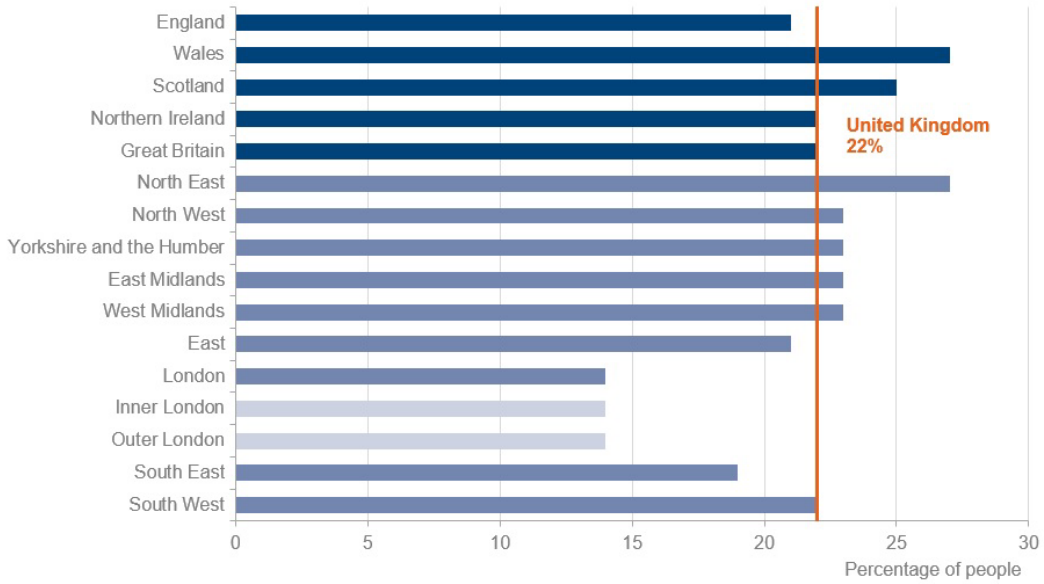
Cheshire and Merseyside Partnership 'Ethnicity Profiles in Cheshire and Merseyside' (2020)

Disability Profile – Warrington and Halton

A person is considered to have a disability if they have a physical or mental impairment that has 'substantial' and 'long term' negative effects on their ability to do normal daily activities. 18% of the population in Warrington have reported themselves disabled; this is lower in comparison to 21.5% of the population in Halton.

Results from the 'Family Resources Survey (FRS) [2019 to 2020] found that 14.1 million people in the UK reported a disability in 2019 to 2020, which equates to one in five people. When broken down by region this accounts for 21% of the population in England and 23% of the North West population, a one percent increase in comparison to the national average.

Diagram Six: Disability prevalence by region and country, 2019 to 2020, UK



It is noted that a higher proportion of females than males reported that they are disabled as part of the report at 24% and 19% retrospectively, which is reflective of data captured over the previous ten years.

GOV.uk. Family Resources Survey: financial year 2019 to 2020. Published 25th March 2021 Family Resources Survey [Accessed on 29th July 2021]

Sexual Orientation Profile – Warrington and Halton:

It is noted that sexual orientation was recorded in the latest Census (2021) for the first time therefore there is no local population data for sexual orientation in Warrington and Halton

until results of this Census are published. The government estimate is that 5-7% of the population of England and Wales are Lesbian, Gay or Bisexual (LGB), it is noted this does not include Trans people.

Religion Profile – Warrington and Halton:

Warrington

The religious make up of Warrington's population from the Census (2011) highlighted that 71.4% of the population followed a Christian religion, 20.4% identified as having 'No religion', 1% identified as Muslim, 0.60% identified as Hindu with 6.6% identifying with other religions or did not declare.

Halton

The religious make up of Halton's population from the Census (2011) highlighted that 75% of the population followed a Christian religion, 18.7% identified that they did not follow a religion. 0.2% of the population identified as following Muslim, Buddhist and Hindu faith retrospectively with 5.7% of the population following other religions or did not declare.

Deprivation – Warrington and Halton

Evidence finds that there are inequalities faced between people living in areas of low-level deprivation and high-level deprivation. Local populations from more deprived areas generally have poorer outcomes in terms of health, education, employment, income, life expectancy etc.

The Index of Multiple Deprivation (2019) report published by the Ministry of Housing, Communities and Local Government evidenced that Halton was the 23rd most deprived area in England, in comparison with Warrington which ranked 148th of 317 local authorities.

In comparison to other Cheshire local authorities, Cheshire East was ranked 216th and Cheshire West and Chester were ranked 161st.

References:

Office for National Statistics © Crown Copyright. Adapted from data from the Office for National Statistics licensed under the Open Government License v3.0. – ONS - Population Estimates

Warrington Borough Profile (2020) - https://www.warrington.gov.uk/sites/default/files/2020-03/warrington_borough_profile_2020.pdf /

Warrington Borough Council (2011) Census Comparator Report - https://www.warrington.gov.uk/sites/default/files/2019-09/warrington-census-2011-comparator-report.pdf

Halton Borough Council Census and Statistics Report - https://www3.halton.gov.uk/Pages/councildemocracy/pdfs/CensusandStatistics/Census2011_SpineCharts.pdf

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Workforce Equality, Diversity and Inclusion Strategy 2022-2025

Welcome to Our Workforce Equality, Diversity and Inclusion Strategy

Michelle Cloney, Chief People Officer

I am delighted to welcome you to our Workforce Equality, Diversity and Inclusion Strategy (WEDI).

This strategy sets out our commitment to make Warrington and Halton Teaching Hospitals NHS Foundation Trust (WHH) the best place to work and details how we will be an inclusive employer creating a culture of belonging for all.

Across health and social care, organisations are facing a number of workforce challenges which have and remain further compounded by the COVID-19 Pandemic. Shortages of clinical staff nationally, an older workforce, changing demand for service delivery along with workforce recovery means that we need to empower our staff to think and work differently.

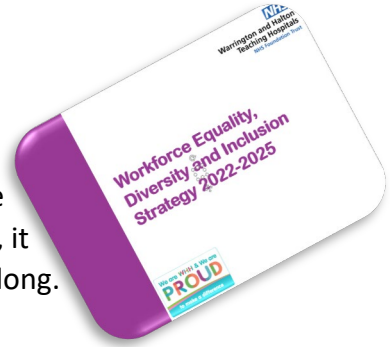
The Workforce Equality, Diversity and Inclusion Strategy is inextricably linked to the Trust's People Strategy. Since the development of our 2018-2021 People Strategy there has been a national focus on the NHS workforce and the first national NHS Chief People Officer has been appointed which has led to the publications of the *NHS People Plan*, *NHS People Promise* and the *Future of NHS HR and OD Report*. These national documents form the foundations of our WHH Workforce Equality, Diversity and Inclusion Strategy 2022-2025.

It's important to recognise the achievements the Trust has made in the last 3 years, including investing, and responding to our staff's wellbeing and development. This has included focussing on workforce recovery following the COVID-19 Pandemic, increasing our workforce through the introduction of new roles, rolling out compassionate leadership development programmes, and reviewing and then embedding the Trust's Values.

We've also appointed our Wellbeing Guardian, Cliff Richards (Non-Executive Director) and assessed ourselves using the NHS Health and Wellbeing Framework. This strategy is our commitment to Workforce Equality, Diversity and Inclusion (WED&I) and outlines our ED&I People Promises.

Welcome

Foreword



The NHS was established on the principles of social justice and equity. Sometimes, the treatment of our colleagues with protected characteristics falls short and not addressing this limits our collective potential. It prevents the NHS from achieving excellence in healthcare and from identifying and using our best talent. Given recent national and international events, it has never been more urgent to create an organisational culture where everyone feels they belong.

The NHS Long Term Plan published in 2019 was drawn up to enable the NHS to continually move forward so that in 10 years' time we have a service fit for the future. The NHS People Plan is the workforce strategy for delivering the Long Term Plan with a clear ambition of 'more staff, working differently, in a compassionate and inclusive culture. The NHS People Plan is organised around four pillars:

- Looking after our people – with quality health and wellbeing support for everyone
- Belonging in the NHS – with a particular focus on tackling the discrimination that some staff face
- New ways of working and delivering care – making effective use of the full range of our people's skills and experience
- Growing for the future – how we recruit and keep our people, and welcome back colleagues who want to return

This strategy explains and responds to the Trust's statutory duties to promote equality amongst all our employees. It replaces and builds on our previous workforce pledges within the overarching Equality, Diversity & Inclusion Strategy (2019 – 2022).

We have recently refreshed our Trust strategy and our strategic People objective states that we will …. ***be the best place to work with a diverse, engaged workforce that is fit for the future***.

The Workforce Equality, Diversity and Inclusion Strategy will guide practical work within the organisation aimed at continuing to implement the commitment to equality and as such, will be reviewed and monitored on a regular basis.

We have involved all stakeholders in the development of this Strategy. We will also ensure that all stakeholders have a real influence in implementing the Strategy in order to achieve demonstrable benefits for everyone.

Simon Constable, Chief Executive Officer

WHH Equality, Diversity & Inclusion Strategy 19-22 – What have we achieved?

The Trust Workforce element of the Equality and Diversity Strategy 2019-2022 focused on 2 objectives:

- Empowered, Engaged and Well Supported Staff
- Inclusive leadership at all levels

Under this Strategy, the Trust has made a number of advances in supporting our workforce including:

Empowered, Engaged and Well Supported Staff

- Embedded Equality, Diversity and Inclusion into all workforce related policies, training and development
- Equality, Diversity and Inclusion Champions Introduced
- Staff networks and forums established
- Good working relationships established with external stakeholders
- Equality Impact Assessment (EiA) training delivered to managers and staff network chairs
- EiA audits conducted to monitor quality of process and actions taken
- Commenced NAVAJO accreditation
- Equality, Diversity and Inclusion Calendar established
- Improvement in statutory reporting, WRES, WDES, EDS2, staff survey

Inclusive leadership at all levels

- Dedicated Equality, Diversity and Inclusion page established on the extranet
- Improvement of representation of staff with protected characteristics in leadership roles
- Reciprocal mentoring programme commenced
- Inclusive recruitment change programme commences
- Improvement in statutory reporting, WRES, WDES, EDS2, staff survey
- Implemented a career development support programme for under-represented groups
- Delivery of bespoke ED&I training for board members

WHH Trust Strategy

NHS
Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Our Mission, Vision, Values, Aims and Objectives

Our Mission

We will be outstanding for our patients, our communities and each other

Our Vision

We will be a great place to receive healthcare, work and learn

Our Objectives

Quality

We will... **Always put our patients first** delivering safe and effective care and an excellent patient experience.

People

We will... **Be the best place to work** with a diverse and engaged workforce that is fit for now and the future.

Sustainability

We will... **Work in partnership** with others to achieve social and economic wellbeing in our communities.

We are WHH and together we make a difference

Our Values

Working Together · Excellence · Inclusive · Kind · Embracing Change

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WHH Strategic People Objectives

At Warrington and Halton Teaching Hospitals NHS Foundation Trust our strategic objective for our workforce is to **…Be the best place to work with a diverse and engaged workforce that is fit for now and the future.** We will achieve this aim through the four strategic People Pillars set out below:

Looking After Our WHH People	We will prioritise the safety, health and wellbeing of our people to ensure work has a positive impact through the recognition and appreciation of our people, and by providing the best patient and staff experience.
Innovating the Way we Work	We will embrace new ways of working to attract and retain an engaged, responsive, diverse and flexible workforce to care for our patients.
Growing our WHH Workforce for the Future	We will support personal and professional development, ensuring equal access to opportunities, and will nurture, grow and develop diverse teams with a shared purpose to care for our patients.
Belonging in WHH	We will enable staff to have a voice, through the development of a just and learning culture which values diversity, inclusion, compassionate leadership and equity for all.

Our Workforce Equality, Diversity and Inclusion Strategy sets out what each of these People Pillars mean for our workforce, how we will deliver them and what success will look like.

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Strategic People Objectives

Where Are We Now?

- With the launch of the refreshed WHH Strategy (Mission, Vision, Objectives and Values) and People Strategy (2022-2025) and an increased national focus on Equality, Diversity & Inclusive workplaces, the new Workforce Equality, Diversity and Inclusion Strategy (2022-2025) will create the golden thread between what we do here at WHH, what we need to do going forward and what we must do to meet the requirements set out in the NHS People Plan, Promise and NHS Operational and Workforce Recovery plans.

- It presents an opportunity to reframed the ***Workforce Equality, Diversity and Inclusion Strategy*** to build on our previous achievements and focus on areas of inequality impacting on our workforce – employment, health and wellbeing

9 Protected Characteristics
Race, Disability, Sex, Sexual Orientation, Gender Reassignment, Marriage & Civil Partnership, Pregnancy & Maternity, Age, Religion or Belief

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Workforce Equality Diversity & Inclusion

This strategy frames an approach where equality, diversity and inclusion is not an end in itself, but an integral means of delivering better outcomes for our workforce. In 3 years our overall success in delivering this strategy will means WHH:

values diversity of teams – challenging *groupthink* and inspiring a greater diversity of thinking

values and invests in its people – enabling career development through accessible training and development

has collaborative partnerships underpinned by our values – systems and communities working collectively to deliver improved inclusion amongst our workforce

tackles bullying, harassment and discrimination – with specific actions for departments, CBUs and Care Groups to take in continuing to address bullying, harassment and discrimination

tests its policies – with activity to be data-driven, evidence-led, and delivery focussed

Our ED&I People Promises

Looking After Our WHH People

We will prioritise the safety, health and wellbeing of our people to ensure work has a positive impact through the recognition and appreciation of our people, and by providing the best patient and staff experience

Our ED&I People Promise (1)	Our ED&I People Promise (2)
We will address health inequalities at WHH.	We attract and retain people at WHH creating a positive impact on our communities.
Our ED&I People Outcomes	**Our ED&I People Outcomes**
• Develop a standard set of skills, competencies and behaviours for leaders to support staff's health and wellbeing. • Adopt the NHS Health and Wellbeing Cultural Framework best practice and EDS outcomes that support our staff to remain in work and be present. • Understand where there are workplace inequalities in staff health and wellbeing and take action to address them through delivery of bespoke health promotion programmes.	• Overhaul recruitment processes to take account of ED&I considerations and be responsive to personal circumstances. • Ensure equality impact assessment tools are used to inform decision-making at all levels and periodically reviewed to assess progress. • Ensure that all individuals, teams and organisations have measurable objectives on ED&I, including all board members.
What Does Success Look Like?	**What Does Success Look Like?**
• Enhanced and accessible resilience and wellbeing support • Contribution of staff networks to staff health and wellbeing initiatives and agenda and access to the Wellbeing Guardian • Improved community engagement evidenced by WHH staff actively participating in C&M Integrated Care System and / or Warrington and Halton projects, workstreams, groups etc. • Improved year on year Health and Wellbeing Cultural Toolkit indicators • Equality impact assessments for all organisational change, policies, training and development	• Improved Staff Survey, WRES and WDES results • Increased attendance in line with the best comparator organisation in Cheshire and Merseyside • Evidence of inclusive career progression for all internal appointments • Agreed and available Succession Plans for all posts above Band 8A (Agenda for Change) and all consultant staff • Improved retention and turnover rates for all staff groups with a protected characteristic • Improved WRES and WDES results • All staff have achieved ED&I objective(s)

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Innovating the Way we Work

We will embrace new ways of working to attract and retain an engaged, responsive, diverse and flexible workforce to care for our patients

Our ED&I People Promise (3)	Our ED&I People Promise (4)
• Create an open, productive and learning environment that educates and addresses privilege and everyday bias.	• Reach into WHH communities, understanding and drawing from the communities it serves, acting as an 'anchor institution'.
Our ED&I People Outcomes	**Our ED&I People Outcomes**
• Take account of and explicitly address, issues of equality, diversity and inclusion in culture change programmes. • Create a continuous improvement process, through seeking regular feedback from staff networks. • Role modelling compassionate, inclusive leadership through open and honest conversations with teams, creating calls to action for the Trust Board and strengthen the role of staff networks in decision-making. • Ensure that all job appointment processes, including promotions, include evidence of the candidate's personal positive impact on equality, diversity and inclusion.	• Collaborate with local communities – through multiple agencies, non-profit organisations and academic establishments – to improve the talent supply pipeline. • Provide clear and inspiring pathways to address the under-representation of our staff with protected characteristics. • Reduce the health inequalities of our workforce through the use of population health data and targeted wellbeing interventions, which capture the specific needs of those with protected characteristics • Working with Place based partners create a pipeline for local communities to access employ to broaden representation and accessibility to people from all backgrounds.
What Does Success Look Like?	**What Does Success Look Like?**
• Improved retention across all staff groups with protected characteristics and reduced turnover rates • Year on year Improved WRES and WDES outcomes aligned to Model Employer milestones • Reciprocal mentoring programme positively evaluated with developed case studies • Equality Impact Assessments completed for all change programmes impacting on the workforce • Annual Health and Wellbeing conversations for all staff • Attainment of EDS inclusive leadership outcomes • Designed and implemented Talent Management framework with a focus upon inclusion and diversity • Improved access to Staff Networks	• Improved year on year the utilisation of the Apprentice Levy for staff with protected characteristics • Embedded inclusive recruitment targeted at local communities • Year on year Improved WRES and WDES outcomes aligned to Model Employer milestones • Reduction in gender pay gap • Accredited Navajo Charter Mark with evidence of implemented action plan • Accredited ***Disability Confident Employer*** Level 4 with evidence of community networking

Our ED&I People Promises

Our ED&I People Promises

Growing our WHH Workforce for the Future

We will support personal and professional development, ensuring equal access to opportunities, and will nurture, grow and develop diverse teams with a shared purpose to care for our patients

