Warrington and Halton Teaching Hospitals
NHS Foundation Trust

WHH Board of Directors Meeting Part 1

Wednesday 2nd August 2023
10.00am-12.30pm
Trust Conference Room WHH/Via MS Teams

Supplementary Pack

BM/23/08/94 – Annual Complaints Report
BM/23/08/95 - Safeguarding Annual Report
BM/23/08/96 - Infection Prevention and Control Board Assurance Framework Compliance – Bi-annual report
BM/23/08/97 - DIPC Infection Control Annual Report
BM/23/08/98 - Annual Health & Safety Report
BM/23/08/99 - Risk Management Strategy Annual Report
BM/23/08/100- Digital Strategy Group Update Report
BM/23/08/101 - Emergency Preparedness Annual Report
BM/23/08/102 - Learning from Deaths Q4
BM/23/08/103 - In-Patient Survey & Action Plan
BM/23/08/104 – Perinatal Mortality Annual Report
BM/23/08/105 - Patient Experience bi-Annual Report
BM/23/08/106 - Guardian of Safe Working – Annual Report

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/23/08/94 - BM/23/08/106**	
SUBJECT:	**Supplementary Papers**	
DATE OF MEETING:	2nd August 2023	
AUTHOR(S):	John Culshaw, Trust Secretary	
EXECUTIVE DIRECTOR SPONSOR:	Simon Constable, Chief Executive	
LINK TO STRATEGIC OBJECTIVE:	SO1 We will.. Always put our patients first delivering safe and effective care and an excellent patient experience.	✓
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF):	All	
EXECUTIVE SUMMARY *(KEY ISSUES):*	In following best NHS corporate governance practice, and to support WHHs commitment to openness and transparency, the papers listed below are provided as supplementary papers for the Trust Board meeting 2nd August 2023. No actions are required from the Trust Board – they are provided for information only. The papers provided are: • **BM/23/08/94 – Annual Complaints Report** presented at Quality Assurance Committee 13.06.2023 • **BM/23/08/95 - Safeguarding Annual Report** presented at Quality Assurance Committee 11.07.2023 • **BM/23/08/96 - Infection Prevention and Control Board Assurance Framework Compliance – Bi-annual report** presented at Quality Assurance Committee 11.07.2023 • **BM/23/08/97 - DIPC Infection Control Annual Report** presented at Quality Assurance Committee 11.07.2023 • **BM/23/08/98 - Annual Health & Safety Report** presented at Quality Assurance Committee 11.07.2023	

	• **BM/23/08/99 - Risk Management Strategy Annual Report** presented at Quality Assurance Committee 11.07.2023 • **BM/23/08/100- Digital Strategy Group Update Report** presented at Finance & Sustainability Committee 28.06.2023 • **BM/23/08/101 - Emergency Preparedness Annual Report** presented at Finance & Sustainability Committee 26.07.2023 • **BM/23/08/102 - Learning from Deaths Q4** presented at Quality Assurance Committee 11.07.2023 • **BM/23/08/103 - In-Patient Survey & Action Plan** presented at Quality Assurance Committee 13.06.2023 • **BM/23/08/104 – Perinatal Mortality Annual Report** presented at Quality Assurance Committee 11.04.2023 • **BM/23/08/105 - Patient Experience bi-Annual Report** presented at Quality Assurance Committee 11.04.2023 • **BM/23/08/106 - Guardian of Safe Working – Annual Report** presented at Strategic People Committee 19.07.2023			
PURPOSE: ***(please select as appropriate)***	Information	Approval	To note ✓	Decision
RECOMMENDATION:	The Trust Board is asked to note the supplementary papers provided for information.			
PREVIOUSLY CONSIDERED BY:	**Committee**	Multiple Committees, as listed above		
	Agenda Ref.	As listed above		
	Date of meeting	See above		
	Summary of Outcome	Noted		
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None			

QUALITY ASSURANCE COMMITTE

AGENDA REFERENCE:	**QAC/23/06/129**
SUBJECT:	**Complaints Annual Report 2022/23**
DATE OF MEETING:	13th June 2023
AUTHOR(S):	Layla Alani, Director Governance, Deputy Chief Nurse Nicola Edmondson, Associate Director of Governance
EXECUTIVE DIRECTOR SPONSOR:	Kimberley Salmon-Jamieson, Chief Nurse & Deputy Chief Executive
LINK TO STRATEGIC OBJECTIVE:	SO1: We will... Always put our patients first through high quality, safe care and an excellent patient experience.
EXECUTIVE SUMMARY	This annual report includes a summary of formal complaints raised by patients or their relatives between 1 April 2022 and 31 March 2023. • 285 new complaints were received during the reporting period, a decrease of 4 (289). • 2011 PALS enquiries were received (4% decrease from 2021/22 when PALS received a total of 2091 enquiries). • Overall, in 2022/2023 the Trust has maintained a position of a higher number of PALS rather than complaints evidencing active management of concerns with resolve. • Urgent and Emergency Care received the highest number of complaints followed by the Women's and Childrens Business Unit. This is not uncommon as these are areas of high clinical risk, with high activity and acuity. Urgent and Emergency Care reported an increase from 95 complaints reported in 2021/22 to 97 in 2022/23 (2%). • During the reporting period the Women's and Childrens Clinical Business Unit reported: - Increase from 31 complaints to 55 (77%) - Highest number in Maternity 27 (49%) - Gynaecology 20 (37%) - Increase in the number of PALS received, from 214 to 257 (20%). 147 relate to gynaecology and 69 (31%) relate to maternity (28%). A deep dive is being undertaken by the Clinical Business Unit for both PALS and complaints. At the time of writing the report within the Clinical Business Unit 13 complaints have not been upheld, 28 partially upheld and 6 upheld. • The Trust closed 261 complaints. • The percentage of upheld complaints (9%) reduced from 26% in 2021/22 • The majority of complaints were partially upheld (49%). A static position compared to the previous reporting period.

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

- The percentage of complaints not upheld improved from 26% to 42%.
- Following triage, 18 complaints were considered to be Serious Incidents (8 – static position) or Concise Investigations (10 - increase of 4).
- 42 complaints are open at the time of reporting (30 May 2023), with no breached timeframes throughout the reporting period.
- The Trust received 5 PHSO notifications during 2022/2023, 2 of which remain under investigation. The PHSO have concluded four investigations within the reporting period. 2 were not upheld and 2 were partially upheld.

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<tr><td>PURPOSE: (please select as appropriate)</td><td>Information</td><td>Approval</td><td>To note
X</td><td>Decision</td></tr>
<tr><td>RECOMMENDATIONS:</td><td colspan="4">The Quality Assurance Committee is asked to note the report.</td></tr>
<tr><td>PREVIOUSLY CONSIDERED BY:</td><td colspan="2">Committee</td><td colspan="2">Choose an item.</td></tr>
<tr><td rowspan="3"></td><td colspan="2">Agenda Ref.</td><td colspan="2"></td></tr>
<tr><td colspan="2">Date of meeting</td><td colspan="2"></td></tr>
<tr><td colspan="2">Summary of Outcome</td><td colspan="2"></td></tr>
<tr><td>NEXT STEPS:
State whether this report needs to be referred to at another meeting or requires additional monitoring</td><td colspan="4">Submit to Trust Board</td></tr>
<tr><td>FREEDOM OF INFORMATION STATUS (FOIA):</td><td colspan="4">Release in Full</td></tr>
<tr><td>FOIA EXEMPTIONS APPLIED:
(If relevant)</td><td colspan="4">Section 22 - Information intended for future publication</td></tr>
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Quality Assurance Committee

SUBJECT	Complaints Annual Report	AGENDA REF:	QAC/23/06/129

1. BACKGROUND

Warrington and Halton Teaching Hospitals NHS Foundation Trust is committed to providing high standards of patient centred care utilising the views and opinions of patients and their families.

The purpose of the annual complaints report is to satisfy the requirements of the NHS complaints procedure in England, effective from 1 April 2009. The report provides analysis of formal complaints identifying themes and trends to support further learning.

The Trust recognises that there are times when its actions do not meet the expectations of those that use our services. When that happens, the Trust has a policy which sets out a procedure to ensure that we listen and respond to complaints and concerns from patients, their relatives and carers.

The Trust understands that by listening to people about their experience of our services, staff can learn new ways to improve, and prevent the same issues from happening in the future. By seeking, monitoring and acting upon feedback, we are able to make improvements in areas that patients, their relatives and carers say matter most to them.

Effective complaints handling is a cornerstone of patient experience and the Trust aims at all times to provide local resolutions to complaints taking all complaints seriously. By listening and responding to complaints we aim to remedy the situation as quickly as possible and ensure that the individual is satisfied with the response they receive. The learning from complaints is used to improve services for the people who use them as well as for the staff working in them.

In accordance with the NHS complaints procedure, the annual complaints report is made available to the public. It is publishable as part of the Freedom of Information Act publication.

1.1 Principle of Application

- Complaints and concerns will be dealt with in a fair, flexible and conciliatory manner, encouraging open communication between all parties.
- High standards of conduct are expected from all staff at all times to ensure that service users/representatives will be treated respectfully, courteously and sympathetically.
- The requirement to maintain confidentiality during the complaints process will be absolute (unless indicated otherwise).
- All patients and their families will be advised how they can raise a concern or make a formal complaint via information leaflets available on all wards and clinical service units and the internet.
- All people who make complaints will be advised of the various independent support agencies that are available to assist them in making their complaint.
- As far as possible, people who make complaints will be involved in decisions about how their complaints are handled and considered.
- The Trust will aim to resolve complaints within the Trust as part of local resolution (first stage of the national complaints procedure) wherever possible.
- Complainants receive a meaningful apology when appropriate.
- The Trust will identify appropriate learning and implement change as the result of a complaint where appropriate.
- The Trust will co-operate with other organisations when a complaint involves other outside organisations.
- No person who makes a complaint will be discriminated against on the grounds of religion, gender, race / ethnicity, disability, age or sexual orientation or because they have made a complaint.

1.2 NHS Complaints Standards 2022

In December 2022, the NHS Complaint Standards set out how organisations providing NHS services should approach complaint handling. The standards apply to NHS organisations in England and independent healthcare providers that deliver NHS-funded care. The Complaint Standards support organisations to provide a quicker, simpler and more streamlined complaint handling service. They have a strong focus on:

- Early resolution by empowered and training.
- All staff, particularly senior staff, regularly reviewing what learning can be taken from complaints.
- How all staff, particularly senior staff, should use this learning to improve services.

The focus referenced within these standards will continue to be progressed in 2023/2024. As part of the complaints work plan an ‘Access Line’ for use predominantly out of hours will

be piloted and implemented to further support early resolution, improve patient experience and reduce clinical risk.

1.3 Complaints Monitoring

The complaints team report learning into the Patient Experience Sub-Committee each month. Learning is also shared in the quarterly Learning from Experience report presented at the following committees:

- Patient Safety and Clinical Effectiveness Sub Committee.
- Quality Assurance Committee.
- Clinical Quality Focus Group (PLACE).
- Complaints Quality Assurance Group, led by the Trust Chairman.
- Council of Governors also receive updates on complaints.

The Complaints Quality Assurance Group, led by the Trust Chairman meets monthly. Assurances are provided with detailed learning on a cyclical basis from Clinical Business Units with full discussion regarding specific complaints. The Head of Complaints, Claims and PALS also presents a Trustwide overview for assurance detailing the number of complaints received, the location of complaints and any themes and trends identified.

2. KEY ELEMENTS

During the last financial year work has focused on:

- Maintaining the timeliness of responses to complainants.
- Working collaboratively with CBUs to improve standards of care and the production of high quality complaints responses.
- To ensure a timely response to PALS concerns.
- All complainants to be offered a meeting with appropriate teams as a first offer.
- Improving the sharing of learning from complaints and compliance of actions arising through the quarterly audits provided to the Quality Assurance Committee. Complaints handlers continue to meet with the CBU senior management teams weekly with dissemination of actions to the CBU teams.
- Triangulation of the themes of complaints and PALS concerns alongside incidents and claims to provide greater focus for improvement.

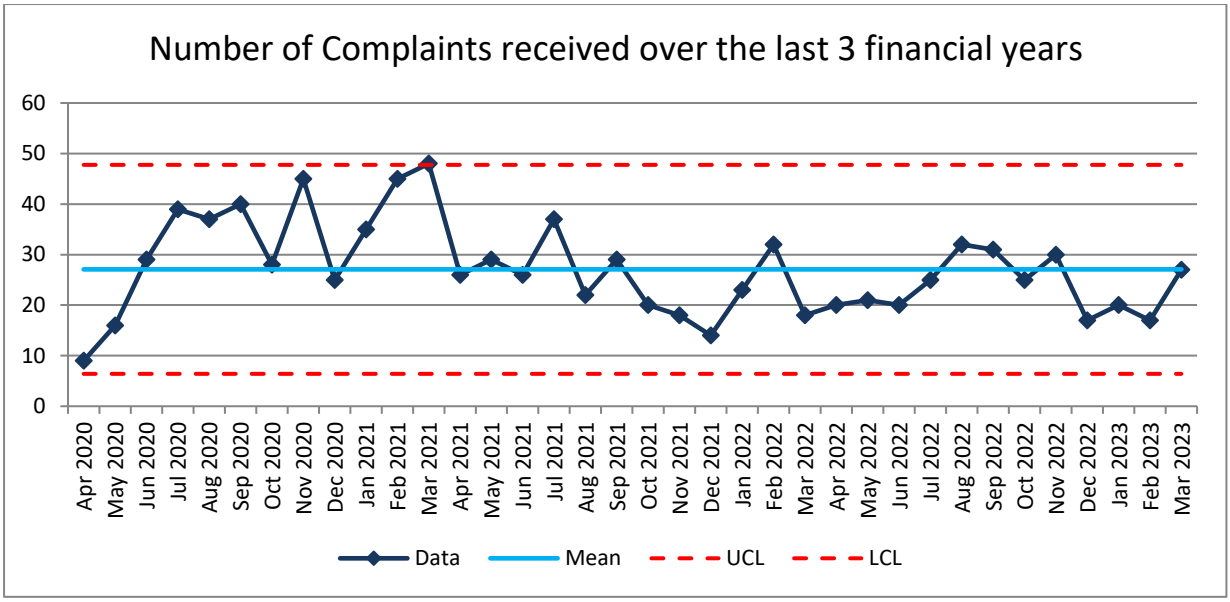
The successes in 2022/23 have included:

- Timeliness of complaints has consistently exceeded the Trust's target of 90%.
- WHH has continued to have 0 breached complaints throughout the reporting period.
- The PALS service continued to provide timely responses to concerns, with the average response time being 3 working days, which is line with the Trust's response target of 3 days.
- Working collaboratively with the Trust's Patient Experience and Inclusion Team to identify what matters most to our patients and considering how the PALS and Complaints Team can continually improve services for our patients and their loved ones.
- The Trust Quality Assurance Group has continued to meet since being established in July 2017. Led by the Trust Chairman, the Complaints Quality Assurance Group ensures all Clinical Business Unit (CBU) leads present a complaint and discuss their processes for complaints handling and learning.
- The number of reopened complaints received reduced from 42 in 2020/21 to 24 in 2021/22. In 2022/23 this reduction has remained static (24).

We are invested in our patients' lives

2.1 Complaints received

285 complaints were received during the reporting period, a decrease of 4 from the previous year (289). The graph below details the number of complaints opened from 1 April 2022 to 31 March 2023. In 2022/2023 the Trust received an average of 24 complaints per month. This was the same as the average for 2021/22. In August 2022, the Trust received the highest number of complaints for the 2022/23 financial year (32). The number of complaints received remains within normal variation. NB: the Trust has worked hard to ensure that concerns are resolved at local level, via PALS enabling a proactive response to resolution. All complainants are offered a meeting in person with the clinical teams to ensure that the opportunity for full discussion is made available to all.



2.2 Complaint themes

Formal complaints can be received for a variety of reasons. The table below identifies the themes noted for the reporting period with 2021/22 data displayed for comparison.