Our ED&I People Promise (5)	Our ED&I People Promise (6)
Ensure that WHH talent management, recruitment and career pathways address under-representation and promote diversity.	Champion policies and practices that achieve tangible, measurable improvements to workforce equality, diversity and inclusion.
Our ED&I People Outcomes	**Our ED&I People Outcomes**
• Recognise and sponsor high-potential individuals from under-represented backgrounds to enable them to fulfil potential and ambition. • Ensure that high-potential individuals from under-represented backgrounds have a clear development plan, to help them reach their potential.	• Provide appropriate developmental support and pathways, including coaching, mentoring and role modelling for staff in underrepresented groups. • Monitor key indicators of impact the WRES, WDES, gender pay gap assessment, and NHS staff survey data to pick up other protected characteristics.
What Does Success Look Like?	**What Does Success Look Like?**
• Improved appraisal rates for all staff groups with a focus upon those with a protected characteristic • Evidence of fair access to training resources for all staff groups irrespective of Protected Characteristics • Increased numbers of internal promotions for staff groups with Protected Characteristic equitable to those with no Protected Characteristics • Implementation of the Scope for Growth framework across all Care Groups, CBUs and Corporate Areas • Fair and accessible allocation of CPD resources across staff groups • Line manager development programme available for all staff with people management responsibilities • Equality, Diversity and Inclusion training for all leaders and line managers • Attainment of EDS inclusive leadership outcomes • Improved retention and turnover rates for all staff groups with a protected characteristic	• All WHH workforce policies reviewed by Equality Lead prior to ratification • All WHH policies, training and development Equality Impact Assessed • Equality Impact Assessments audited annually to enable lessons learned and best practice to be promoted • Established, well attended, thriving Staff Networks Designed and implemented Talent Management framework with a focus on inclusion and diversity • Accredited Navajo Charter Mark with evidence of implemented action plan • Attainment of the BAME Assembly Anti-Racist Accreditation • Attainment of EDS workforce health and wellbeing outcomes • Compliance at all levels of staff with EDI competency framework from 2023 onwards

Belonging in WHH

We will enable staff to have a voice, through the development of a just and learning culture which values diversity, inclusion, compassionate leadership and equity for all

Our ED&I People Promise (7)	Our ED&I People Promise (8)
To understand, encourage and celebrate diversity, making WHH a place where we all feel we belong.	Develop and embed a 'restorative just culture' across WHH that helps to eliminate cultures that bring blame or fear.
Our ED&I People Outcomes	**Our ED&I People Outcomes**
• Ensure our staff feel valued, and confident that their insights are being used to shape learning and improvement at WHH. • WHH to be recognised nationally as an organisation that promotes and celebrates diversity. • Equip our staff to have the skills to be an ***inclusive ally*** who recognise that though they may not be a member of a marginalised group (s) they are able to support and display a concerted effort to better understand the struggle of another's circumstances and act to improve them. • All leaders at WHH act with kindness, prioritise collaboration, and foster creativity in the people they work with.	• Embed the principles of a restorative just culture into all people practices and policies • Develop all WHH leaders and line managers to create psychological safety within teams to enact and sustain restorative just cultures. • Build on existing interventions and develop new mechanisms at WHH to support our staff to speak up and feel heard, without fear of reprisal – including staff networks, freedom to speak up channels and trade union • Equip line managers with skills to conduct facilitated conversations with their staff and implement a framework for appropriate escalation to access mediation
What Does Success Look Like?	
• Year on year increased uptake of the national People Pulse Survey irrespective of role with representation across all Protected Characteristics • Sustained year on year improvement of WRES and WDES indicators commencing in 2022 • Accredited Navajo Charter Mark with evidence of implemented action plan • Nationally awarded recognition for inclusion and diversity. • Implementation of kindness and civility campaign and evidenced sustainment of principals. • Established network of inclusive allies who understand the needs of colleagues, the impact of privilege and seek to address workforce inequality or injustice	• Reduced number of Employee Relation cases, related to Bullying and Harassment with a focus on staff with protected characteristics (WRES & WDES) • Evidence of Staff Voices at Assurance Committees – staff networks to attend and present on a regular basis • Evidence of Staff Networks influence Trust Board / Assurance Committees decision making on key topics • Implementation and sustainment of just culture principals and improving people practices • Increased accessibility to staff networks and investment in their development. • Attainment of EDS workforce health and wellbeing outcomes

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Our ED&I People Promises

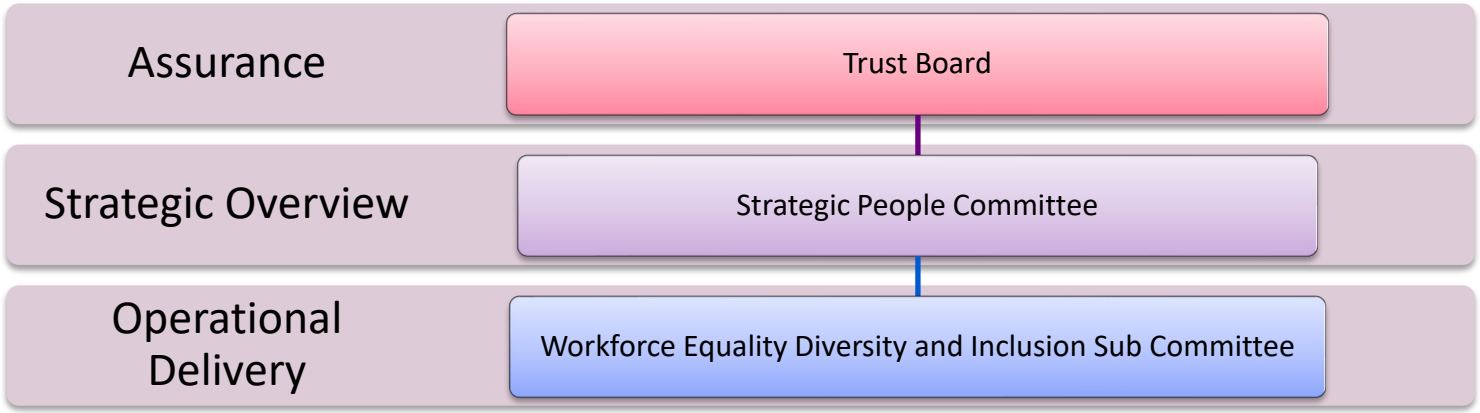
Workforce ED&I Strategy Delivery

Delivering the Workforce ED&I Strategy

We will deliver our Workforce Equality, Diversity & Inclusion Strategy over a 3 year period through partnership working with internal and external stakeholders.

A work plan will be introduced to underpin each of the promises outlined. Workforce Equality, Diversity and Inclusion Sub Committee (WEDISC) will oversee the delivery plan for the People ED&I Promises and will monitor all the operational aspects of this Strategy. The WEDISC reports to the Strategic People Committee and provides assurance to Trust Board.

There will be a strong link to the Patient Equability, Diversity and Inclusion Sub Committee which reports to Quality Assurance Committee.



We are WHH & We are PROUD to make a difference

Statutory Reports 2022-2025:

WRES, WDES, EDS3,
WEAR, EDAR, &
Gender Pay Report

If you would like to receive this document in another format, including another language, easy read or large print please do not hesitate to contact us.

Cantonese:
如果你希望以另外一種格式接收該資訊，請和我們聯絡，不必猶豫。

Gujarati:
જો તમને આ માહિતી બીજી રચના કે ફોર્મેટમાં મેળવવાની ઈચ્છા હોય, તો કૃપા કરી અમારો સંપર્ક કરતા અચકાશો નહિ.

Hungarian:
Kérjük, vegye fel velünk a kapcsolatot, ha más formában kéri ezt az információt.

Polish:
Jeżeli chciał(a)by Pan/Pani otrzymać niniejsze informacje w innym formacie, prosimy o kontakt.

Punjabi:
ਜੇ ਤੁਸੀਂ ਕਿਸੇ ਹੋਰ ਫਾਰਮੈਟ ਵਿਚ ਇਹ ਜਾਣਕਾਰੀ ਲੈਣਾ ਚਾਹੁੰਦੇ ਹੋ ਤਾਂ ਸਾਡੇ ਨਾਲ ਸੰਪਰਕ ਕਰਨ ਤੋਂ ਨਾ ਝਿਜਕੋ।

Urdu:
اگر آپ اس معلومات کو کسی اور صورت میں حاصل کرنا چاہتے ہیں تو برائے مہربانی ہم سے رابطہ کرنے میں ہچکچاہٹ محسوس نہ کریں۔

Communications and Engagement Team
Kendrick Wing
Warrington and Halton Hospitals
Lovely Lane, WA5 1QG email: whh.communications@nhs.net
web: www.whh.nhs.uk tel: 01925 664222

Contact the Foundation Trust Governors at:
Foundation Trust Office
Warrington and Halton Hospitals
Whh.foundation@nhs.net
Whh.nhs.uk/about us

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Workforce Equality Analysis Report

(WEAR)

2021

Contents

Section 1 - Introduction

1.1 About this report

All NHS organisations have to demonstrate how they are meeting their Specific Public Equality Duty by:

- Publishing information outlining how Warrington and Halton Teaching Hospitals NHS Foundation Trust will comply with the General Duty on an annual basis
- Publish data on our workforce which should reflect relevance to the local population

This report looks at the profiles of those individuals currently working within Warrington and Halton Teaching Hospitals NHS Foundation Trust (WHH), those entering or leaving the workforce and those accessing opportunities within the Trust. The data for this report refers to the period 15th November 2020 to 15th November 2021 and a comparative data for the time period 1st December 2019 to 30th November 2020 (unless otherwise indicated).

The report refers to the profile of our workforce by "Protected Characteristic" as outlined in the Equality Act (2010), the protected characteristics are as follows:

- Age
- Disability
- Gender reassignment
- Marriage or civil partnership
- Pregnancy and Maternity
- Race
- Religion or belief
- Sex
- Sexual Orientation

1.2 About the organisation

Warrington and Halton Teaching Hospitals NHS Foundation Trust comprises three acute (secondary) care hospitals across two sites in the boroughs of Warrington and Halton.

Our vital statistics

- We employ around 4,883 strong workforce
- We serve a population of 330,000 across both Warrington and Halton boroughs
- We deliver 500,000 individual patient appointments, procedures and stays
- We have an annual turnover of over £240million
- We became a Foundation Trust in 2008 and have circa 15,000 members

It is important to our organisation that we provide an equitable, supportive and fair workplace free from discrimination to support our workforce in providing the best possible care for our patients.

Our Equality, Diversity and Inclusion strategy is committed to improving the health and wellbeing of the people we serve and employ, aiming to be a leading organisation for promoting equality, diversity and inclusion.

Section 2 - Data Reporting Principles

2.1 Measurements and Indicators

This report measures various indicators based on the requirements of the Equality Act 2010 to ensure we meet our Public Sector Equality Duty (PSED). The indicators are shown in **Table one** with associated data sets that are available in this report.

Table One: Data Indicators

Indicator	Data set 15th November 2020 – 15th November 2021 1st December 2019 – 30th November 2020
Workforce profile	• Staff group • Banding • Medical and Dental staff by role • Nursing and Midwifery staff by role • By protected characteristic
Recruitment profile	• Applications and shortlisted by protected characteristic • Promotions by protected characteristic and pay band • Starters and leavers by protected characteristic

The data set out in **Table one** will enable the organisation to identify any areas for improvement if individuals suffer a detriment as a result of any policies, procedures or processes.

2.2 Overall Headcount

As at 15th November 2021, WHH's headcount was: 4883. This figure includes staff employed on both permanent and fixed term contracts, bank and agency staff as well as locums.

2.3 Data Sources

The data used within this report is sourced from the following areas:

- Electronic Staff Record (ESR)
- NHS Jobs Records
- NHS Staff Survey – data taken from the NHS Staff Survey Coordination Centre
- Office of National Statistics
- 2011 Census

- National Online Manpower Information System (NOMIS)

The ONS National Census 2011 is used throughout this report to support comparative analysis against the local population of Warrington and Halton where applicable. As at 15th November 2021 data from the 2021 ONS National Census has not been available for publication or comparison.

2.4 Data Presentation

In relation to the presentation of the data, there are key considerations to be aware of, as illustrated below.

Headcount

Any headcounts of five or less will be shared with the number deleted to avoid individuals being identified. In most cases, percentages will be provided in order to promote staff confidentiality and sound information governance standards.

Ethnicity profiles

The term Black, Asian and Minority Ethnic (BAME) within this report complies with the definition under the Race Relations (Amendment) Act (2000) and therefore encompasses:

- **Asian or Asian British (**Indian, Pakistani, Bangladeshi, Any other Asian background)
- **Black or Black British** (Caribbean, African, Any other Black background
- **Chinese or any other ethnic group**
- **Mixed (**White and Black Caribbean, White and Black African, White and Asian, and other Mixed background)
- **White Irish, White European, Other White background**

Unknown definition

For the parameters of this report, any data referenced as below, will be categorised as **unknown**:

- Unknown
- Not stated
- Unspecified
- Not declared
- Prefer not to answer
- No information available

3 – Workforce Overview

3.1 Introduction

This section reviews the data on the organisation's current workforce and will be broken down by:

- Staff Group
- Agenda for Change pay band
- Medical and Dental staff by role
- Nursing and Midwifery staff by role
- Protected characteristics (Age, Disability, Race / Ethnicity, Religion or Belief, Sex and Sexual Orientation)

This information will be presented alongside the previous reporting year in some instances, in order to offer a comparison. The data for this section of the report will be taken from an organisational Staff List compiled from ESR at a snapshot date of **15th November 2020** and **15th November 2021.** Any headcount 5 or below will be removes in order to provide confidentiality.

3.2 Profile of Staff 2020/2021 by Staff Group and Banding

This section provides an overview of our staff in relation to their staff group and also by Agenda for Change pay banding scales. The snapshot date for each of the comparative years is 15th November. **Table two** highlights the breakdown of staff by staff group, and **Table three** illustrates the breakdown by Agenda for Change pay scales.

Table Two: Workforce Profile by Staff Group

	2020	2021
Total Staff	4540	4831
Total Staff numbers by staff group		
Add Prof Scientific and Technical	182	145
Additional Clinical Services	834	871
Administrative and Clerical	986	1031
Allied Health Professionals	368	413
Estates and Ancillary	501	509
Healthcare Scientists	104	113
Medical and Dental	452	540
Nursing and Midwifery Registered	1111	1209

Table Three: Workforce Profile by Agenda for Change banding scale

Agenda for Change Banding	2020	2021
Band 1	110	82
Band 2	1154	1164
Band 3	505	481
Band 4	352	358

Band 5	664	740
Band 6	711	679
Band 7	475	490
Band 8a	152	159
Band 8b	56	53
Band 8c	19	27
Band 8d	12	15
Band 9	7	6

The workforce profile split by medical and dental roles is illustrated in **Table four** and by nursing and midwifery roles in **Table five.**

Table Four: Workforce profile split by Medical and Dental Roles

Role	2020	2021
Associate Specialist (closed to new entrants)	7	5
Clinical Assistant (closed to new entrants)		
Consultant	216	227
Foundation Year 1	37	36
Foundation Year 2	37	41
GP Locum		3
Hospital Practitioner (closed to new entrants)	1	1
Medical Director	3	3
Speciality Doctor	42	38
Speciality Registrar	12	21
Staff Grade (closed to new entrants)	1	1
Trust Grade Doctor – Career Grade Level	5	1
Trust Grade Doctor – Specialist Registrar Level	1	
Trust Grade Doctor – Speciality Registrar	90	163

Table Five: Workforce profile split by Nursing and Midwifery roles

Role	2020	2021
Advanced Practitioner	11	20
Director of Nursing	3	2
Midwife	118	118
Midwife – Consultant	1	
Midwife – Manager		1
Midwife – Specialist Practitioner	7	8
Modern Matron	22	19
Nurse Consultant	4	4
Nurse Manager	55	66

Sister / Charge Nurse	156	169
Specialist Nurse Practitioner	203	215
Staff Nurse	531	587

3.2 Profile of staff by ethnicity

The following section analyses the workforce profile by ethnicity as set out in the Race Relations (Amendment) Act 2000 and identified in section 2.4. **Diagram one** highlight the workforce profile split from an ethnicity perspective as at the snapshot date of 15th November 2021. The term Black, Asian and Minority Ethnic refers to non-white, ethnic minority employees.

Diagram One: Workforce ethnicity profile, 2021

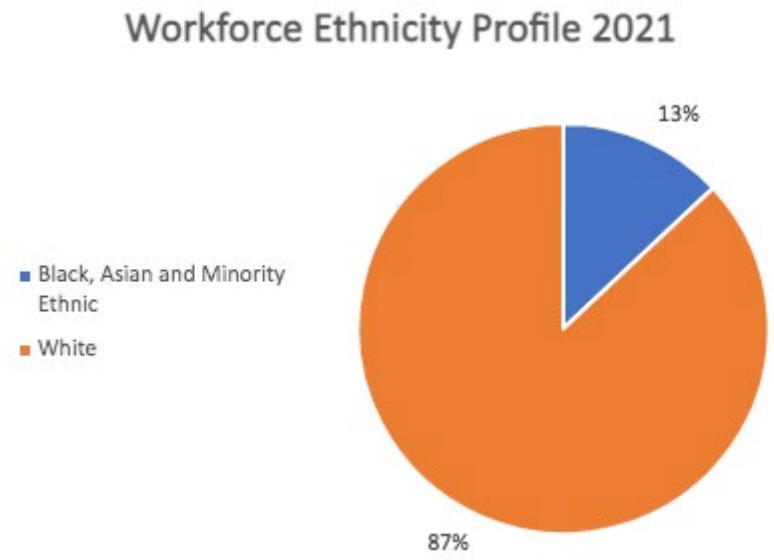


Table six identifies the workforce profile by staff group and ethnicity compared between 2019 and 2020.

Ethnicity	White		Ethnic Minority	
	2020	2021	2020	2021
Add Prof Scientific and Technical	169	131	10	13
Additional Clinical Services	776	791	55	69
Administrative and Clerical	956	996	26	31
Allied Health Professionals	341	380	24	30
Estates and Ancillary	467	466	33	43
Healthcare Scientists	91	97	13	15
Medical and Dental	210	251	228	275
Nursing and Midwifery Registered	969	982	111	197

Table seven illustrates the workforce profile split by ethnicity for the snapshot date of 15th November 2021.

Table Seven: Workforce profile split by ethnicity

Ethnicity	2020	2021
White - British	3856	3938
White - Irish	44	45
White – Any Other White Background	91	102
White – Northern Irish		2
White – English		3
White – Welsh		3
White – Mixed		1
White – Other European		2
Mixed – White and Black Caribbean		8
Mixed – White and Black African	6	11
Mixed – White and Asian	16	21
Mixed – Any other mixed background	21	25
Asian or Asian British – Indian	181	244
Asian or Asian British – Pakistani	67	76
Asian or Asian British – Bangladeshi		3
Asian or Asian British – Any Other Asian background	77	88
Asian Sri Lankan		3
Asian British		2
Black or Black British – Caribbean	9	10
Black or Black British – African	40	62
Black or Black British – Any other Black background	4	5
Black British		5
Chinese	17	22
Any other ethnic group	52	59
Filipino		14
Malaysian		2
Other Specified		3
Not stated	60	64

Table Eight illustrates the workforce profile split by ethnicity and staff group.