Theme	2022/2023	2021/2022	Change
Clinical treatment	190	137	53
Attitude and behaviour	30	56	-26
Communication (oral)	23	38	-15
Admissions / transfers / discharge procedure	13	34	-21
Date for appointment	7	10	-3
Communication (written)	4	2	2
Personal records	4	4	0
Bed shortages	2	0	2
Patient privacy / dignity	2	2	0
Patient property / expenses	2	1	1
Premises	2	0	2
Cleanliness / laundry	1	1	0
Competence	1	0	1
Date of admission / attendance	1	1	0
Failure to follow agreed procedures	1	0	1
Outpatient and other clinics	1	0	1
Shortage / availability	1	1	0
Patient status	0	1	-1
Policy & commercial decisions of NHS board	0	1	-1
Test results	0	2	-2

The most common cause for people to complain was associated with clinical treatment or care provided. When comparing the percentage of complaints relating to clinical treatment from 2021/22 to 2022/23, there has been a 39% increase in the percentage of complaints received relating to this theme. This is reflective of challenges experienced with the continued high number of patient attends, high patient acuity and waiting times, partially contributed to by the number of patients considered to have no criteria to reside.

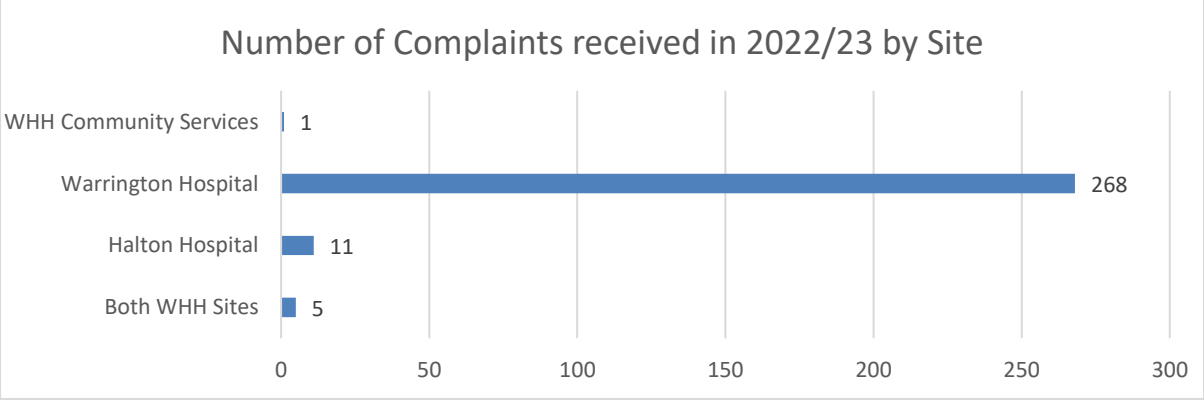
In 2022/23, the percentage of complaints relating to attitude and behaviour as the primary theme has reduced significantly by 46% (56 in 21/222 vs 30 in 22/23), and the percentage of complaints relating to communication (oral) as the primary theme has reduced by 39% (38 in 21/22 vs 23 in 22/23). Some examples of improvement impacted by learning are outlined in section 2.7.

The Complaints and PALS team work closely with the Patient Experience and Inclusion Team. Further improvements will be supported by the revised Patient Experience Strategy 2023 – 2025 which will work to ensure that we place the quality of patient experience at the heart of all we do where "seeing the person in the patient" is our norm by ensuring positive first and lasting impressions. This strategy will build on achievements and focus on four strategic objectives:

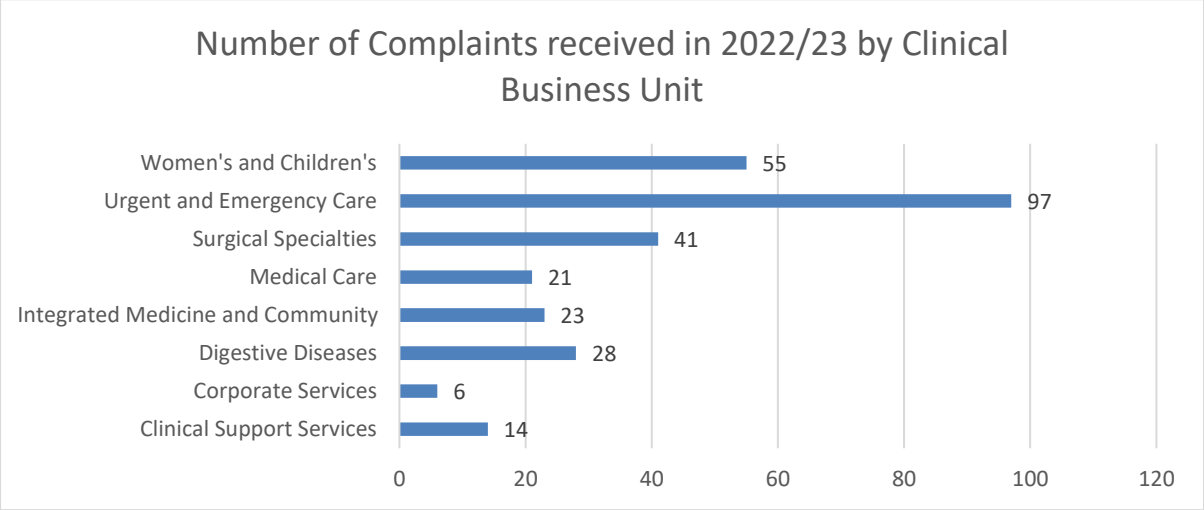
- Communication.
- Actively listen and learn from lived experience.
- Communicating in a way that people understand.
- Utilising a shared care approach to learning.

2.3 Complaints received by Locations/Service

The graph below details that the Warrington hospital site reported more complaints (268) than the Halton site (11). This is to be expected as it is the larger site with significantly more activity and acute care delivery also housing an Emergency Department