Table Eight: Workforce Staff Group split by ethnicity

	2020	2021
Additional Prof Scientific and Technic		
Ethnic Minority	10	13
White	169	131
Additional Clinical Services		
Ethnic Minority	55	69
White	776	791
Administrative and Clerical		
Ethnic Minority	26	31

White	956	996
Allied Health Professionals		
Ethnic Minority	24	30
White	341	380
Estates and Ancilliary		
Ethnic Minority	33	43
White	467	466
Healthcare Scientists		
Ethnic Minority	13	15
White	91	97
Medical and Dental		
Ethnic Minority	228	275
White	210	251
Nursing and Midwifery Registered		
Ethnic Minority	111	197
White	969	982

Analysis

The known ethnicity profile for the Trust remains high at 99% with the highest ethnicity profile being White British (80%). The highest declared non-white ethnicity is Asian or Asian British – Indian (4.9%) of the total workforce. The ethnic minority representation across each staffing group has increased since the previous year and accounts for around 7.5% of each staff group apart from Medical and Dental (50%), Nursing and Midwifery (16%) and Healthcare Scientists (13%). Administrative and Clerical remains the group with least ethnic minority representation (3%). Overall, the ethnic minority workforce profile accounts for 13% of the total workforce which is more than representative of the local population as the Office for National Statistics 2011 Census indicates that 7.1% of the Warrington population identify as a minority ethnicity and this is 3.6% for Halton.

3.3 Profile of staff by Sex

The following section analyses the workforce profile by sex as set out in the Equality Act (2010) **Diagram two** highlights the workforce profile split from a sex perspective at the snapshot date of 15th November 2021.

Diagram Two: Workforce sex profile, 2021

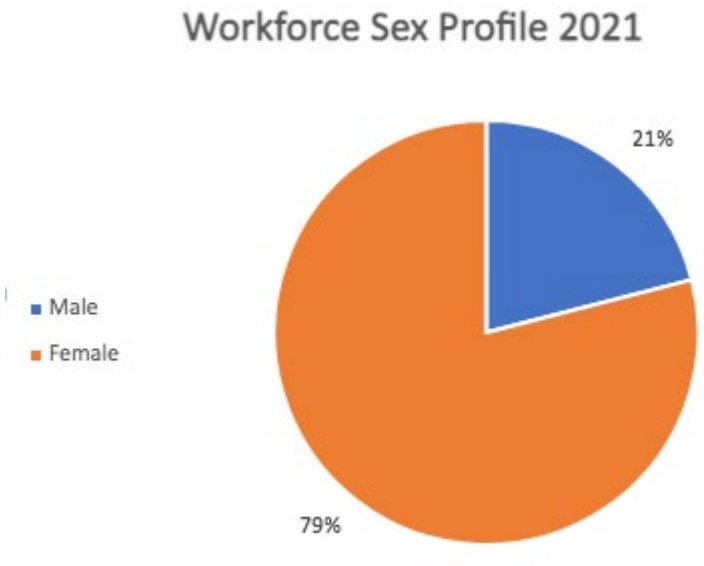


Table Nine highlights the profile of staff split by staff group and sex for the snapshot date of 15th November 2021.

Staff Group	Female		Male	
	2020	2021	2020	2021
Add Prof Scientific and Technical	133	113	49	32
Additional Clinical Services	744	777	90	94
Administrative and Clerical	818	856	168	175
Allied Health Professionals	318	337	50	76
Estates and Ancillary	314	328	187	181
Healthcare Scientists	72	73	62	40
Medical and Dental	175	207	277	333
Nursing and Midwifery Registered	1040	1129	71	80

3.3.a Gender Pay Gap Reporting

The Gender Pay Gap report is a nationally mandated report from central Government to ascertain the different between the average (mean or median) earnings of men and women across a workforce. Due to the COVID-19 pandemic, where gender pay reporting was paused, the below provides a snapshot of the Gender Pay Gap of the organisation from the snapshot date of 31st March 2021.

On the basis of the snapshot date of 31st March 2021, the split by sex is 19% male and 81% female. The figures below are split into two categories, the **median** which is the middle point and the **mean** which is the average.

The data shows that the median hourly pay for men is £1.74 higher for men than it is for women, resulting in a median pay gap of 11.10% in favour of men. This is an increase on 2020's figure of 10.67%.

The mean hourly pay for men is £5.28 higher for men than it is for women, resulting in a mean pay gap of 24.61% in favour of men. This is a slight reduction in the previous year's figure of 25.05%.

Analysis

The data provided indicates that 79% of the workforce are female with 21% being male. The highest groups of female staff are within Nursing and Midwifery which accounts to 24% of the total workforce, whereas the highest number of males are represented in medical and dental which is 11% of the total workforce.

3.4 Profile of staff by Disability

This section analyses the workforce profile by disability.

Diagram Three identifies the workforce profile by declared disability status compared between 2020 and 2021 and **Diagram Four** identifies the disability status of the workforce for 2021. This data is taken from the organisation's Electronic Staff Record (ESR) and are at the snapshot date of 15th November 2021.

Diagram Three: Workforce Disability Status Comparison

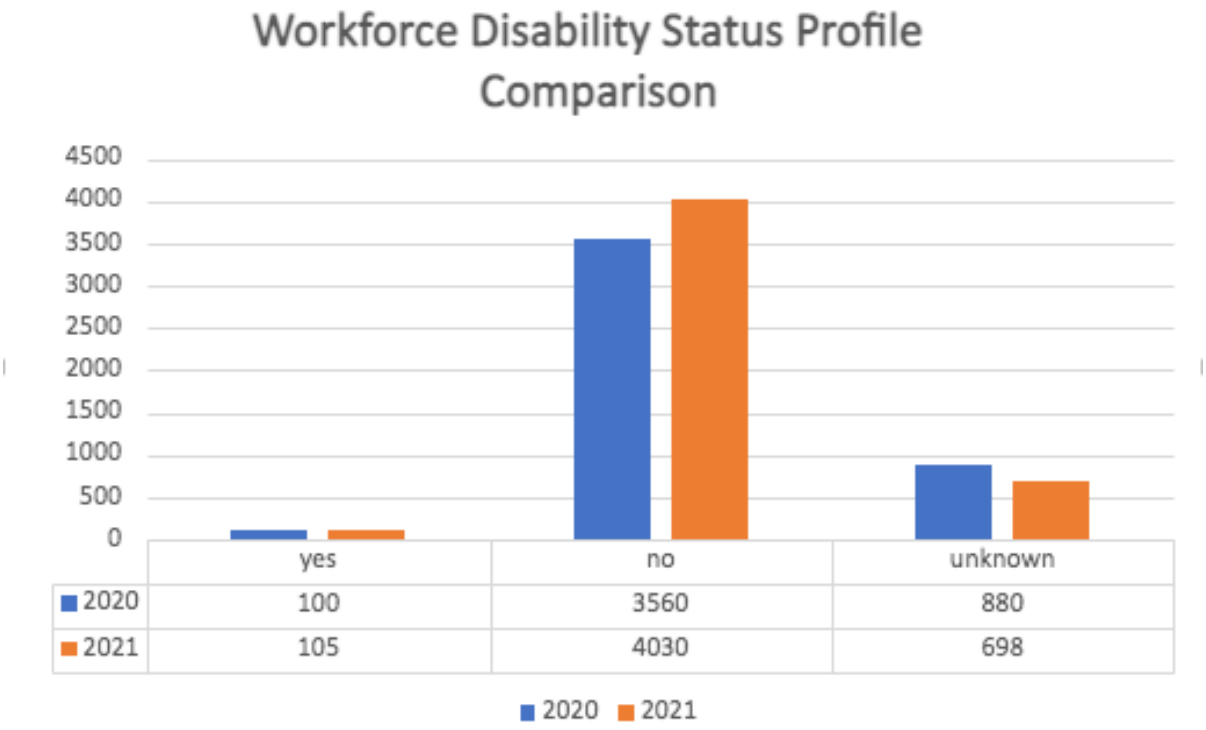


Diagram Four: Workforce Disability Profile, 2021

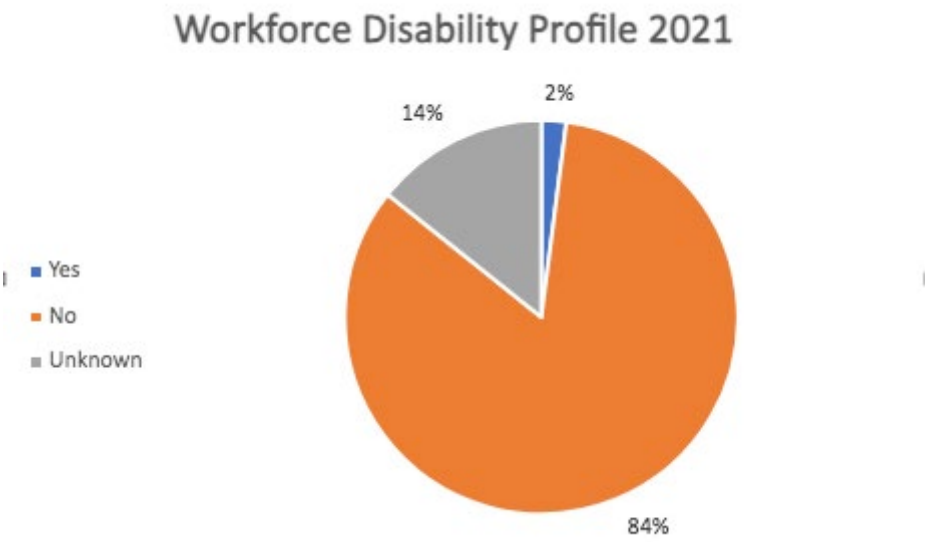


Table ten highlights the workforce profile split by disability declaration. The data shows where individuals have actively declared that they do have a disability (yes) or that they do not have a disability (no).

Table ten: Workforce profile split by Disability declaration and staff group

Staff Group	Disability Declared: No		Disability Declared: Yes	
	2020	2021	2020	2021
Add Prof Scientific and Technical	154	135		
Additional Clinical Services	627	702	13	15
Administrative and Clerical	757	831	39	43
Allied Health Professionals	333	381	11	8
Estates and Ancillary	344	387	7	11
Healthcare Scientists	73	88		
Medical and Dental	391	486	8	7
Nursing and Midwifery Registered	879	1018	19	19

Analysis

The ESR profile for Disability evidences that there are large gaps in the staff data held by the Trust with the known Disability status (being yes and no) at 86% which is an increase of 4% in comparison with 2020. Although the unknown data for disability has decreased there is a still improvement to be made.

The figures for people living in Halton who are claiming Disability Allowance and related disability benefits is very high at 8.9%. In Warrington's local population the same cohort amounts to 5.65%. In

residential estimates, the population who record as being disabled / living with life limiting illnesses for Halton is 21.5% of the local population and for Warrington is 18%.

Work on encouraging staff and highlighting the importance of disability disclosure will continue through 2022/23 as part of the Equality, Diversity and Inclusion strategy for the organisation.

3.5 Profile of staff by Age

The following section analyses the workforce profile by age as set out in the Equality Act (2010) **Diagram Five** highlights the workforce profile split from an age perspective as at the snapshot date of 15th November 2021.

Diagram Five: Workforce Age Profile, 2021

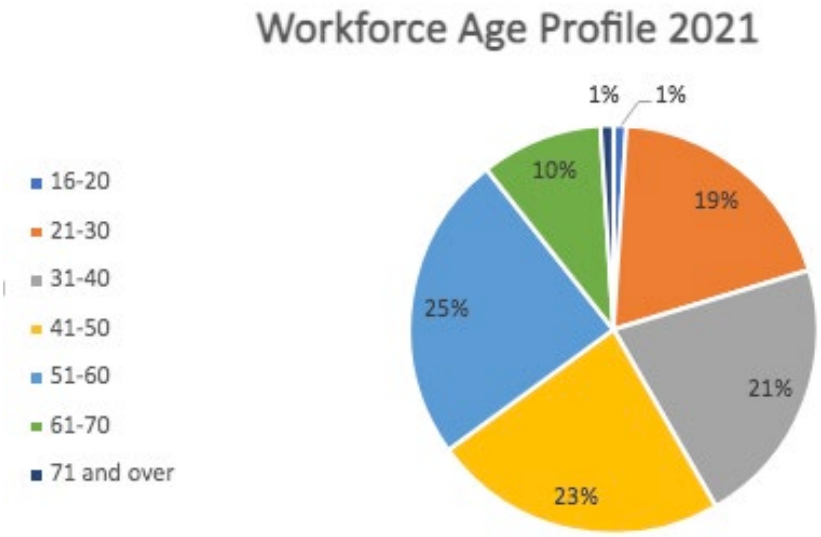


Table Eleven identifies the workforce profile by age split by staff group.

Table Eleven: Workforce Profile by staff group and age

Staff Group	16-20	21-30	31-40	41-50	51-60	61-70	71+

Add Prof Scientific and Technical		49	40	24	22	10	
Additional Clinical Services	22	174	176	198	207	89	5
Administrative and Clerical	12	138	163	244	335	128	11
Allied Health Professionals		111	113	105	72	12	
Estates and Ancillary	4	40	69	99	179	103	15
Healthcare Scientists		27	35	18	22	10	
Medical and Dental		169	124	136	68	36	7
Nursing and Midwifery Registered		218	331	298	284	76	

Analysis

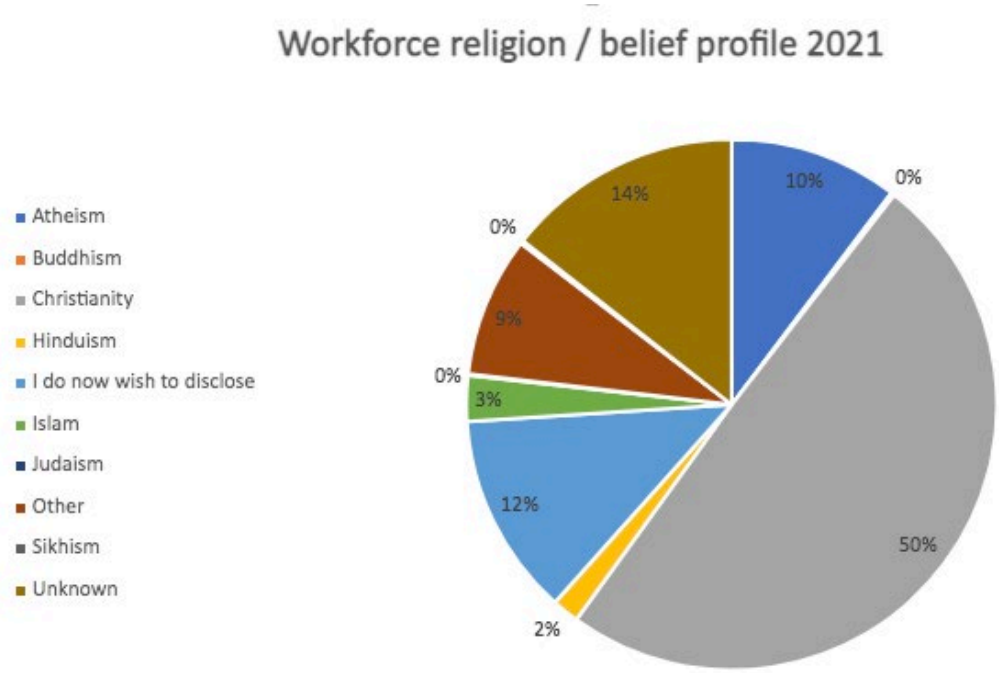
The highest represented age groups for the Trust are in line with previous years with most of the workforce being in the 41-50 years (23%) and 51-60 years (25%). The next largest age bracket is 31-40 at 21%.

11% of the workforce are over the age of 60, which includes 1% being over the age of 71. In 2011, the Employment Equality (Repeal of Retirement Age Provisions) Regulation came into force. This repealed the default retirement age of 65 years and provides protection for those aged 65 years and over from default retirement based on their date of birth. Our workforce profile demonstrates that the Trust is in line with the law in relation to age equality in employment.

3.6 Profile of staff by Religion / Belief

The following section analyses the workforce profile by religion or belief as set out in the Equality Act (2010) **Diagram Six** highlights the workforce profile split from a religion or belief perspective as at the snapshot date of 15th November 2021.

Diagram Six: Workforce religion / belief profile, 2021



Analysis

The total known disclosure of our staff religion or belief is 74% which is an increase from 69% the previous year. The percentage of staff not wishing to disclose their religion or belief is 12% which is less than the previous year and would illustrate that more people may feel comfortable to disclose their religion or belief within our organisation.

As with previous years, Christianity is the most predominant religion within the Trust at 48% and the other two highest are those not wishing to disclose (12%) followed by atheism (10%).

This would compare similarly to the ONS Censure (2011) which highlighted the percentage of the population living in Warrington identifying as Christian being 71.4% with Halton being 75%. The 2011 ONS Census indicates that the organisation's non-disclosure rates when compared to the population is much higher at 31% than Warrington's 5.9% and Halton's 5.4%.

3.7 Profile of staff by Sexual Orientation

The following section analyses the workforce profile by sexual orientation as set out in the Equality Act (2010) **Diagram Seven** highlights the workforce profile split from a sexual orientation perspective at the snapshot date of 15th November 2021.

Diagram Seven: Workforce Sexual Orientation profile, 2021

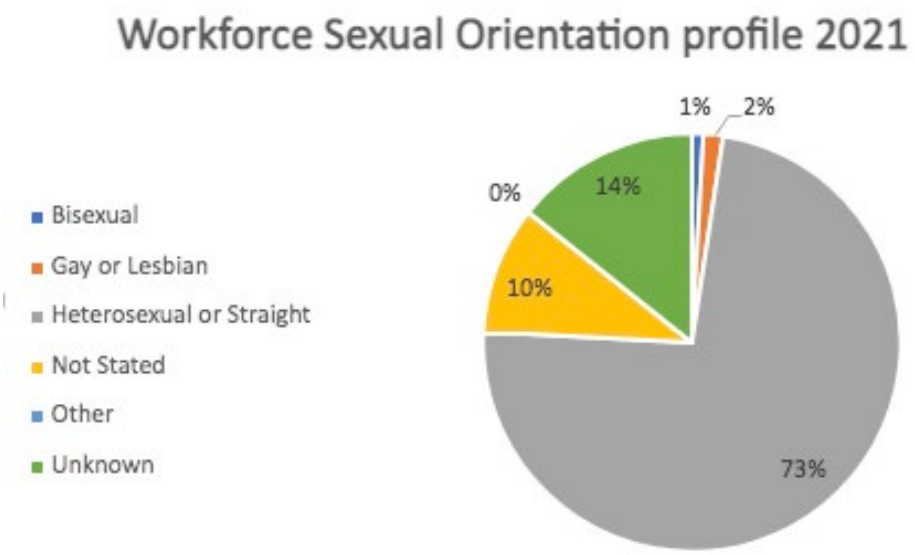


Table twelve identifies the workforce profile split by sexual orientation and staff group.

Table Twelve: Sexual Orientation by Staff Group

Staff Group	Bisexual	Gay or Lesbian	Heterosexual or Straight	Not stated	Other sexual orientation	Not known
Add Prof Scientific and Technical			113	8		19
Additional Clinical Services	7	13	649	65		65
Administrative and Clerical	8	19	760	91		153
Allied Health Professionals	8	8	293	32		72
Estates and Ancillary	5		363	38		102
Healthcare Scientists			71	13		29
Medical and Dental		15	389	112		18
Nursing and Midwifery Registered	9	14	892	116		176

Analysis

The known status for sexual orientation is 75%, with figures for lesbian, gay or bisexual amounting to 1.5%. The unknown status for sexual orientation is 25% which includes those who preferred not to say and those who did not answer (not known).

The national estimation for people identifying as Lesbian, Gay, Bisexual or Other (LGB) is between 5-7%. There are no population census records for the Local Authority domains and the national 2011 ONS Census did not ask for sexual orientation status.

4 – Recruitment Profile

This section will analyse the recruitment profile of the Trust and will identify the following information:

- Applications and shortlisted candidates by protected characteristic
- Promotions by protected characteristic and pay band
- Starters and leavers by protected characteristic.

The protected characteristics within this section are age, gender, religion or belief, ethnicity, disability and sexual orientation. The data will be compared with the previous reporting period, where applicable to demonstrate any significant changes or developments.

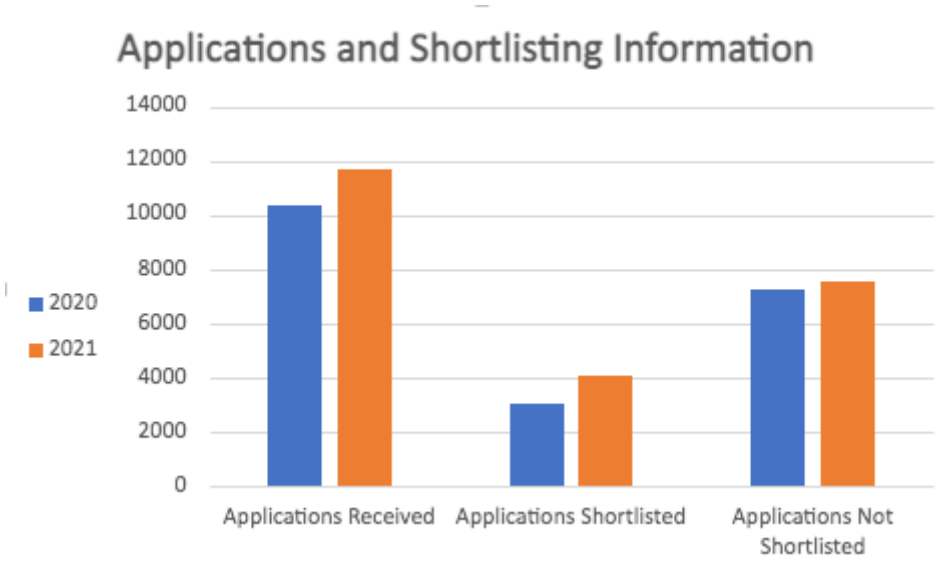
The data for this section of the report will be taken from NHS Jobs and an organisational staff list compiled from ESR at a snapshot date of **15th November 2020** and **15th November 2021.** Data that identifies 5 or less individuals will be removed and greyed out in order to protect the confidentiality of our staff.

4.1. Application and Shortlisting overview

Diagram Eight illustrates the number of applications received and those applications that have been shortlisted during the following time periods:

- 2019/20 – 1st December 2019 – 1st November 2020
- 2020/21 – 1st December 2020 – 1st November 2021

Diagram Eight: Applications and Shortlisting information



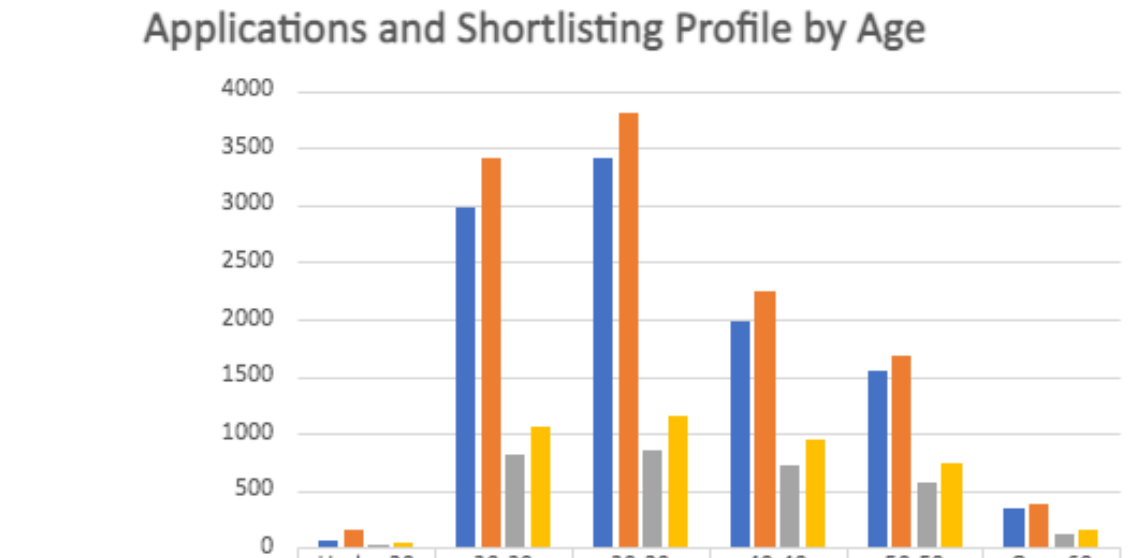
Analysis

The organisation received 11,686 applications in 2021 which is an increase of 8.9% on the previous year, which is likely to be attributable to the organisation's response to the COVID-19 pandemic.

4.1.a Application and Shortlisting profile by Age

This section provides an overview of the profile of candidates who have applied and were shortlisted by age.

Diagram Nine: Profile of applications and shortlisted candidates by age



	Under 20	20-29	30-39	40-49	50-59	Over 60
Applications 2019 - 2020	69	2985	3413	1976	1557	336
Applications 2020 - 2021	156	3409	3807	2248	1674	387
Shortlisted 2019 - 2020	16	816	858	712	564	120
Shortlisted 2020 - 2021	46	1055	1147	953	745	150

Diagram ten: Applications by age profile

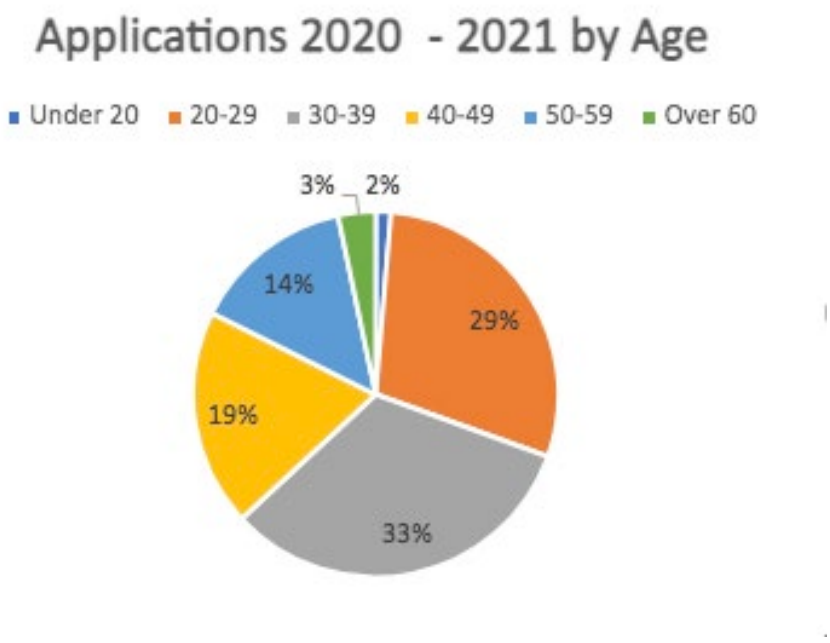
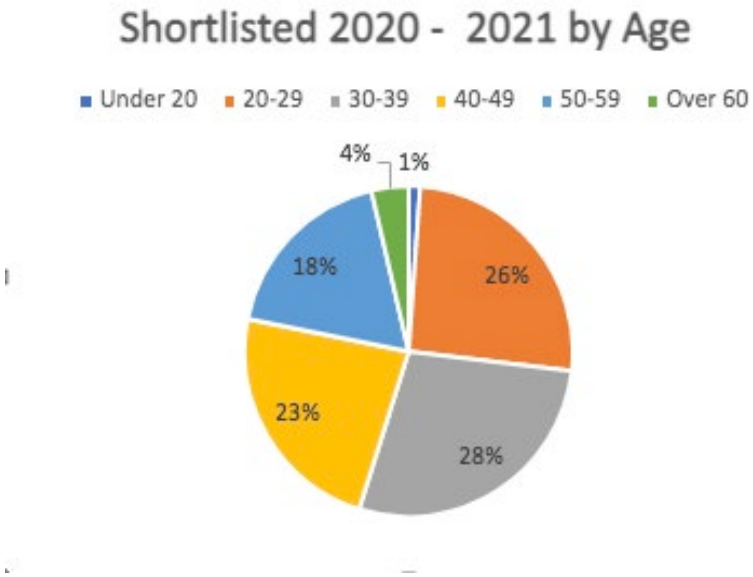


Diagram eleven: Shortlisted by age profile



Analysis

Diagram nine highlights comparative data between individuals who applied and were shortlisted by their age demographic for 2019-2020 and 2020-2021. The biggest increase in applications was seen in the 30-39 age group, which is also reflected in the shortlisted candidates as evidenced in **Diagram eleven**.

4.1.b Application and Shortlisting profile by Sex

This section provides an overview of the profile of candidates who have applied and were shortlisted by sex.

Diagram twelve: Profile of applications and shortlisted candidates by sex

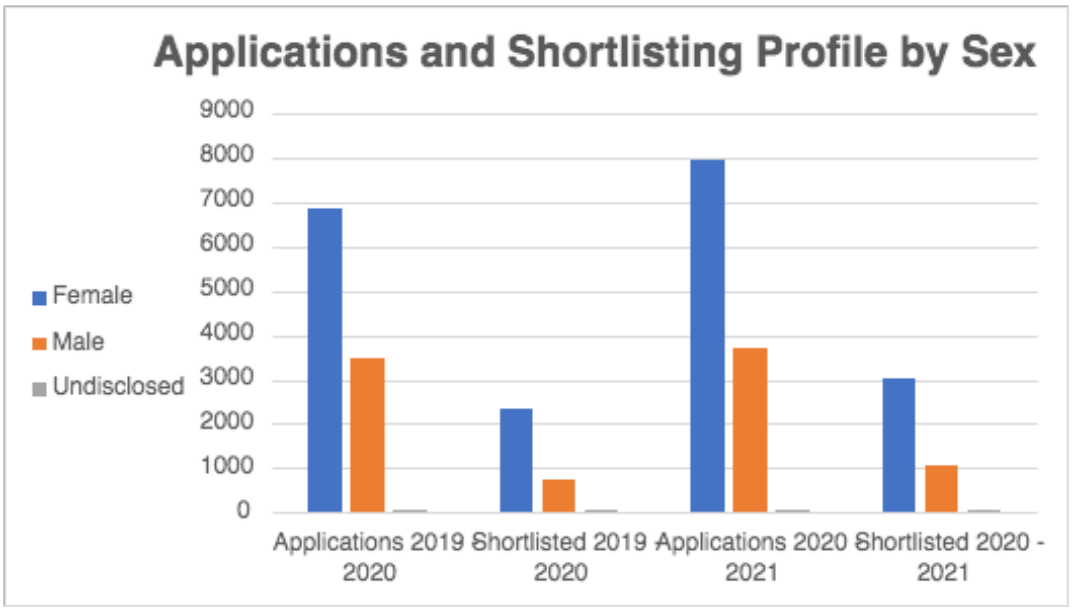


Diagram thirteen: Applications sex profile

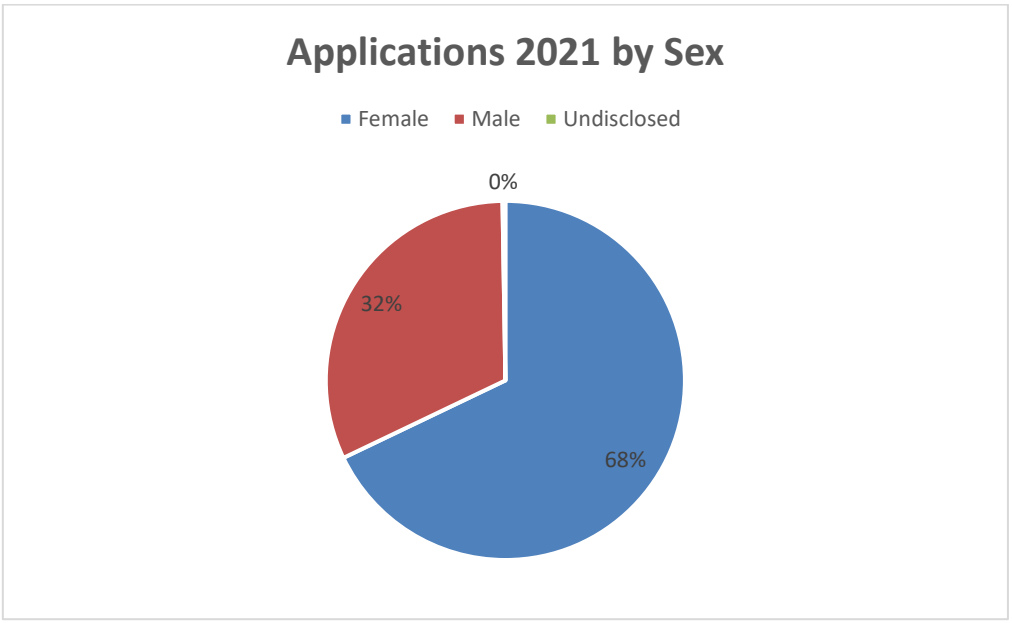
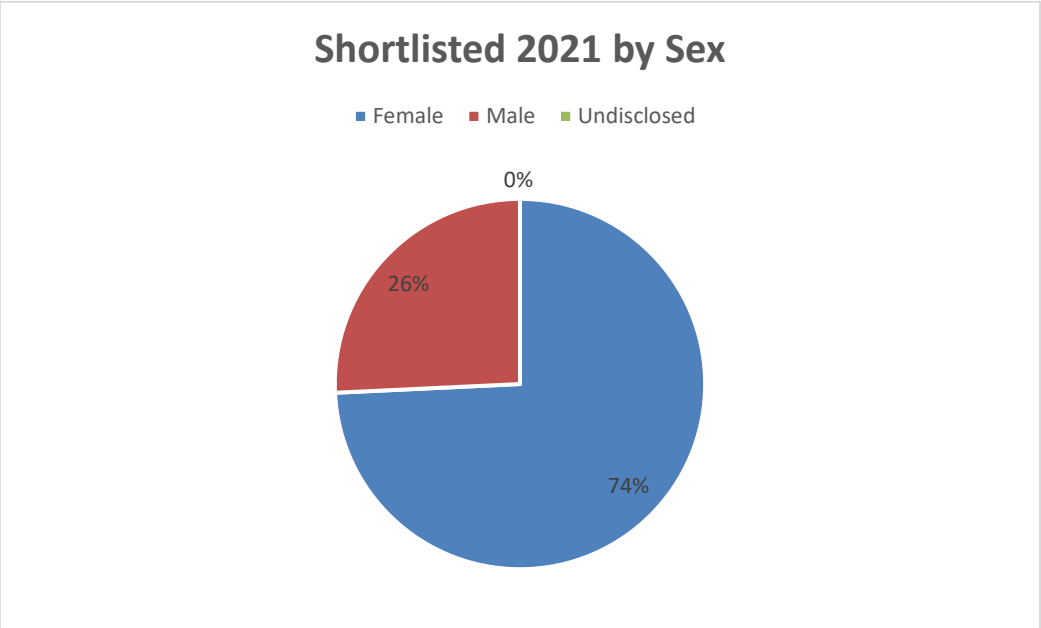


Diagram fourteen: Shortlisting sex profile



Analysis

Diagram twelve demonstrates the comparative application and shortlisted data by sex between 2020 and 2021. There are significant more numbers of females than males applying, which is also reflected in the shortlisting data.

In comparison to the local population, the Trust's application data would indicate that it may not be representative of the local population, with Halton having 48.8% male and 51.2% female and Warrington 49.6% male and 50.4% female. However, it is important to note that there are other factors to consider in relation to this data such as the amount of specialist roles and access to further learning and development for the population.

4.1.c Application and Shortlisting profile by Religion / Belief

This section provides an overview of the profile of candidates who have applied and were shortlisted by disclosed religion / belief.