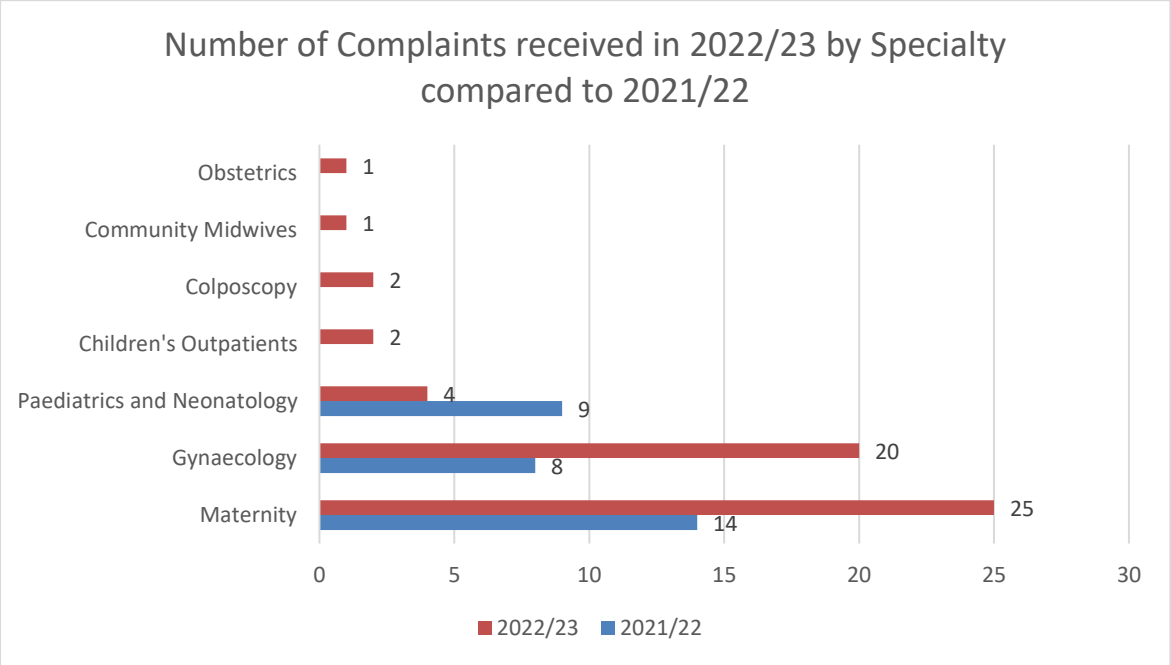


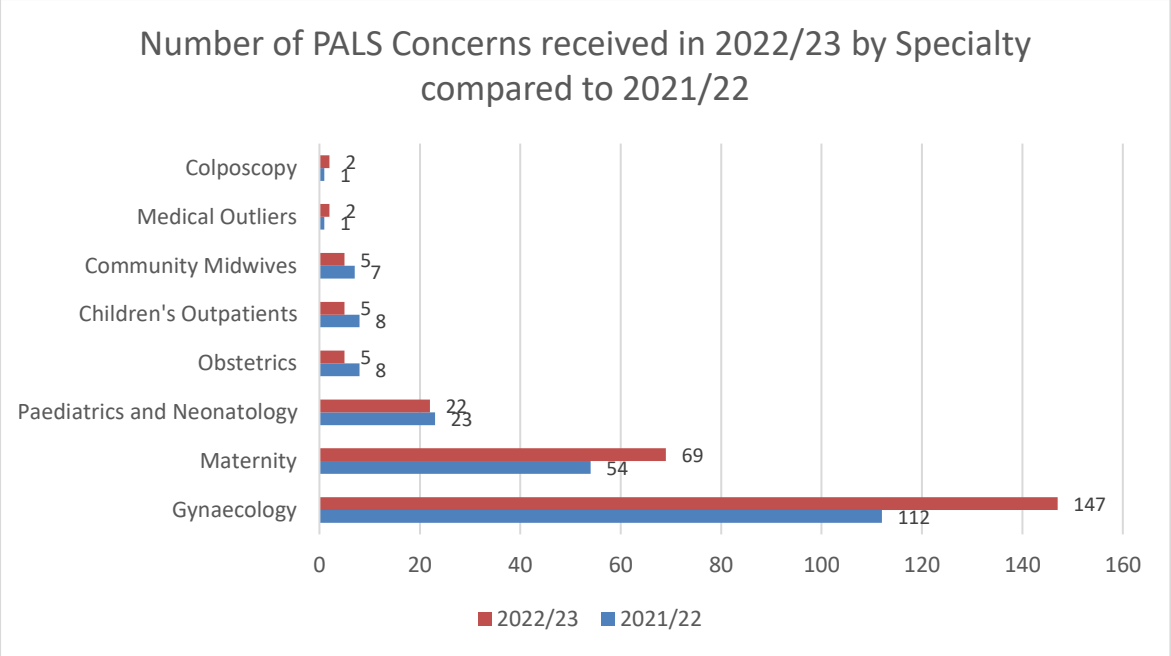
The following graph details the 285 complaints received by the Trust in the reporting period by Clinical Business Unit (CBU) and Trust wide service:



Urgent and Emergency Care received the highest number of complaints followed by the Women's and Childrens Clinical Business Unit. When comparing 2021/22 data to complaints received from 2022/23 for Urgent and Emergency Care, there was an increase from 95 complaints reported in 2021/22 to 97 in 2022/23 (2%).

When comparing 2021/22 data to complaints received from 2022/23 for Women's and Childrens, there was an increase from 31 complaints reported in 2021/22 to 55 in 2022/23 (77%). In 2022/23 the highest number of complaints were received in Maternity (27) (49%) and Gynaecology (20) (37%).





During the reporting period there was an increase from 214 PALS reported in 2021/22 to 257 in 2022/23 (20%), within the Women's and Children's Clinical Business Unit. In 2022/23 the highest number of PALS were received in Gynaecology (147) (31%) and Maternity (69) (28%).

On 17th May 2023 the acting head of midwifery reviewed all open complaints and PALs from March 2023 to 13 May 2023. There were no new themes or trends identified. The majority of the PALS concerns relate to gynaecology referencing delays in appointments and clinical pathways. A gynaecology recovery plan is in place and will be monitored via the Patient Safety and Clinical Effectiveness Sub Committee. For completeness, the Clinical Business Unit are undertaking a deep dive on all complaints and PALS received during the reporting period.

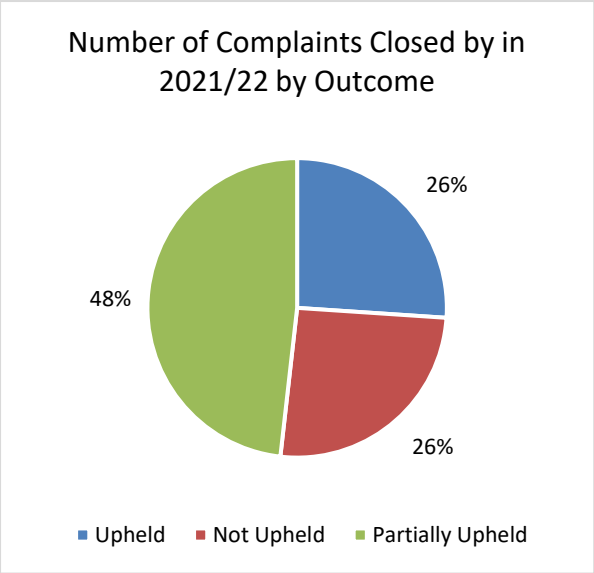
2.4 Complaints Outcomes

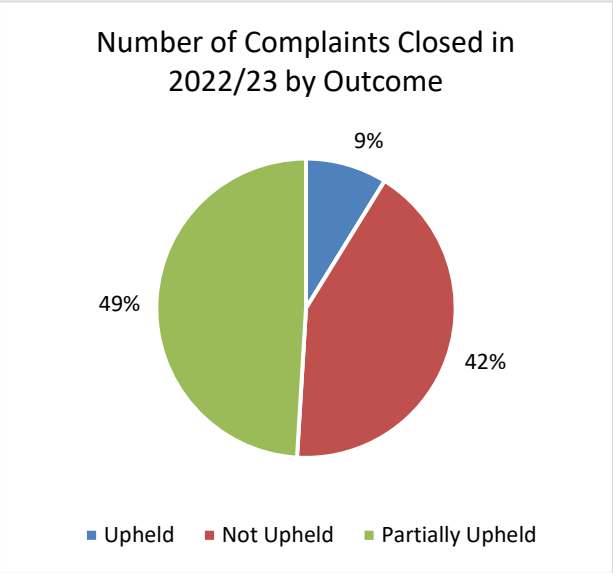
Once a complaint has concluded (either following a local resolution meeting or once a formal written response has been sent) the outcome is recorded in line with the findings of the investigation. Upheld complaints are those where the concerns raised have been found to be valid. Not upheld complaints are those where the investigation has not found any deficiency in the care, treatment or service provided. Partially upheld complaints are those where aspects of the case are upheld, but the main issues are not.

The chart below shows the outcome of closed complaint during the reporting period:

- The percentage of upheld complaints was lower in the 2022/23 reporting period (9%) than in the 2021/22 reporting period (26%).
- The majority of complaints in the reporting period were partially upheld (49% -static position).
- The percentage of not upheld complaints has improved (42%) when compared with the 2021/22 reporting period (26%).