Diagram 15: Application and shortlisting profile information by religion and belief

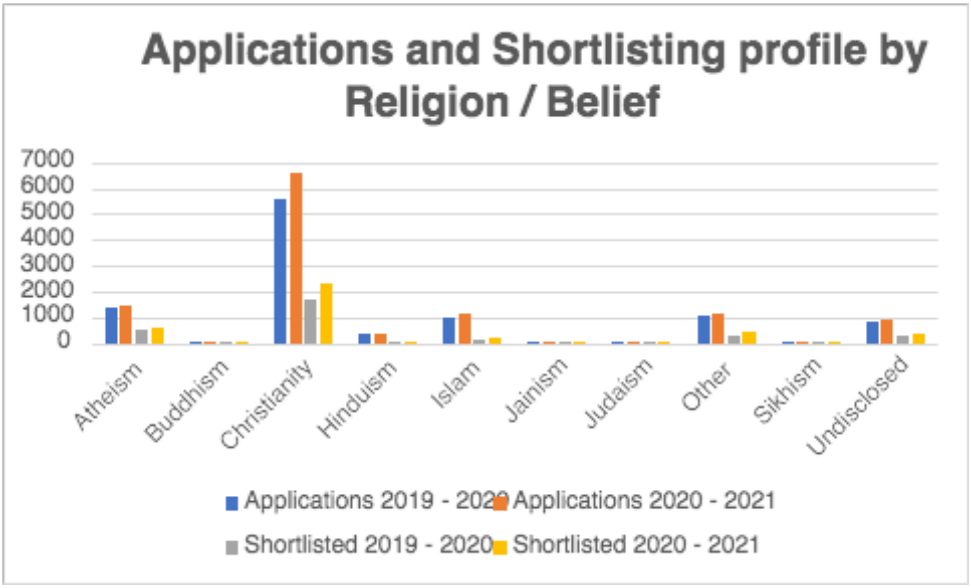


Diagram Sixteen: Applications profile by religion or belief, 2021

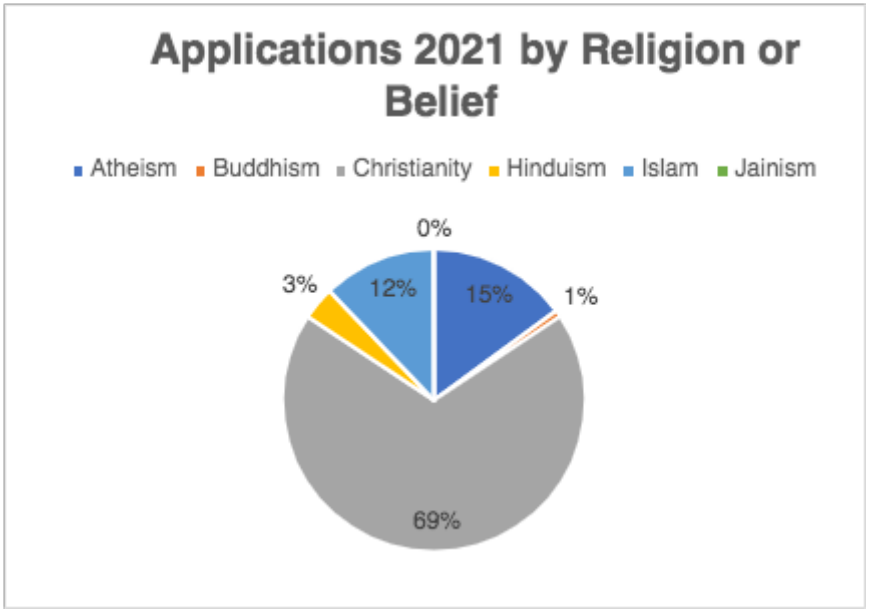
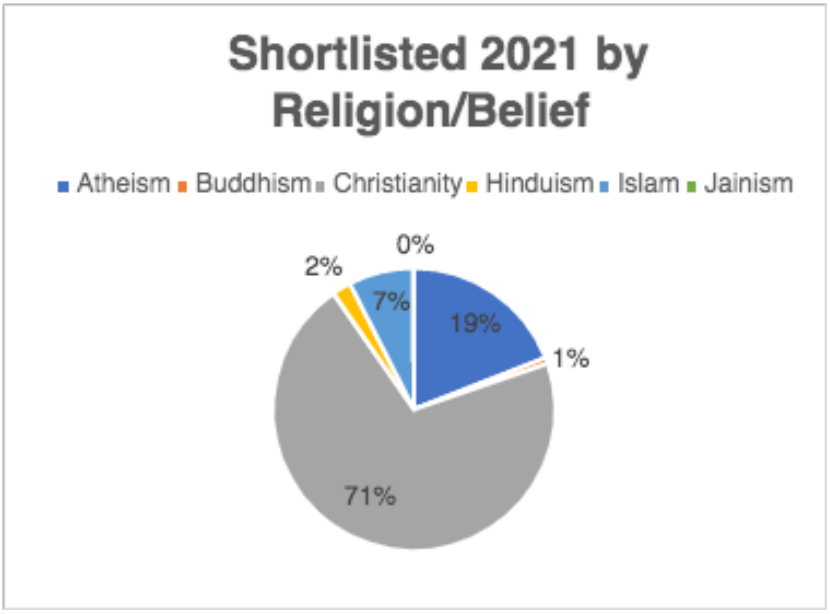


Diagram seventeen: Shortlisting profile by religion or belief, 2021



Analysis

Diagram fifteen provides comparative information by religion and belief between 2020 and 2021. It is clear from **Diagram fifteen** that there are no significant differences between 2020 and 2021.

The highest number of applicants declare to be Christian (56% of applications and 56% shortlisted) followed by Atheism, Other and Undisclosed which reflects the local demographic information.

4.1.d Application and Shortlisting profile by Ethnicity

This section provides an overview of the profile of candidates who have applied and were shortlisted by ethnicity.

Diagram eighteen: Application and shortlisting profile by ethnicity

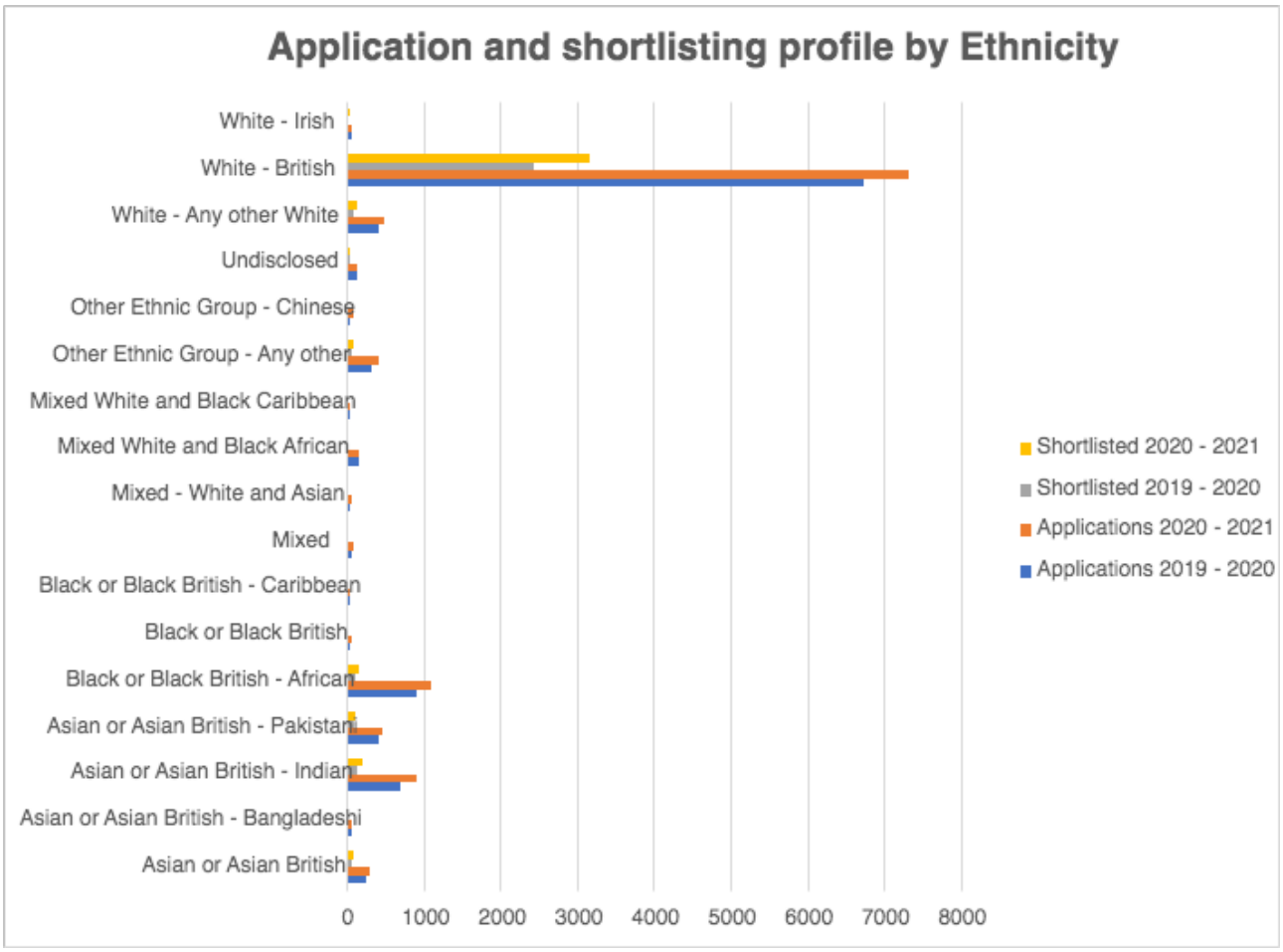


Diagram nineteen: Application ethnicity profile, 2021

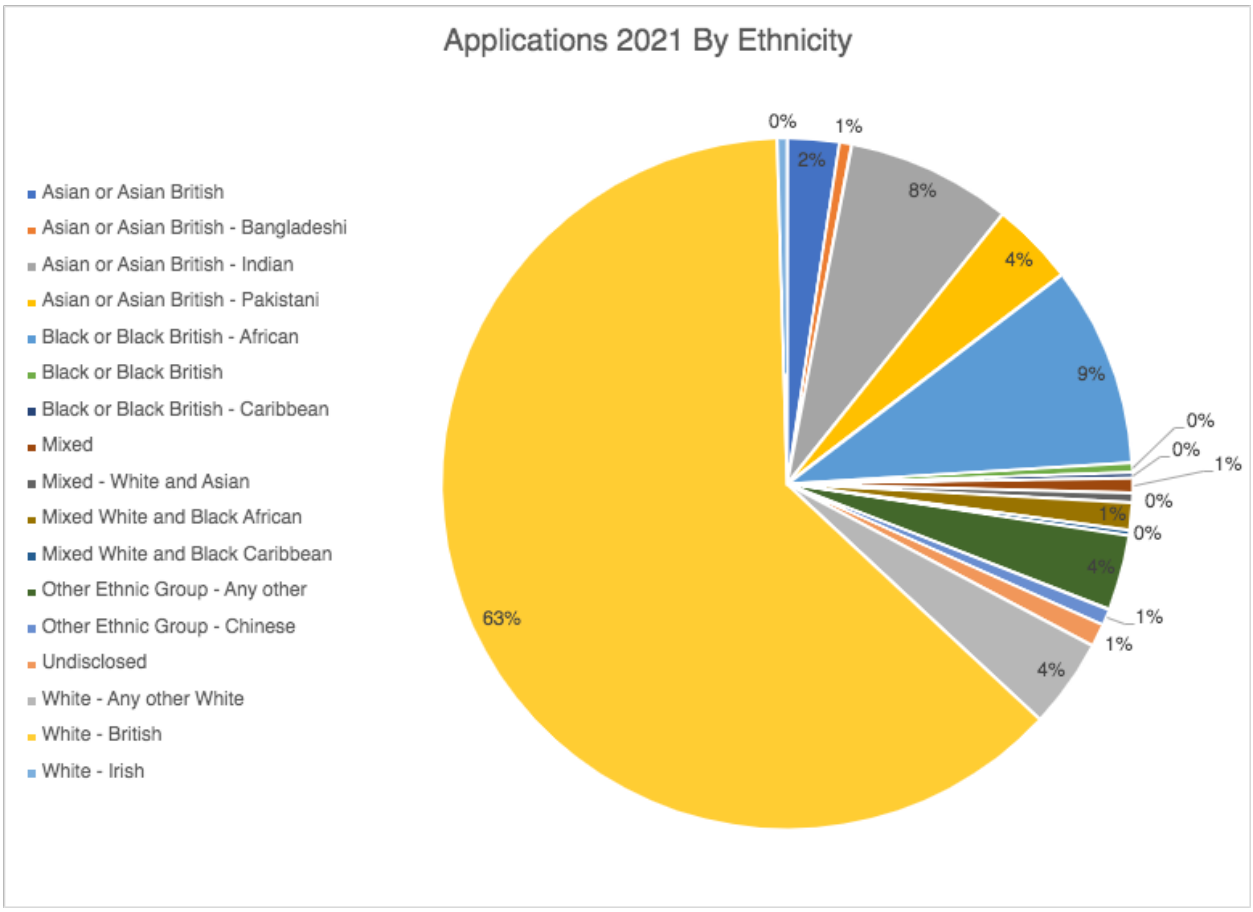
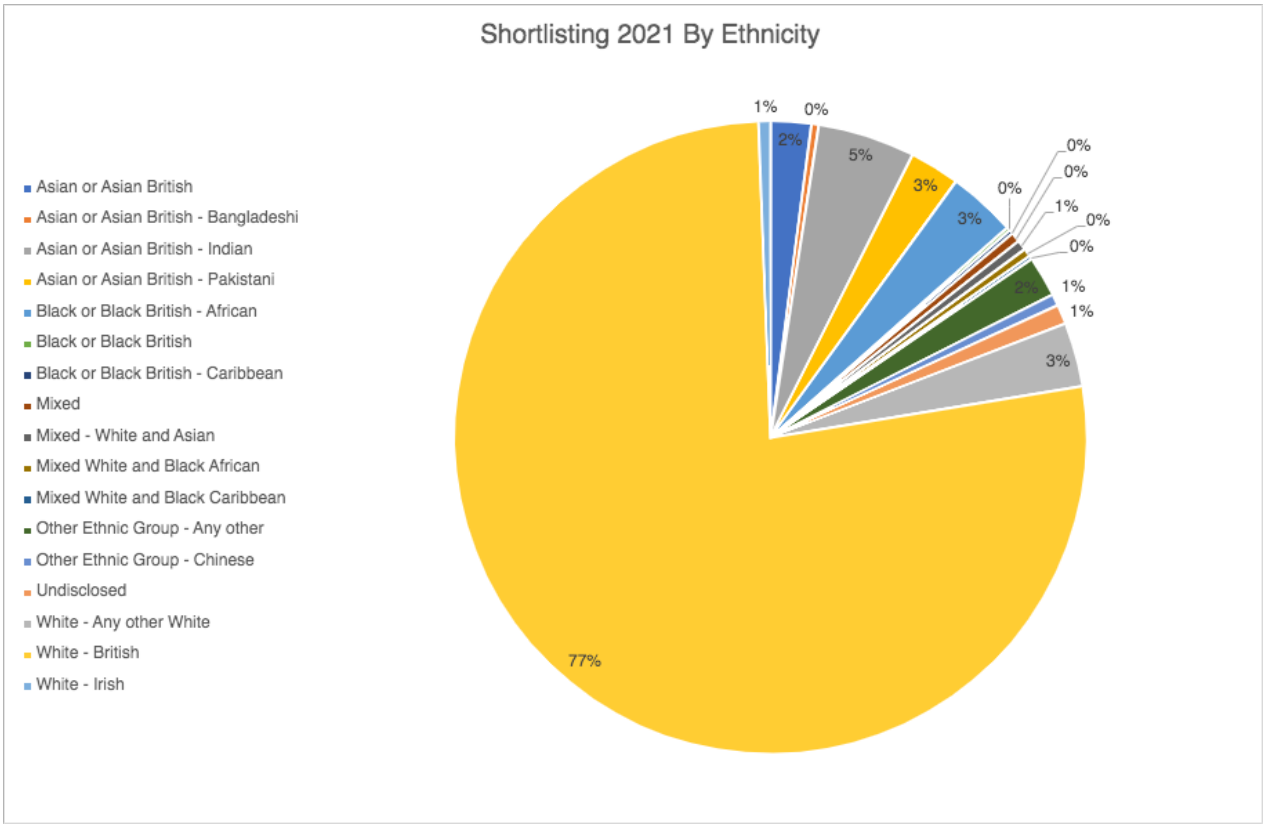


Diagram Twenty: Shortlisting profile by ethnicity, 2021



Analysis

Diagram eighteen illustrates the comparative application and shortlisting information for 2020 and 2021. There are no changes between each of the years that would be considered to be statistically significant.

Based on the information above, the majority of applicants that are shortlisted are White British. The largest ethnic minority group that is shortlisted is Asian or Asian British - Indian as illustrated in **Diagrams nineteen** and **twenty**. This is relatively reflective of the local population of Warrington and Halton. To continue to monitor recruitment processes, the organisation has developed a robust Inclusive Recruitment action plan as a result of the Workforce Race Equality Standard data which is highlighted in Section five.

4.1.d Application and Shortlisting profile by Disability

This section provides an overview of the profile of candidates who have applied and were shortlisted by disability.

Diagram twenty one: Application and shortlisting profile by disability 2020-2021

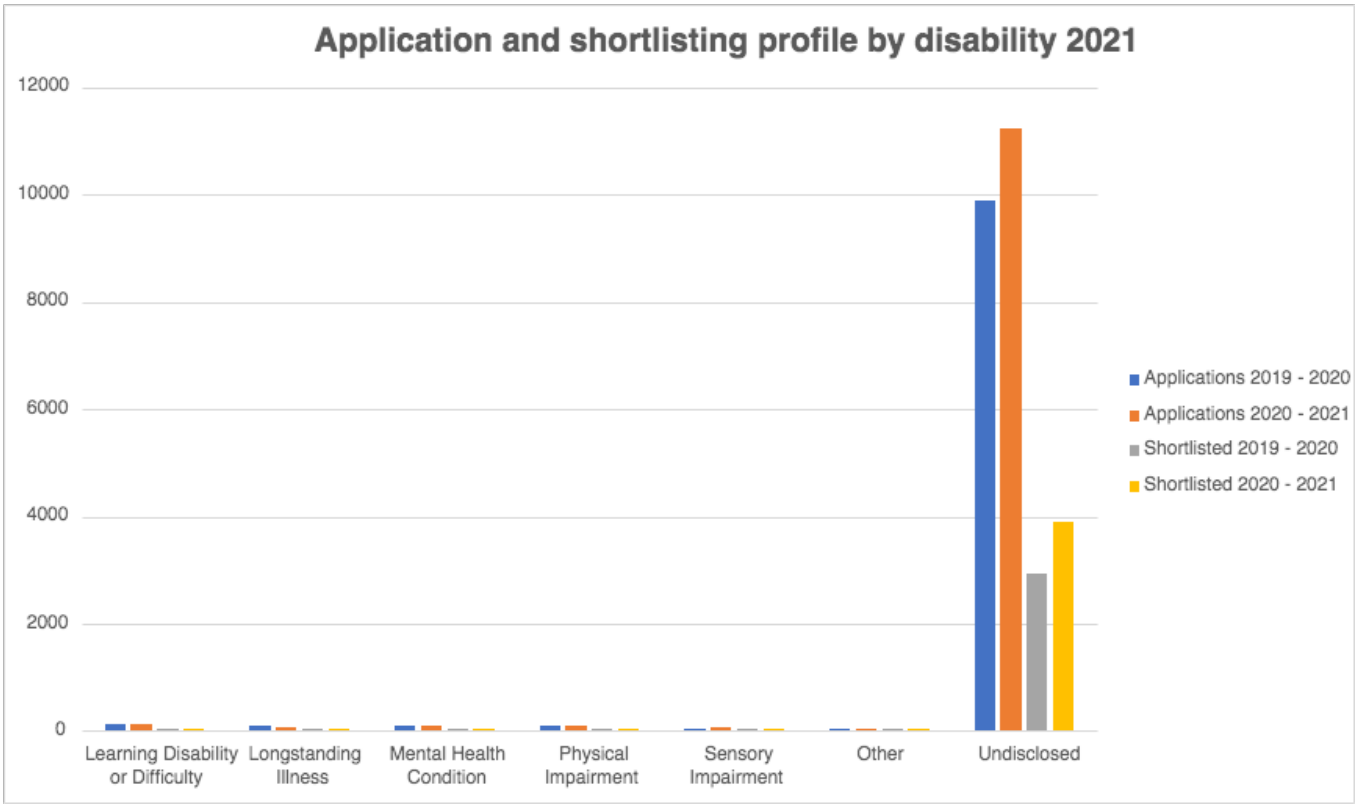


Diagram twenty two: Applications by disability profile

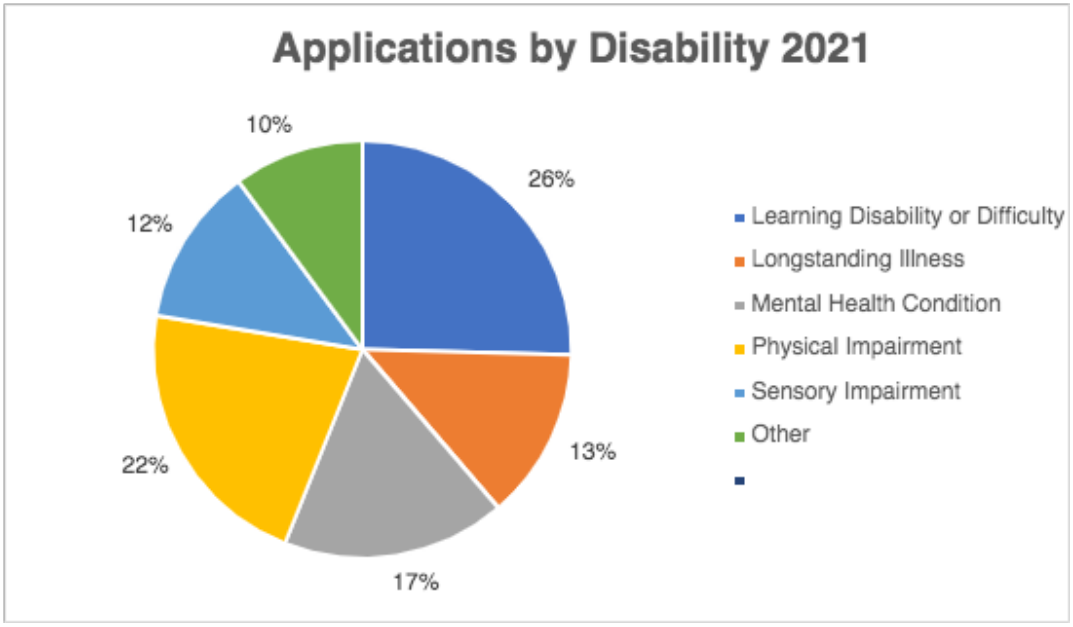
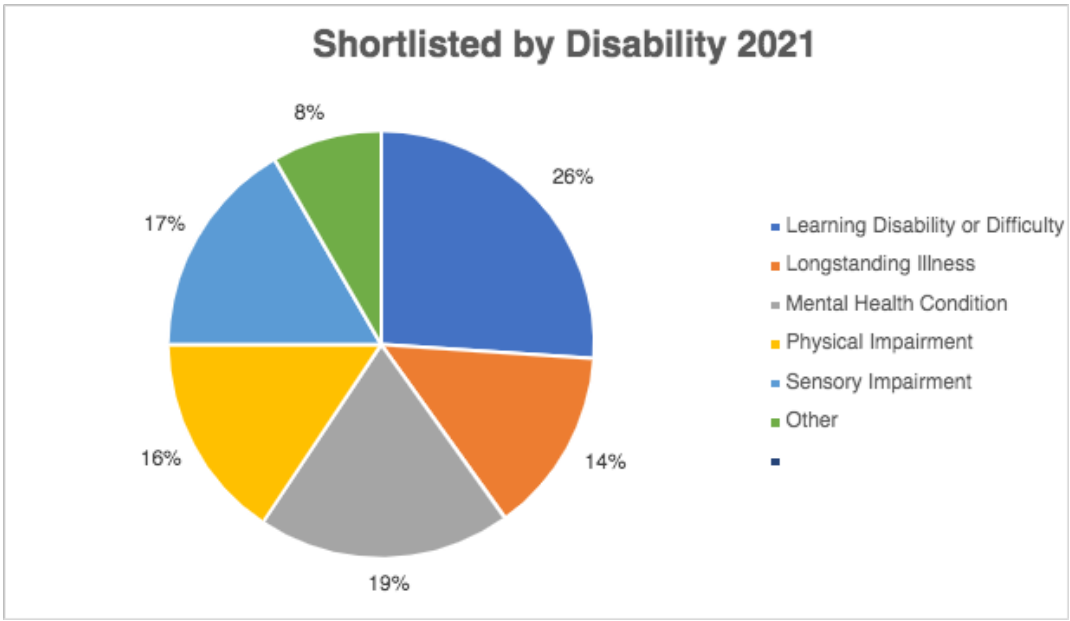


Diagram twenty three: Shortlisting by disability profile



Analysis

Diagram twenty one offers comparative application and shortlisting information by declared disability for 2020/21, which shows an increase in applications from individuals not disclosing status.

Diagram twenty two and **twenty three** highlights that of individuals having declared a disability, the highest number of applications and shortlisted individuals have a declared learning disability or difficulty, which is closely followed by a long standing illness and mental health condition.

Within the local population, 11.58% of Halton report a disability compared with 8.387% of Warrington residents. Given that 4% of the organisation's applications report a disability, it would suggest that the workforce is not representative of the local population. However, the local population data does not indicate whether all individuals are eligible for work or not, which makes drawing meaningful conclusions on representation difficult.

4.1.e Application and Shortlisting profile by Sexual Orientation

This section provides an overview of the profile of candidates who have applied and were shortlisted by sexual orientation.

Diagram twenty four: Applications and shortlisting profile by sexual orientation

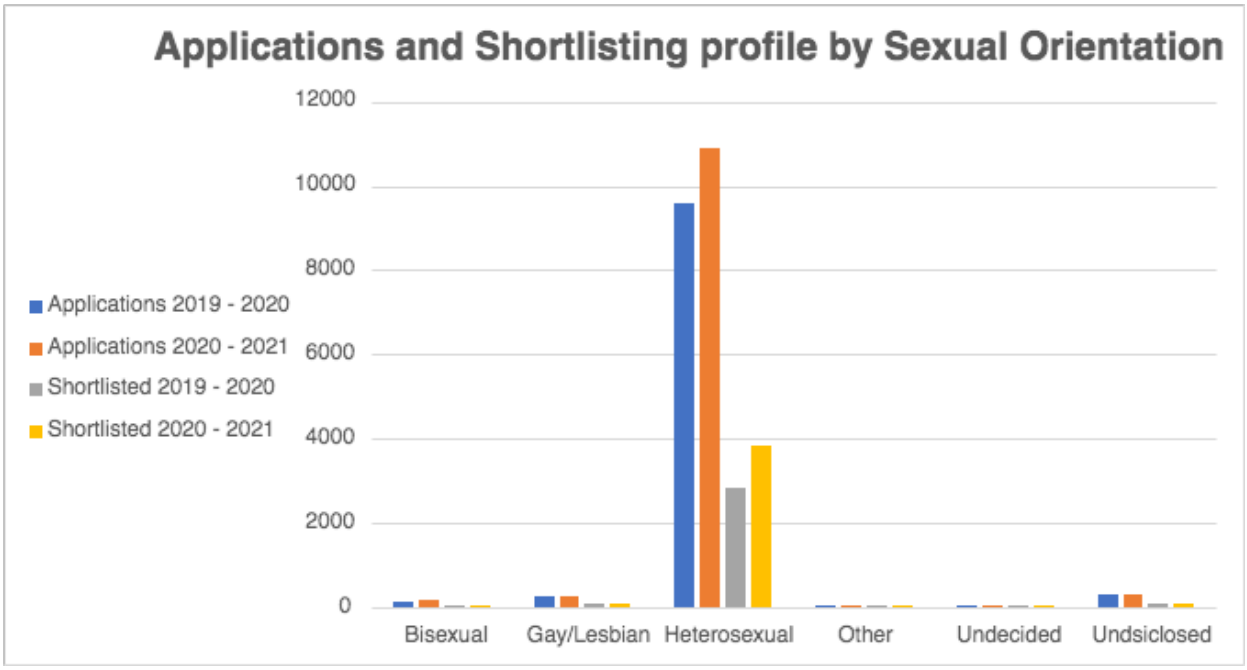


Diagram twenty five: Applications profile

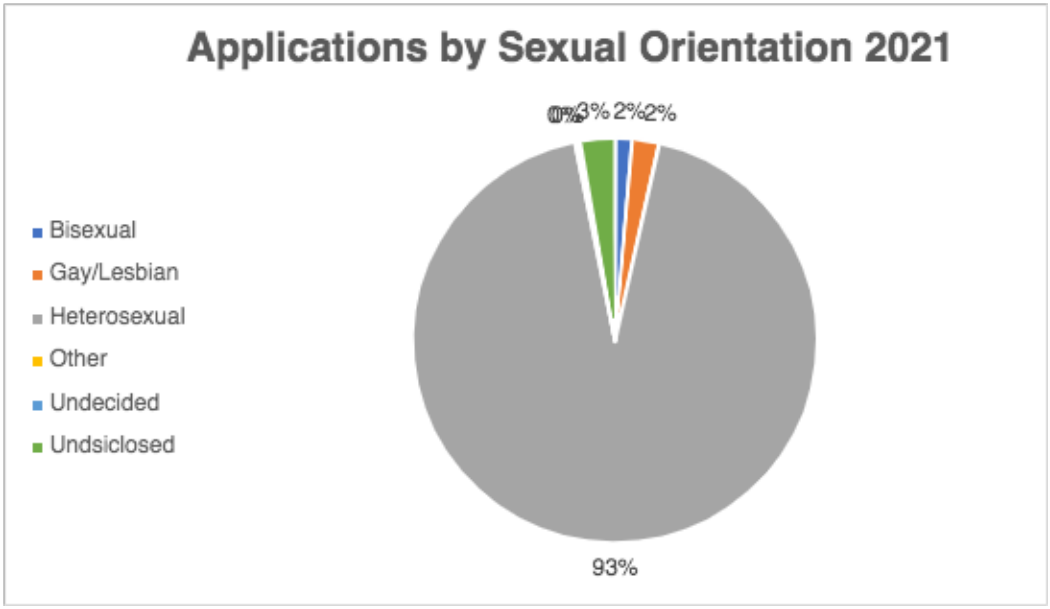
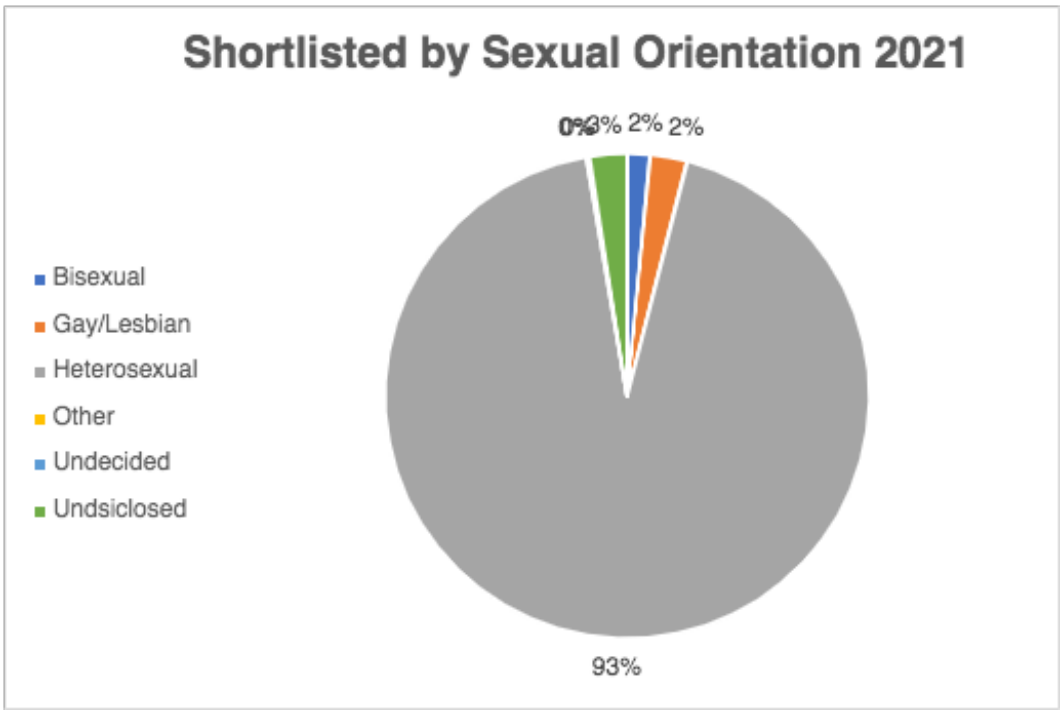


Diagram twenty six: Shortlisting profile



Analysis

Diagram twenty four illustrates the application and shortlisting data by sexual orientation for 2020 and 2021, which shows no significant difference between the years. Hetereosexual / Straight individuals still account for over 93% of those who have applied and are shortlisted for our positions.

When comparing data to the local population, there is no residential data available for Warrington and Halton but compared with the North West statistics it would indicate that we are representative of our region (heterosxual, 94.89% and Bisexual, Gay or Lesbian at 1.66%).

Encouraging disclosure is a key action for the organisation's Equality, Diversity and Inclusion strategy.

4.2. Promotion profile by Protected Characteristic

This section provides an overview of the profile of promotions within the organisation by protected characteristic and pay band. 79 promotions in total for 2020-2021 year. The recording period for this data is 1st December 2020 – 1st November 2021.