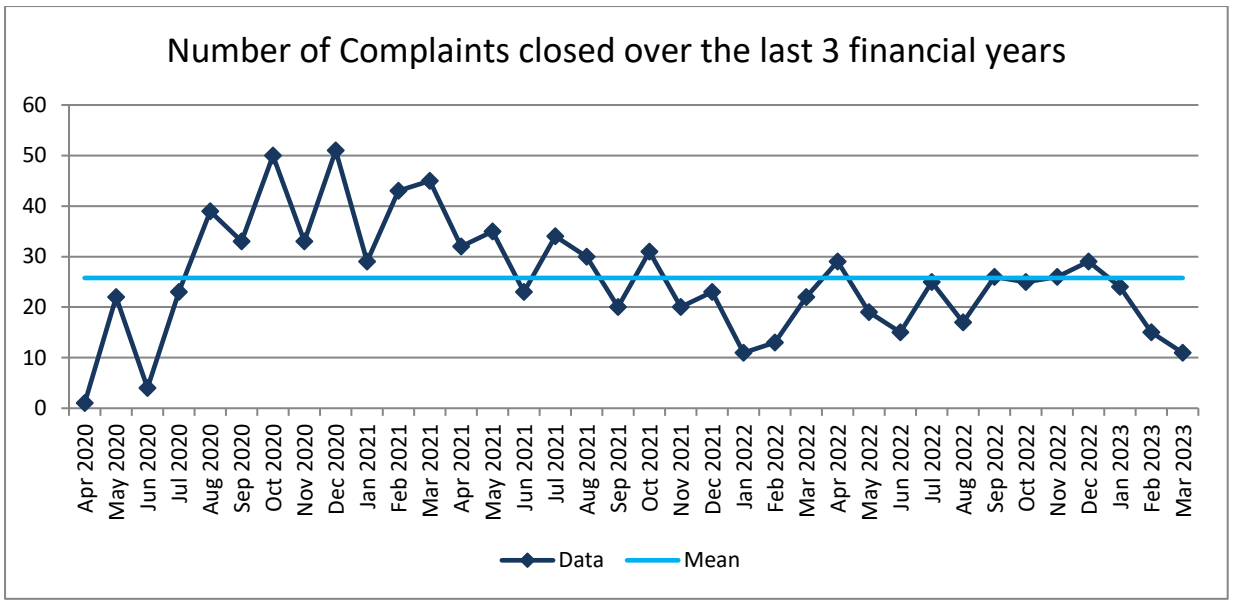
The increase in complaints not upheld and the decrease in complaints upheld indicates that, complaint investigations are concluding that care provision has been appropriate albeit with learning identified.





2.5 Complaints Resolved

The Trust closed 261complaints (this is due to closing those that were received in the previous reporting period). The graph below shows the closed complaints over time.



Timeliness of responding to complaints

Within the reporting period, the Trust had 0 breached complaints.

	2022									2023		
CBU	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Clinical Support Services	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Digestive Diseases	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Estates and Facilities	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Human Resources	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Integrated Medicine and Community	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Medical Care	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Surgical Specialties	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Urgent and Emergency Care	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Women's and Children's	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Grand Total	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**

2.6 Referrals to Parliamentary Health Service Ombudsman

Complainants dissatisfied with the Trust's response have the right to ask the Parliamentary Health Service Ombudsman (PHSO) to consider their complaint. However, the complainant must be able to provide reasons for their continued dissatisfaction (in writing) to the PHSO. The Trust may also refer the complainant to the PHSO if they feel that the response has been thoroughly investigated and responded to.

The PHSO will consider the complaint file, medical records and any other relevant information, as necessary. The PHSO may decide not to investigate further and no action will be required from the Trust. Alternatively, recommendations might be made for the Trust to consider. The PHSO may decide to conduct a full investigation which might result in the Trust being required to make an apology, pay compensation and / or produce an action plan to describe what actions are planned to rectify the situation and prevent further occurrences.

The Trust received 5 PHSO notifications during 2022/2023, 2 of which remain under investigation. The PHSO have concluded 4 investigations within the reporting period. 2 were not upheld and two were partially upheld.

a) One case was partially upheld as the Ombudsman found failings relating to not requesting blood culture tests when sending the patient's blood samples for testing . No further action was recommended.

b) The second case related to communication, in that that WHH did not inform the daughter of her parent's placement on a Covid-19 ward. A letter of apology was shared and an action plan put in place. All actions have been completed.

The Ombudsman found no impact occurred as a result of these two points for learning.

The Trust currently has 4 ongoing PHSO complaints 2023/2024.

2.7 Learning from Complaints

You Said….	We Did….
A Doctor was late to clinic due to having to attend a remote MDT meeting off site which overran.	A room has now been allocated for doctors to attend remote meetings. This reduces the need for commuting between sites (where appropriate) and the risk of clinic starting late if the MDT meeting overruns.
A patient raised concerns about the communication between staff on different units. The patient felt that staff on the maternity ward were not always fully aware of the plan in place for babies being cared for on the neonatal unit.	A new process was implemented whereby midwives from the maternity ward now attend the neonatal daily patient reviews, to ensure staff on both wards are aware of the plans of care for mothers and babies.
A medication error occurred whereby a patient was accidentally prescribed an incorrect (too low) dose of his Parkinson's medication.	The concerns were shared with the Doctor involved for individual learning. The concern was also shared with the Trust's Lead Clinical Education Pharmacist, who has recorded a training session for junior doctor induction on accurate drug history taking which will be

	disseminated to all junior doctors at their induction to the Trust. The concern has also been included in the Safer Times Prescriber newsletter.
The Patient's son had concerns regarding a delay in his father's death being referred to the Medical Examiners and a cause of death being issued. He also had concerns regarding a lack of communication from the Bereavement Office.	Following receipt of this complaint the Head of Patient Experience and Inclusion met with the Medical Examiner's Office to discuss how the Bereavement and Medical Examiner team could work together to provide a more efficient service for bereaved families. This resulted in joint escalation processes to ensure greater efficiency. A digital referral form was implemented in January 2023 to promote accessibility and reduce the risk of delays. Within the Bereavement Office an improved structured routine has been agreed with tasks being allocated to individual team members at the beginning of each day to ensure greater accountability.
The Patient had concerns about the communication and unclear explanations of staff regarding the loss of her baby.	A sequence of weekly simulation training for all nursing staff and healthcare assistants on Ward C20 was implemented. The training consists of an hour-long session to educate staff on how to effectively discuss pregnancy loss with patients and their partners and how to actively manage and support patients who are experiencing the trauma of the loss of their baby. The training will also advise staff on how to support patients and their partners through post treatment care.
The Patient's mother had concerns that her husband and son were left waiting at the triage window with no communication.	It was identified that at the time of the patient's attendance, the triage navigation window was closed. In response to this concern, the signage at the window was reviewed and further information has been displayed with clear information as to where patients need to report to upon arrival in the department.

2.8 Patient Advice and Liaison Service (PALS)

During the reporting period, PALS received 2011 enquiries - a 4% decrease from 2021/22 (2091 enquiries).

The below graph shows the variance between PALS received each month in 2021/22 against those received for each month in 2022/23.

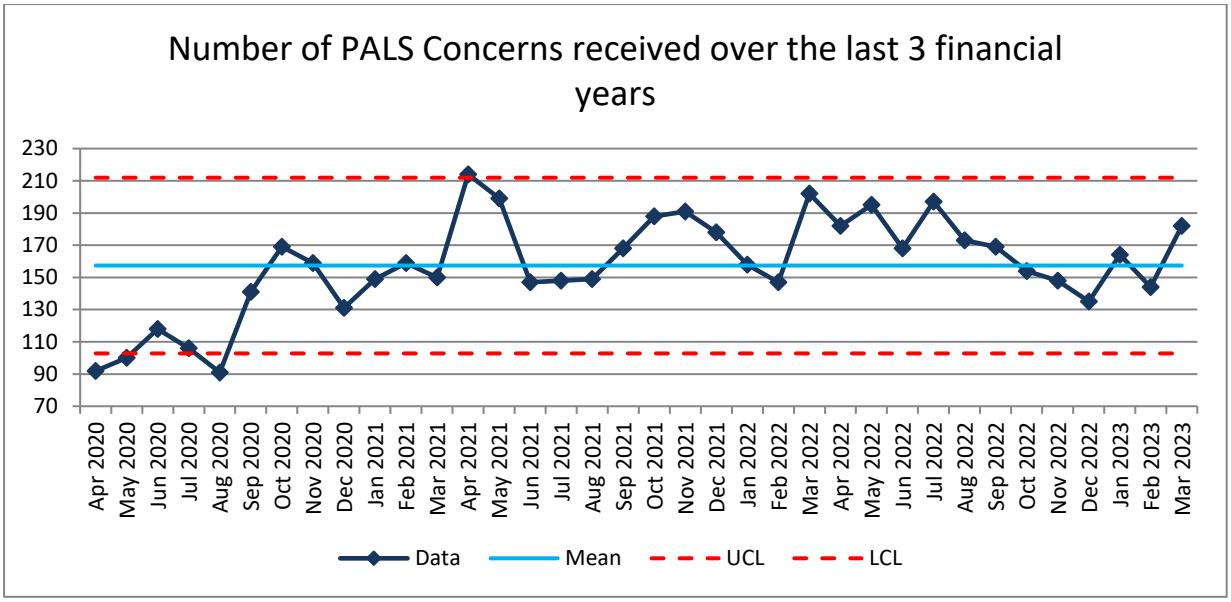


Table 2 below show the top themes for PALS during the 2021/22 and 2022/23 reporting periods.