Diagram twenty seven: Promotion profile by age

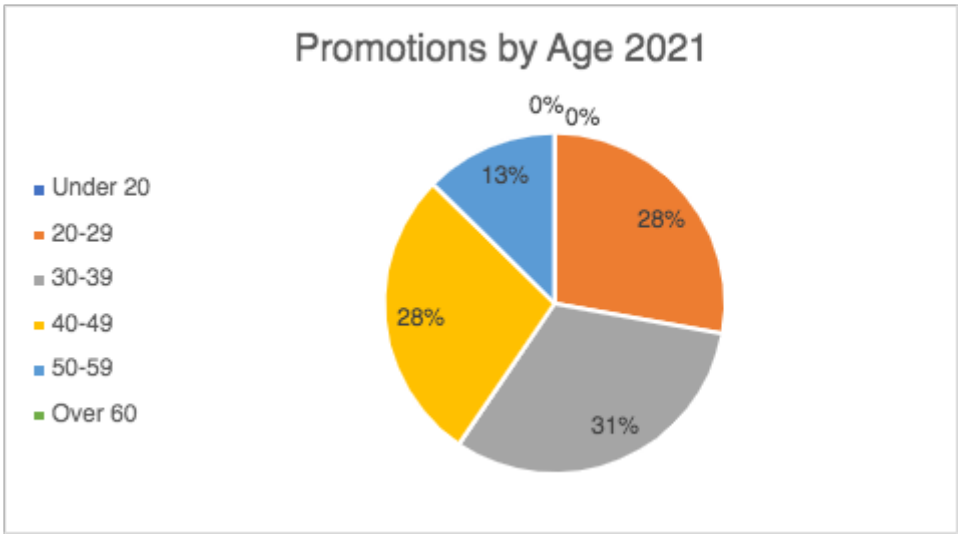


Diagram twenty eight: Promotion profile by sex

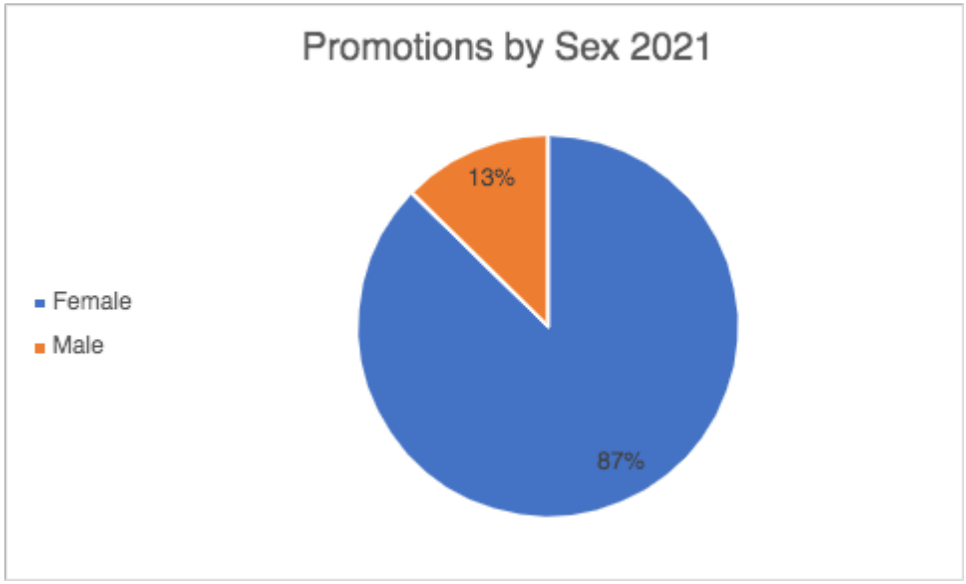


Diagram twenty nine: Promotion profile by ethnicity

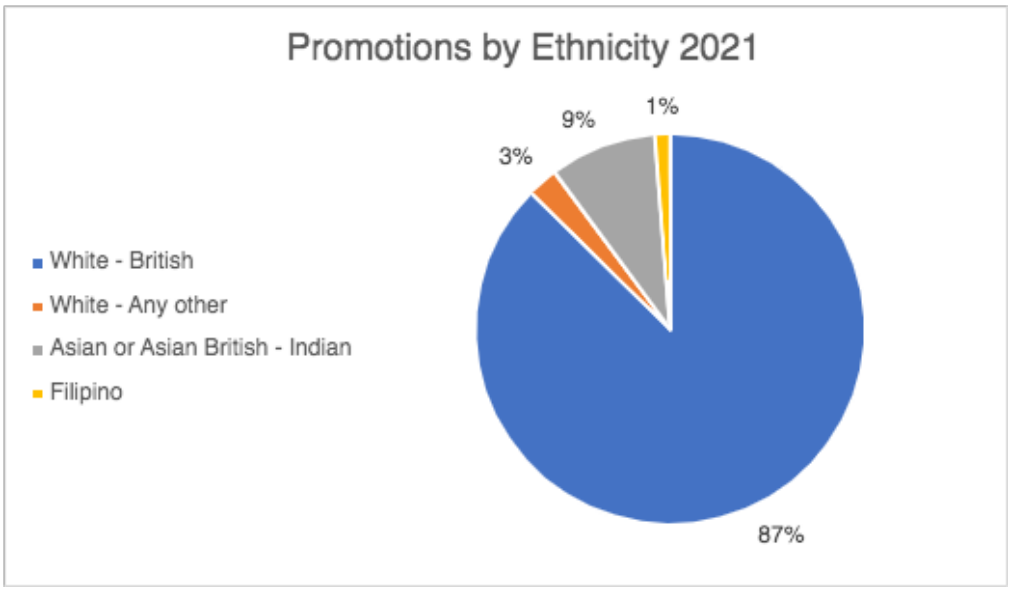


Diagram thirty: Promotion profile by religion or belief

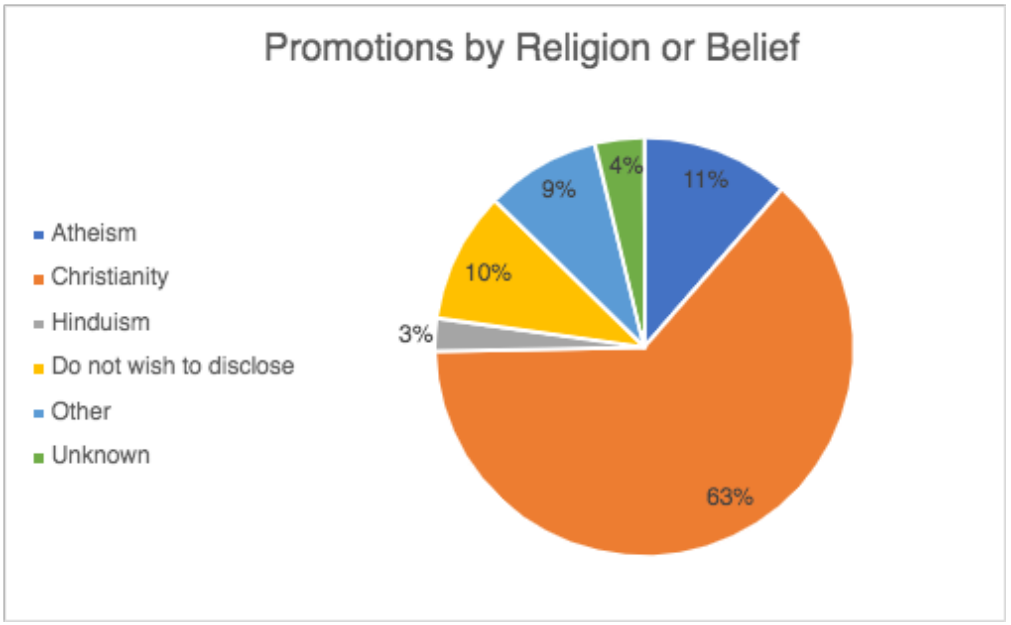


Diagram thirty one: Promotion profile by sexual orientation

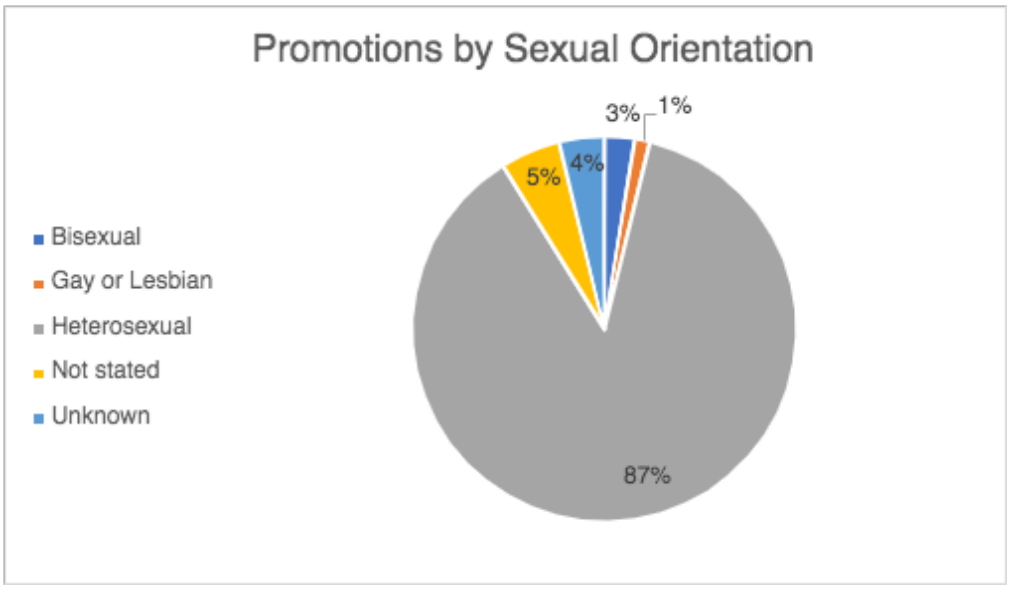
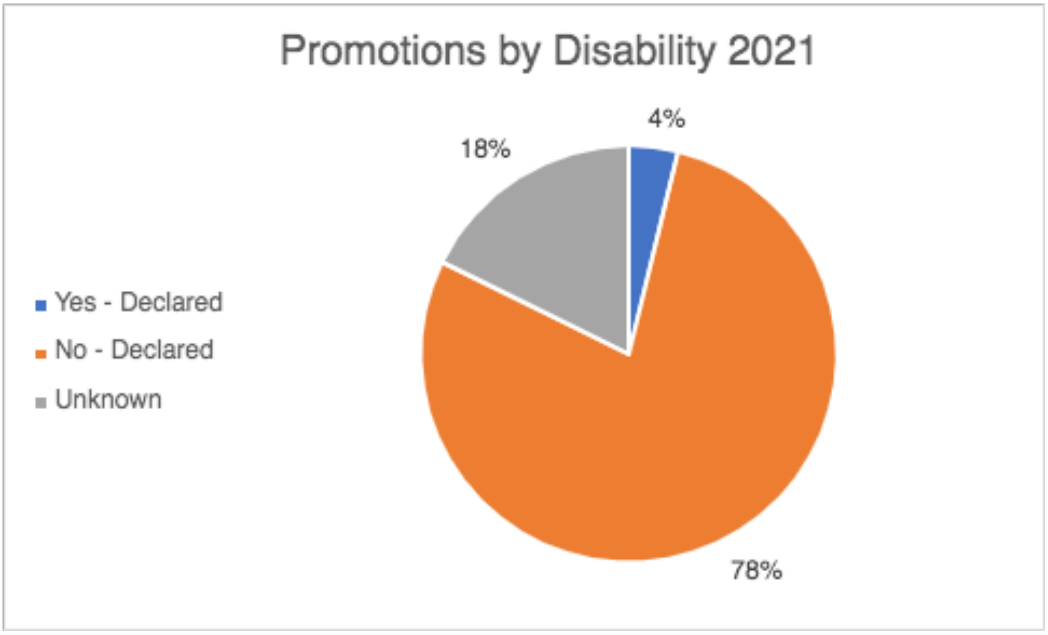


Diagram thirty two: Promotion profile by disability



Analysis

For 2020/21 there were 79 promotions in total across the organisation, with the highest percent of promotions being for female staff, those aged 30-39, White British, Christian, Heterosexual / Straight and those with no declared disability.

Diagrams twenty seven to **thirty two** indicate that promotions are largely reflective of the overall workforce profile. However, promotions by age band was the only characteristic not in line with the overall workforce with the majority of the workforce aged 50-59 (25%) but the majority of promotions (31%) were staff aged 30-39.

4.3 Starters and Leavers profile by Protected Characteristic

This section provides an overview of the starters and leavers in the reporting period of 1st December 2020 – 1st November 2021 and has been obtained by the Electronic Staff Record (ESR).

For this reporting the period, the organisation has welcomed 1061 new members of staff and 769 have left the organisation.

Diagram thirty three: New starter age profile

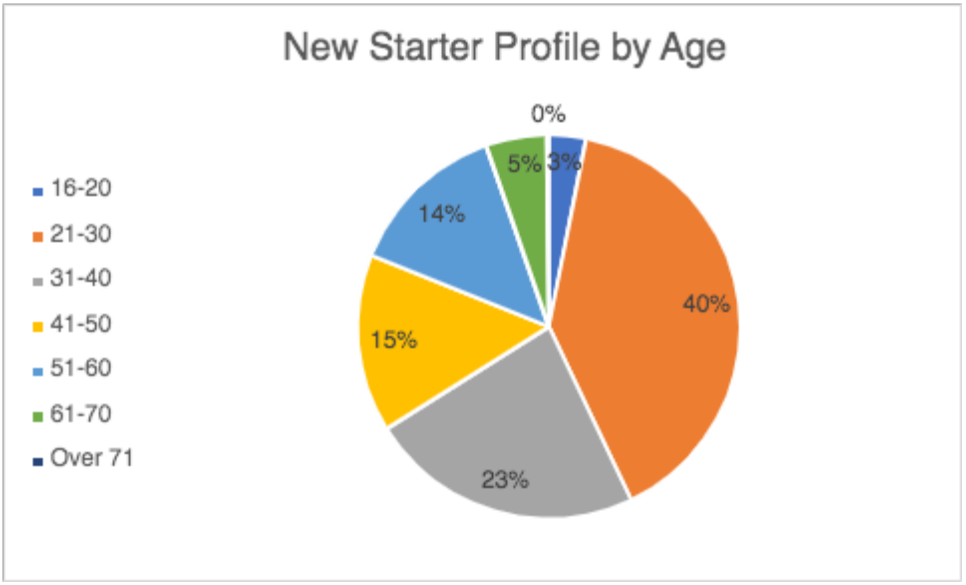
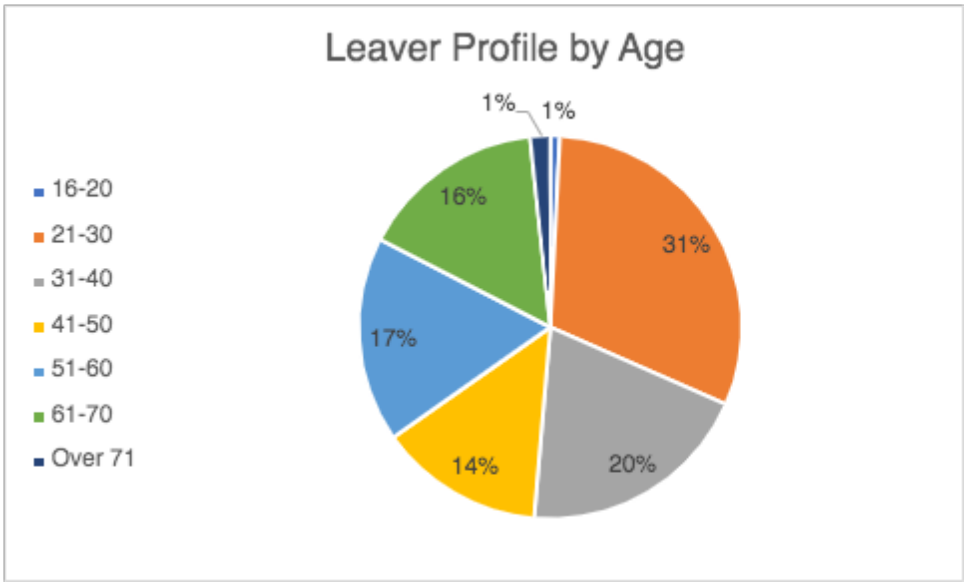


Diagram thirty four: Leaver age profile



Analysis

Based on **Diagrams thirty three** and **thirty four**, the majority of new starts fall within the age band of 21-30, which is also the highest percentage of leavers from the organisation.

Diagram thirty five: New starter sex profile

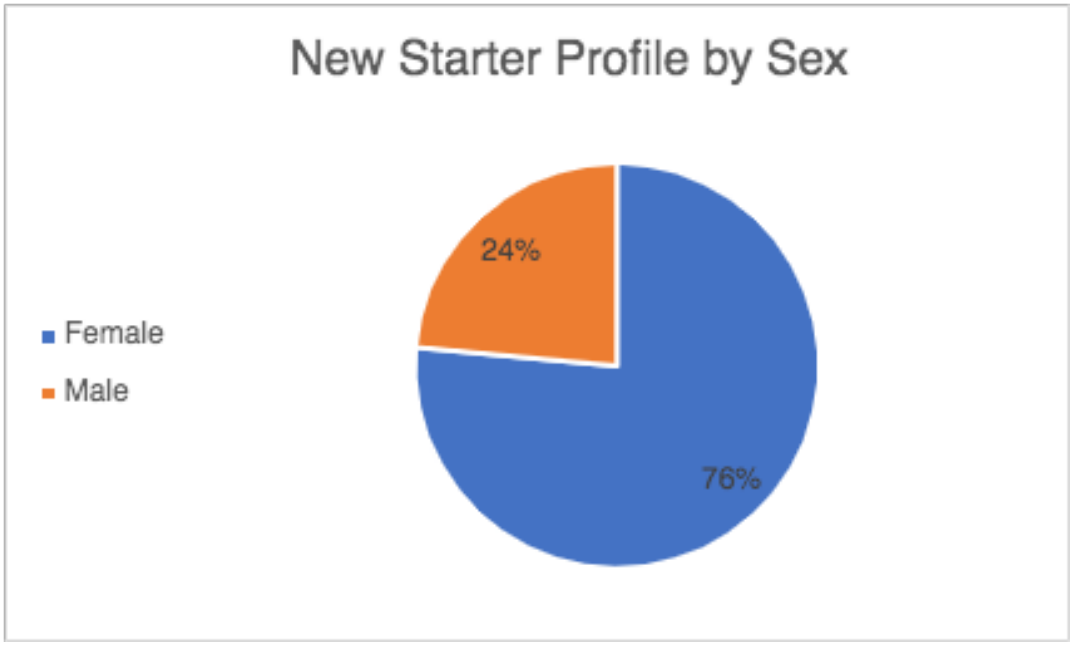
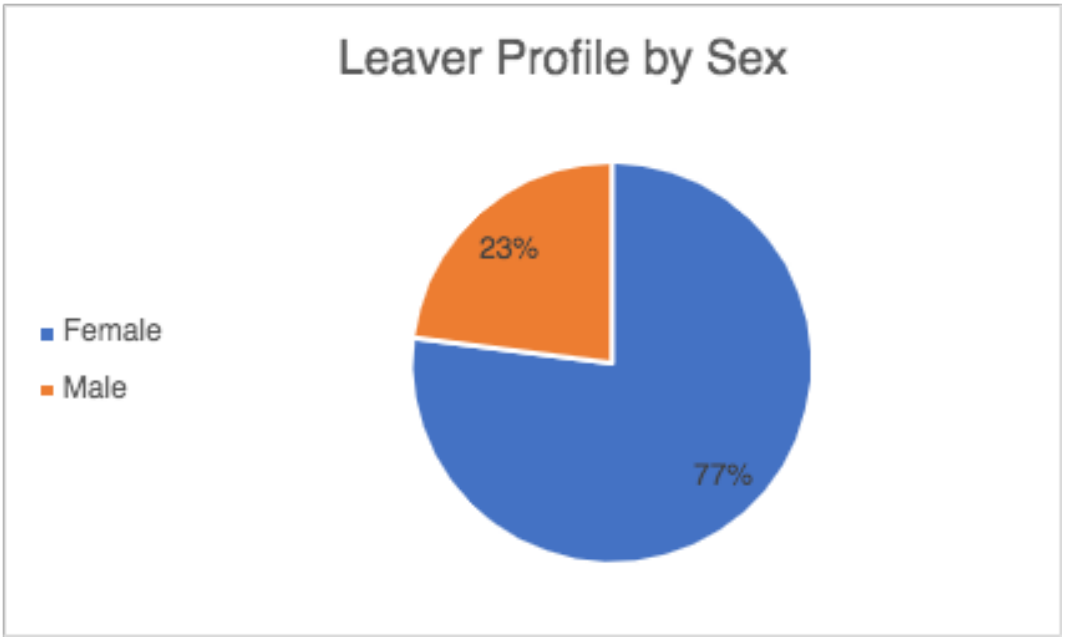


Diagram thirty six: Leaver sex profile



Analysis

On review of the starter and leaver profile on the basis of sex, this data reflects the overall workforce profile of the organisation as identified in **Section Three.**

Diagram thirty seven: New starter disability profile

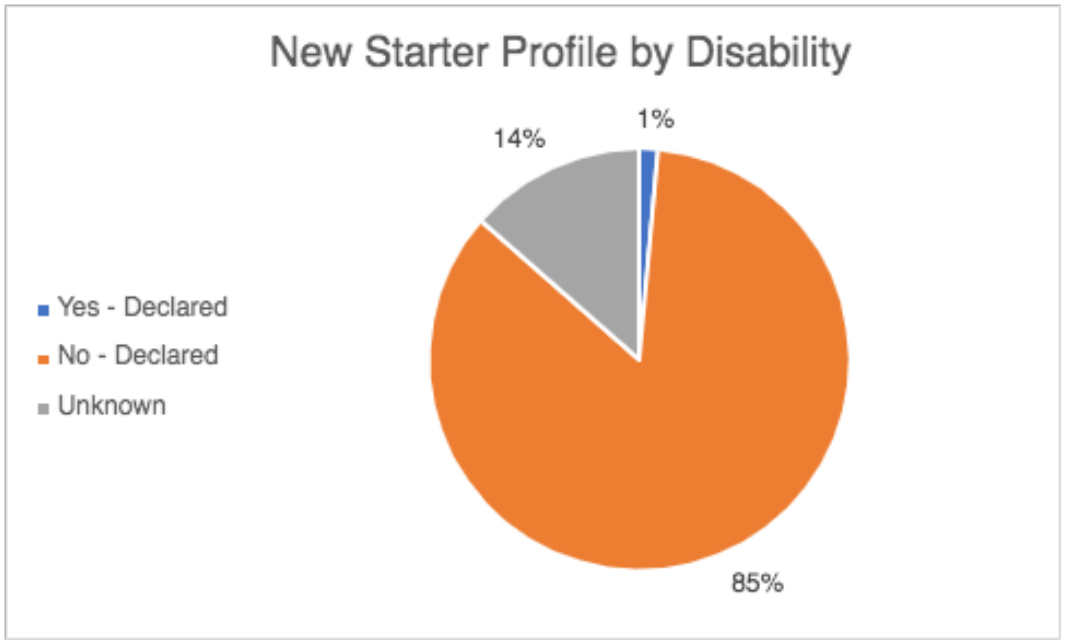
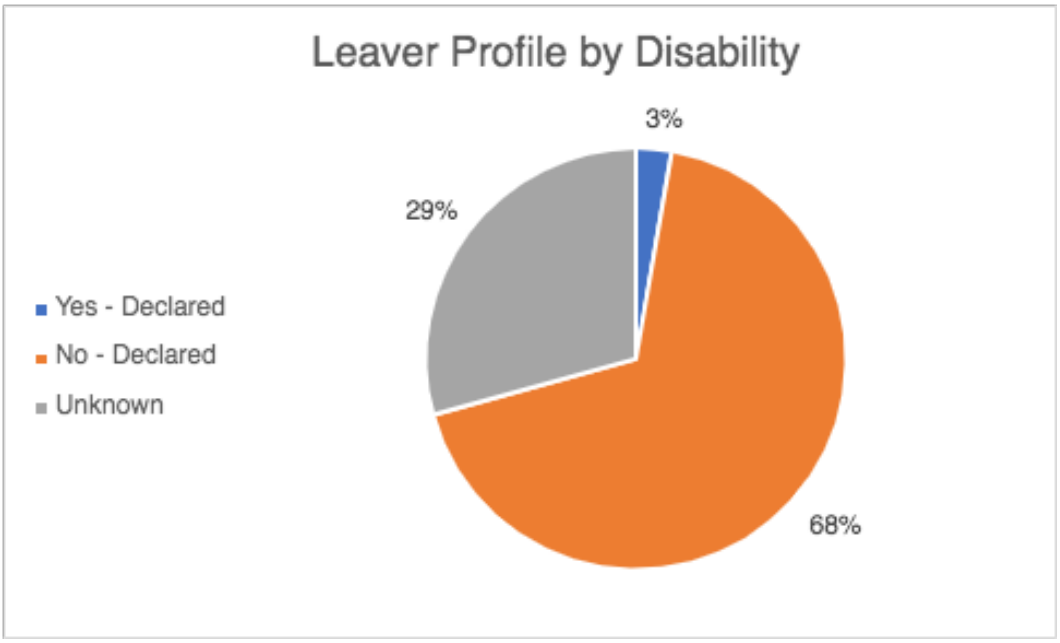


Diagram thirty eight: Leaver disability profile



Analysis

Diagrams thirty seven and **thirty eight** highlight that there is a significant number of individuals whose disability status is unknown which means that it is difficult to identify any meaningful analysis. However, the trends are similar to the overall workforce composition.