Table 2:

Theme	2022/2023	2021/2022	Change
Date for appointment	421	235	186
Clinical treatment	410	402	8
Communication (oral)	338	611	-273
Attitude and behaviour	173	233	-60
Communication (written)	120	179	-59
Patient property / expenses	114	98	16
Test results	99	40	59
Admissions / transfers / discharge procedure	98	104	-6
Date of admission / attendance	65	45	20
Telephone	54	3	51
Personal records	30	42	-12
Premises	29	32	-3
Patient privacy / dignity	26	27	-1
Aids / appliances / equipment	9	9	0
Bed shortages	4	6	-2
Cleanliness / laundry	4	4	0
Outpatient and other clinics	4	1	3
Catering	3	2	1
Failure to follow agreed procedures	3	7	-4
Mortuary / post mortem arrangements	2	1	1
Shortage / availability	2	2	0

Transport	2	1	1
Patient status	1	1	0
Competence	0	1	-1
Complaint Handling	0	1	-1
Consent to treatment	0	2	-2
Policy & commercial decisions of NHS board	0	0	0

Dates for appointment is the highest theme which is triangulated alongside complaints data in terms of wait times. This applies to both waiting lists and delays within departments as a result of continued high patient attends, the number of patients with no criteria to reside and high patient acuity. Whilst there has been an increase in the number of PALS received for this theme, there has been a reduction in the number of formal complaints received. PALS provide a real time response and when a PALS concern is received relating to an appointment issue, PALS work directly with the appointments team/CBU to ensure early resolution.

Clinical Treatment is the second highest theme and there has been an increase in numbers received across both PALS and complaints again, impacted by operational challenges previously described in this report. There has been a decrease in the number of PALS received for communication and attitude and behaviour, this decrease is also reflected in the in the number of formal complaints received.

3. RECOMMENDATIONS

The Quality Assurance Committee are asked to note the report.

QUALITY ASSURANCE COMMITTEE

AGENDA REFERENCE:	**QAC/23/07/151**
SUBJECT:	**S**afeguarding Annual Report
DATE OF MEETING:	11 July 2023
AUTHOR(S):	Layla Alani, Director Governance, Deputy Chief Nurse
EXECUTIVE DIRECTOR SPONSOR:	Kimberley Salmon-Jamieson, Chief Nurse & Deputy Chief Executive
LINK TO STRATEGIC OBJECTIVE:	SO1: We will... Always put our patients first delivering safe and effective care and an excellent patient experience.
EXECUTIVE SUMMARY	The Safeguarding Annual Report provides a summary of safeguarding activity during 2022/2023. **Child safeguarding** referrals have reduced whilst adult safeguarding referrals have continued to significantly increase. When compared to 2019 (year on year) this growth equates to 97.3% in ICE referrals. Whilst the number of internal safeguarding children's referrals have reduced, the activity and external requests for information has increase significantly. Contextual safeguarding (abuse that takes place away from the family home) is increasing nationally and this is demonstrated within the figures. Local pathways are being continuously reviewed and developed to meet the needs and demands of the young people involved. **Adult safeguarding** referrals increased across all categories of abuse with no identified trend. Safeguarding adult incidents have increased by 93% for which a further review will be undertaken to understand this in greater detail. **Liberty Protection Safeguards** The implementation of Liberty Protection Safeguards has been placed on pause nationally, awaiting further guidance. System meetings continue to consider plans for implementation. Deprivation of Liberty Safeguards (DoLS) applications has increase by 41% which equates to an additional 195. **Training** Alternative methods of training have been utilised since quarter 3 of the reporting period which has ensured

	compliance with training with the exception of level 3 training for which plans are in place.			
PURPOSE: (please select as appropriate)	Information	Approval	**To note X**	Decision
RECOMMENDATIONS:	The Quality Assurance Committee are asked to discuss and note the contents of the report.			
PREVIOUSLY CONSIDERED BY:	**Committee**	Safeguarding Sub Committee		
	Agenda Ref.	W&HHFT/ACSC/23/05/339		
	Date of meeting	25/05/2023		
	Summary of Outcome	Annual Report approved at Safeguarding Committee		
NEXT STEPS: ***State whether this report needs to be referred to at another meeting or requires additional monitoring***	Choose an item.			
FREEDOM OF INFORMATION STATUS (FOIA):	**Release in Full**			
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	Choose an item.			

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Safeguarding Annual Report 2022-2023

Contents

1. Executive Summary

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

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

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

2. Introduction

This report provides the Safeguarding Committee and Quality Assurance Committee with a summary of the safeguarding activity during the financial year 2022/2023. This Annual Report provides assurance that WHH is meeting all necessary statutory obligations in safeguarding both adults and children.

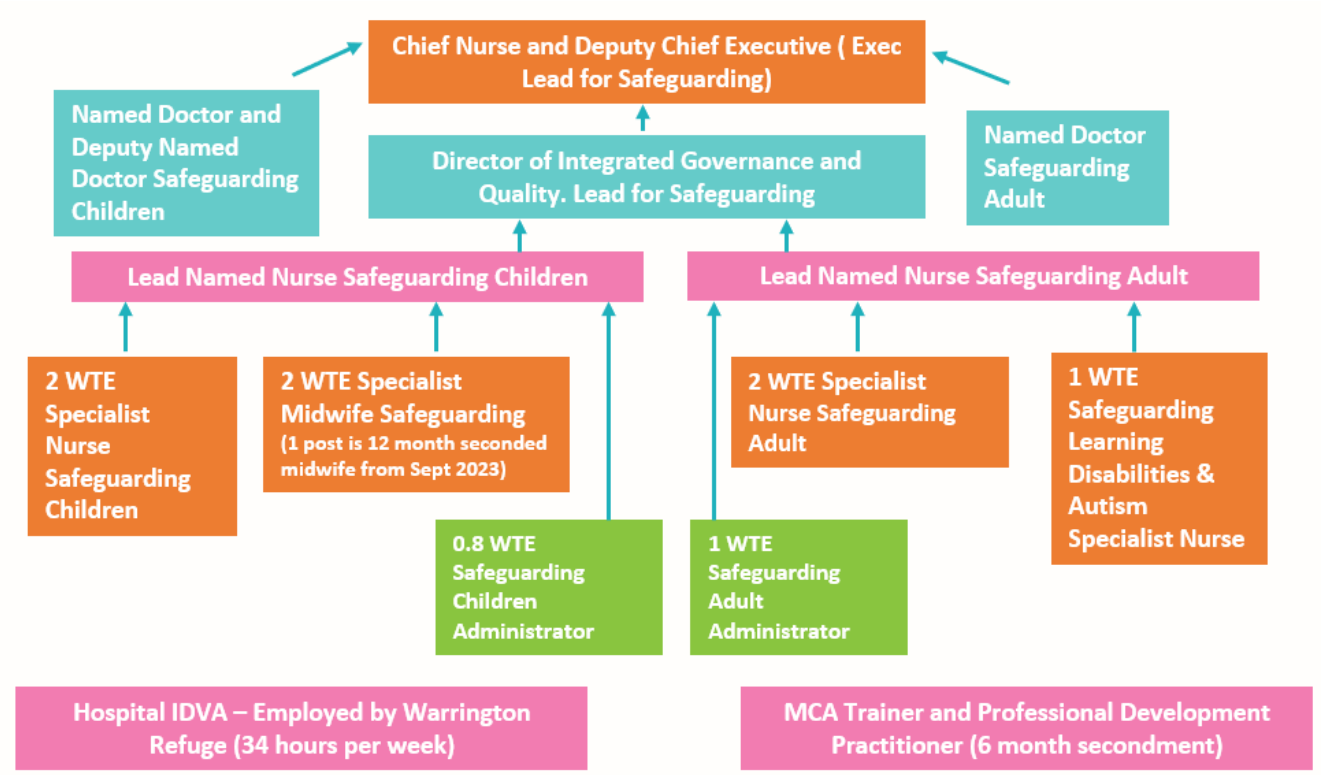
The Safeguarding of children, young people and adults at risk in the NHS, accountability and assurance framework (2019) sets out the safeguarding roles, duties and responsibilities of all NHS organisations and is integral to the safeguarding agenda, thus forming the basis of this report.

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

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

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

3. WHH Safeguarding Management Structure

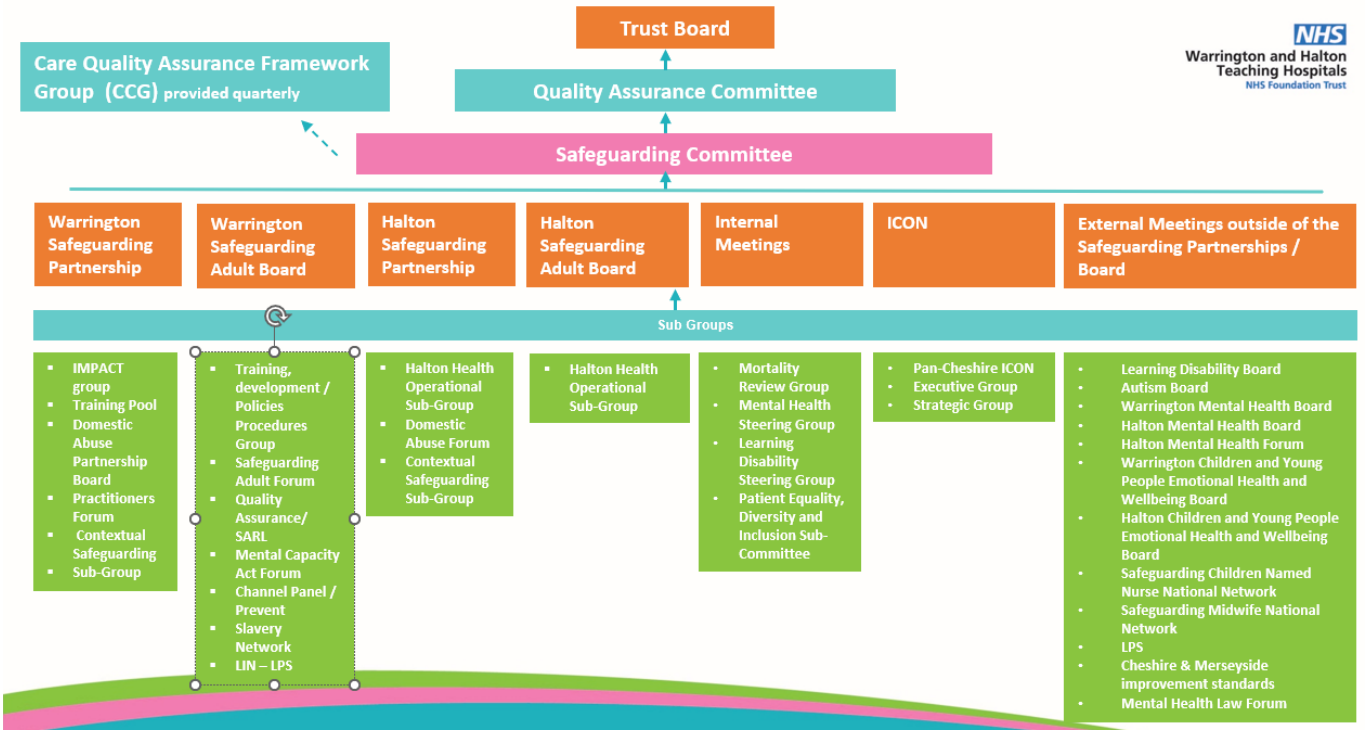


4. Safeguarding Committee Structure

The Safeguarding Committee is a sub-committee of the Quality Assurance Committee (QAC). It is responsible for monitoring the development, implementation, audit and delivery of safeguarding throughout the Trust. The Safeguarding Committee receives reports and has responsibility for the ratification of policies. It is in this way that compliance with external organisational requirements such as the Care Quality Commission, Safeguarding Children Partnerships and Safeguarding Adult Boards are managed.

The Chief Nurse and Deputy Chief Executive is the Chair of the Safeguarding Committee which is accountable to the Quality Assurance Committee (QAC) ahead of Trust Board.

The Safeguarding Committee reporting structure offers assurance from internal to external safeguarding partners as detailed in the below chart.



5. Underpinning Legislation

The following regulations underpin the Trust's approach to safeguarding enabling a safe environment to be maintained *(the list is not exhaustive).*

In addition to the Safeguarding of children, young people, and adults at risk in the NHS, accountability and assurance framework (2019) framework there are several key legislative documents which drive and support the safeguarding agenda:

The Children Act 2014	Mental Capacity Act (2005)
Care Act 2014	Mental Health Act (2007)
Human Rights Act (1998)	Children and Social Work Act 2017
Deprivation of Liberty Safeguards (2007)	Mandatory reporting of female genital mutilation (2016)
Sexual Offences Act (2003)	Domestic Violence, Crimes and Victims Act (2004)
Data Protection Act (1998)	Public Interest Disclosure Act (1998)
Modern Slavery Act (2015)	Controlling or Coercive Behaviour in an Intimate or Family Relationship Statutory Guidance Framework (2015)

6. Safeguarding Activity

The following data describes the activity and provides an analysis of safeguarding activity. Safeguarding notifications to the safeguarding teams are completed using the ICE electronic system. Each ICE notification is reviewed and actioned by a Specialist Safeguarding Nurse. The data collected from the ICE notifications, telephone calls, emails and face to face contacts have been captured to provide the date in this report.

6.1 Safeguarding Unborns, Children and Young People

6.1.1 Safeguarding Notifications

The safeguarding children team activity is difficult to measure with specific data due to the level of complex multi-agency working. Whilst internal activity can be measured with the number if ICE notifications received, the number of phone calls, email requests and intelligence gathering for multi-agency meetings is not collated. Further analysis of this activity is explored later in this report.

When compared to the previous year there has been a 25% decrease in internal notifications to the safeguarding children team (2475 in 2021/2022 versus 3322 2022/2023). Figure 1 provides data for all safeguarding children ICE notifications under the three categories, Children, Maternity and Domestic Abuse. Whilst there has been a decrease in the numbers of ICE notification, the complexity of the cases has increased. Work was undertaken with specific areas of the trust to ensure appropriate ICE notifications were completed, therefore reducing the number of inappropriate referrals. The activity generated from the ICE referrals is explained under this section of the report.

Figure 1

ICE Notifications to the children's team	Children's	Maternity	Domestic Abuse (Children / unborns in the Family)	Adult Patient (where there are safeguarding children concerns)
2020/2021	2021	827	94	371
2021/2022	2421	901	132	402
2022/2023	1786	689	122	399
% change 21/22 to 22/23	↓26%	↓23%	↓8%	↓1%

6.1.2 Safeguarding Children - Inpatients

WHH utilise a 'concerns form' to highlight and ensure compliance with the Laming recommendations. These recommendations set out to safeguard children ensuring best practice is applied. Review of data when compared to the previous year indicated a decrease of 39% (338 in 21/22 versus 205 in 22/23). The significant reduction can be accounted for following the review and updating of the Safeguarding Children Policy. Not all children who present to hospital with mental health concerns or who are open to children's social care require a safeguarding overview and therefore the pathway was changed to reflect this. This large decrease was expected.

The age distribution of the 'concerns form' remains similar to previous year, See figure 2. Under 1's accounted for 32% (65) of forms whilst 42% (86) of the forms were completed on 13–17-year-olds, this again is comparable to the previous year. Concerns for children suffering with mental ill health in the over 13 years old continues to increase in numbers and complexity.