Diagram thirty nine: New starter sexual orientation profile

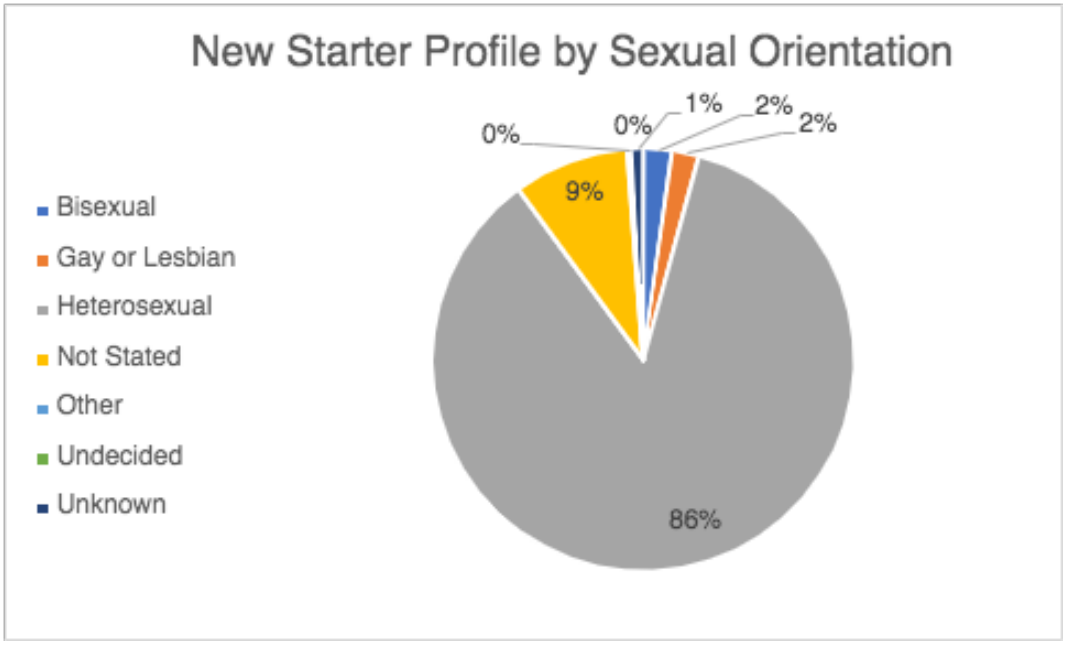
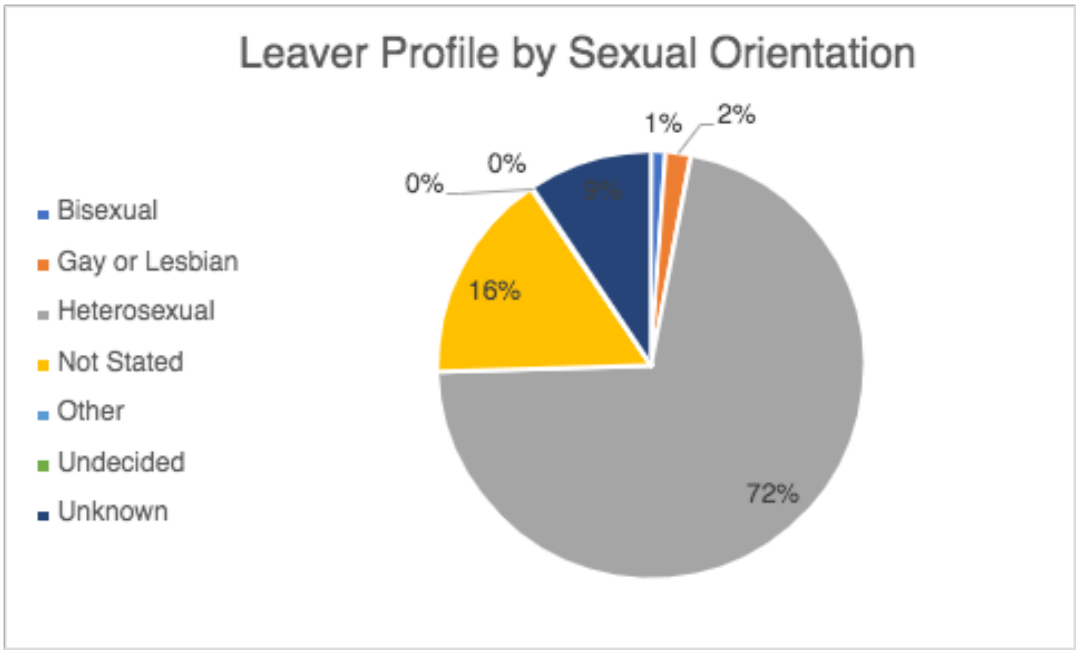


Diagram forty: Leaver sexual orientation profile



Analysis

On review of the above data relating to sexual orientation, it is evident that the data is similar to the overall composition of the workforce as outlined in **Section Three**.

Diagram forty one: New starter ethnicity profile

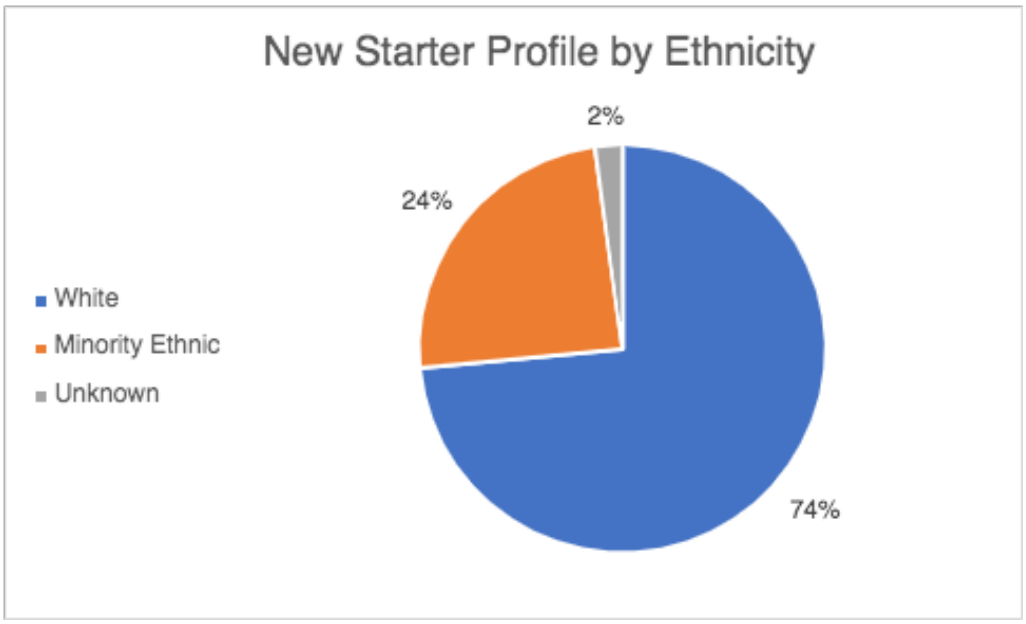
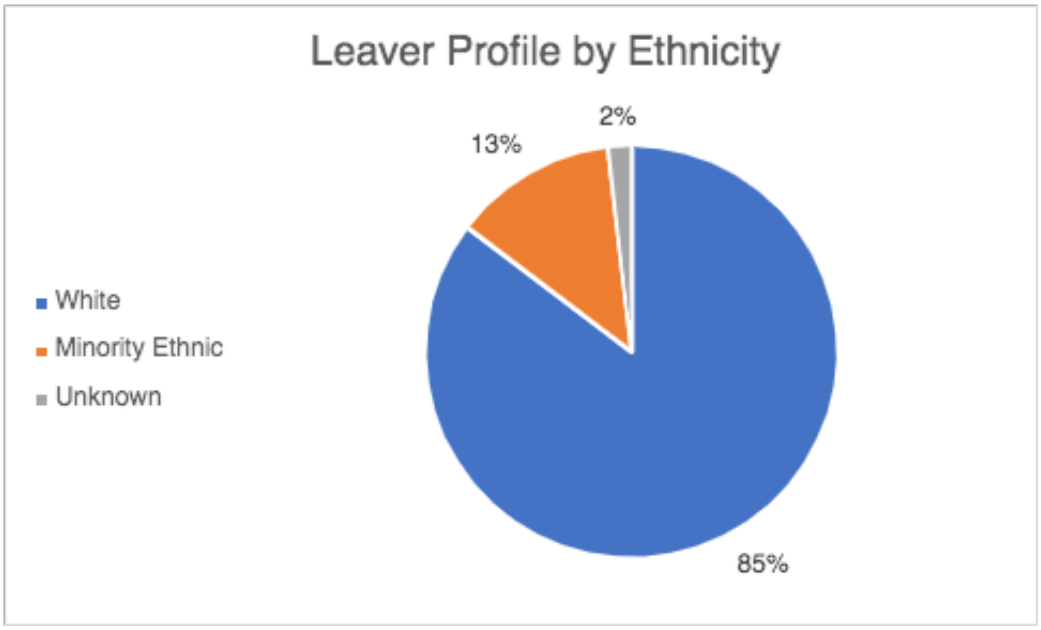


Diagram forty two: Leaver ethnicity profile



Analysis

Diagrams forty one and **forty two** illustrate similar trends to the overall workforce profile, however the impact of non-disclosure of ethnicity means a full picture cannot be ascertained.

Diagram forty three: New starter religion / belief profile

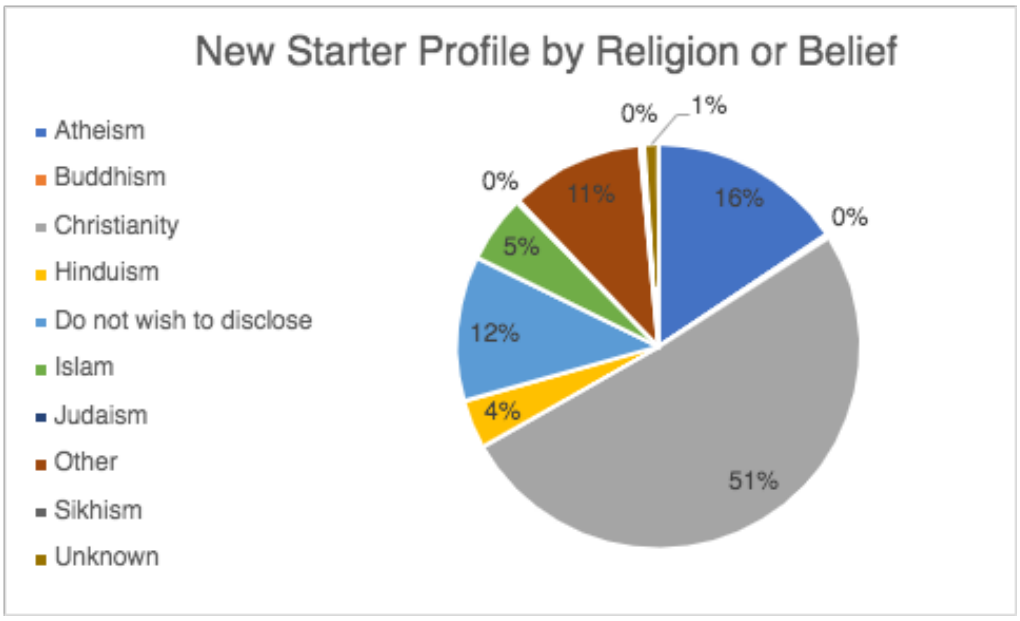
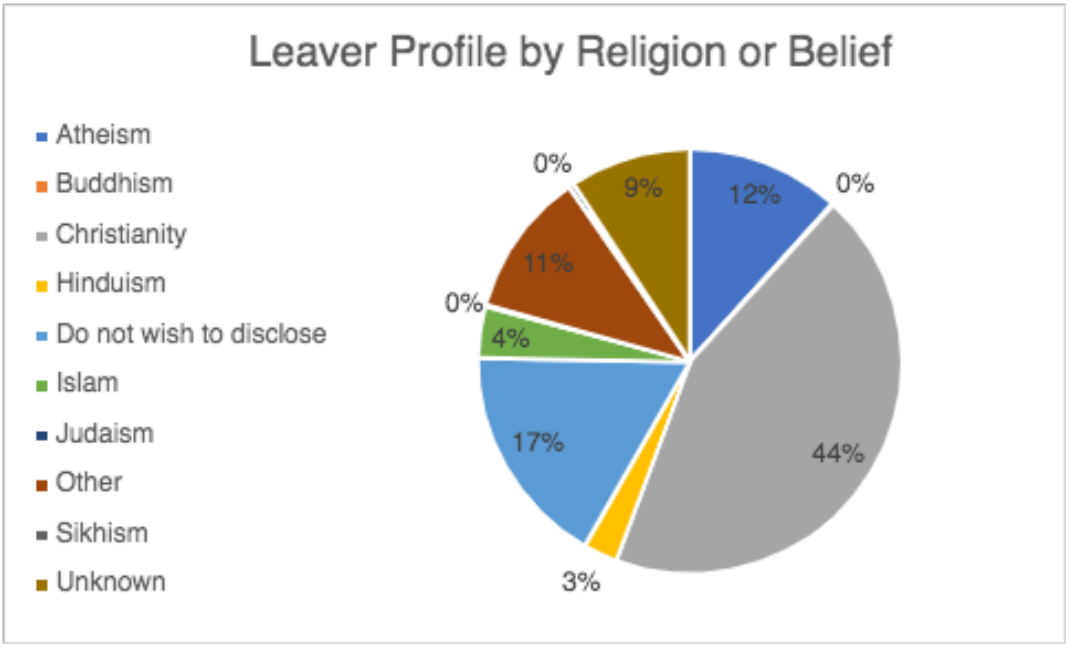


Diagram forty four: Leaver religion / belief profile



Analysis
The data above is aligned to the overall workforce composition but there is a high rate of non-disclosure which is a key action in the organisation's equality, diversity and inclusion strategy. It should be noted that although the Trust is small, the workforce profile is diverse in its religion and belief.

4.4 Recruiting an inclusive workforce

As an organisation we recognise the importance of attracting the right people to our organisation as well as a diverse group of individuals with a diverse range of skills, talents and abilities. A diverse workforce can better meet the needs of our diverse communities. Evidence shows that a diverse workforce enables our staff to be afforded greater workplace opportunities and has a direct impact on increased job satisfaction.

The organisation remains committed to NHS England's Model Employer ambitions of increasing the diversity of leadership within the NHS and have a range of actions that are monitored within the organisation's Equality, Diversity and Inclusion governance procedures. Warrington and Halton Teaching Hospitals NHS Foundation Trust are committed to attracting the right people to enable us to deliver outstanding, inclusive care to our local communities.

The Trust has implemented an inclusive recruitment project which has had far-reaching impacts upon the diversity of our workforce. Aligning to our Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) action plans, along with our organisational values,

the project has reviewed the current recruitment practices, and using EDI metrics and stakeholder engagement, has proposed measures to improve inclusive recruitment practices.

Section 5 – Workforce Equality Standards

5.1 Workforce Race Equality Standard (WRES) 2021

The Workforce Race Equality Standard (WRES) is a requirement to implement for the Trust and is detailed in the NHS standard contract. The annual WRES data set against nine specific metrics enables the organisation the opportunity to develop an action plan to address each of the metrics to continue to push to improve the experiences of our Black, Asian and Minority Ethnic staff within our workforce.

The comprehensive action plan in response to the WRES data for the organisation is available on the external website under the equality, diversity and inclusion pages.

5.2 Workforce Disability Equality Standard (WDES) 2021

The Workforce Disability Equality Standard (WDES) is a requirement to implement for the Trust and is detailed in the NHS standard contract. The annual WDES data set against ten specific metrics enables the organisation the opportunity to develop an action plan to address each of the metrics to continue to push to improve the experiences of our disabled staff within our workforce.

The comprehensive action plan in response to the WDES data for the organisation is available on the external website under the equality, diversity and inclusion pages.

Section 6 – Conclusions

This report has provided significant data in relation to the current workforce profile of Warrington and Halton Teaching Hospitals NHS Foundation Trust and compared this to the previous year, where applicable. The data has been broken down by Protected Characteristic where available in order to ascertain whether there are any concerns or trends that may highlight disparities between groups of staff.

After reviewing the available information, there have been no indications that there is vast disparities between groups of staff according to Protected Characteristic which has not currently been identified and actioned within our equality, diversity and inclusion workplan, including those identified within the WRES and WDES processes.