Figure 2

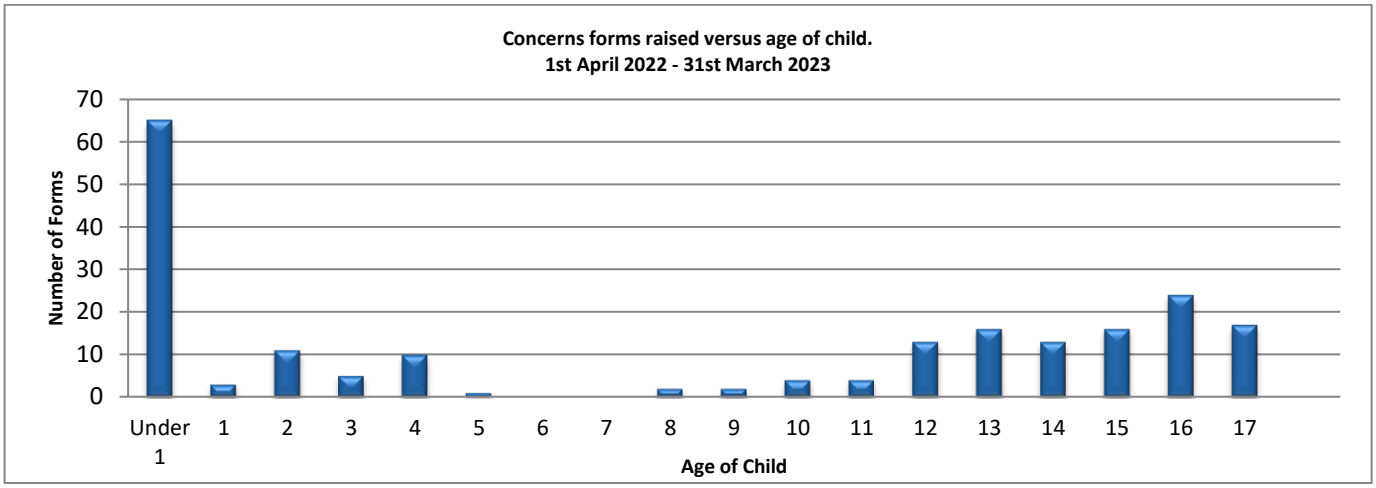


Figure 3

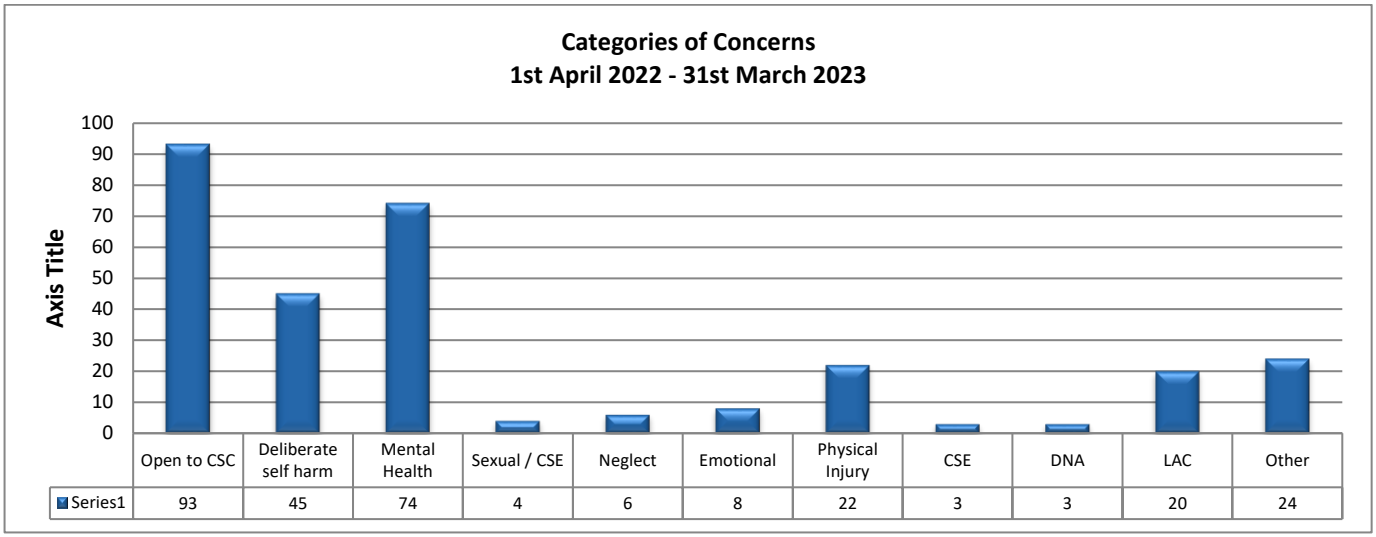


Figure 3 provides an overview of the categories of concern. Several patients identify under more than one category. For example, children who cause harm to themselves could also be known to children's social care. In comparison to the previous year, there has been a significant reduction in the categories – children open to CSC (153 reduced to 93) and children's mental health (191 reduced to 74).

6.1.3 Contextual Safeguarding

Contextual Safeguarding is an approach to understanding, and responding to, young people's experiences of significant harm beyond their families. It recognises that the different relationships that young people form in their neighbourhoods, schools and online can feature violence and abuse. Parents and carers have little influence over these contexts, and young people's experiences of extra-familial abuse can undermine parent-child relationships.

There is a Pan-Cheshire Children's Contextual Safeguarding Strategy 2021 – 2023 driving the priorities which WHH continue to support. Operationally, Warrington local authority and Halton Local Authority have slightly different approaches to the multi-agency meetings required to monitor individual children.

Warrington Local Authority changed their approach in September and now hold twice weekly Contextual Safeguarding Risk Meetings and monthly Mapping meetings for peers and locations. Since September, the safeguarding children team have completed searches on 406 young people. Within Halton once monthly a risk meeting is held. Since April 2022 health information has been shared on 205 young people.

As a trust, staff are informed of the Pan-Cheshire pathway and are trained to recognise and respond to concerns of contextual safeguarding. The number of exploitation screening tools has significantly reduced in 2022/2023. In 2020/2021 there was a high number of screening tools referred on to the risk meeting however the appropriateness of these referrals was challenged by the operational group. Work was completed with front line professionals.

Figure 4

Year	Pan-Cheshire screening tools completed by WHH staff	Screening tool resulted in high risk - Referred on to risk meeting
19/20	80	12
20/21	87	56
21/22	94	11
22/23	29	3

6.1.4 Perplexing Presentations (PP) / Fabricated or Induced Illness (FII) in Children

In March 2021 new guidance on perplexing presentations and fabricated or induced illness in children was launched. The new guidance provides procedures for safeguarding children who present with PP or FII and best practice advice in the medical management of these cases to minimise harm to children.

The guidance updates definitions of FII and PP. The new and wider interpretation of FII includes any clinical situation where the parent or carer's actions are aimed at convincing doctors and other professionals that a child is more seriously ill than is the case. In these circumstances, the parent or carer may be acting on erroneous beliefs about the child's state of health or, in some cases, deceiving professionals. There is a risk that the child will be directly harmed by the parent or carer's behaviour but in some cases, and inadvertently, also by the medical team's response.

In response to the new guidance a health focussed working group has been developed. WHH works in collaboration with Warrington Integrated Care Board, Bridgewater NHS and Mersey CARE NHS to ensure the health safeguarding concerns in respect of perplexing presentation are discussed, addressed and escalated where required.

In 2018 WHH was involved in 4 cases of FII / PP. Since the new guidance and staff awareness of such cases increasing, WHH are currently tracking 14 families with concerns of PP / FII which involves 27 children. Each case is incredibly complex requiring a high level of research and analysis of care.

6.1.5 Child Protection Medicals

A child protection medical (CPM) assessment should always be considered when there is a suspicion of, or a disclosure of, child abuse and/or neglect involving injury, suspected sexual abuse or serious neglect. The need to consider a medical assessment in these cases arises from section 47 of the Children Act 1989 (and 2004) which places a statutory duty on the Local Authority to make enquiries to enable it to decide whether it should take action to safeguard and promote the welfare of a child. A total of 22 child protection medicals were completed during the reporting period which is another significant decrease from the previous year. All child protection medicals and cases of physical harm are discussed at a monthly peer review meeting which is attended by internal teams and multi-agency partners. In 2022/2023 40 cases were discussed. **Figure 5** provides the detail regarding the geographical areas of the children who attended for a child protection medical. In 2021/22 59% of child protection medicals were completed on Warrington children, this has increased to 77% in 2022/2023.

Figure 5

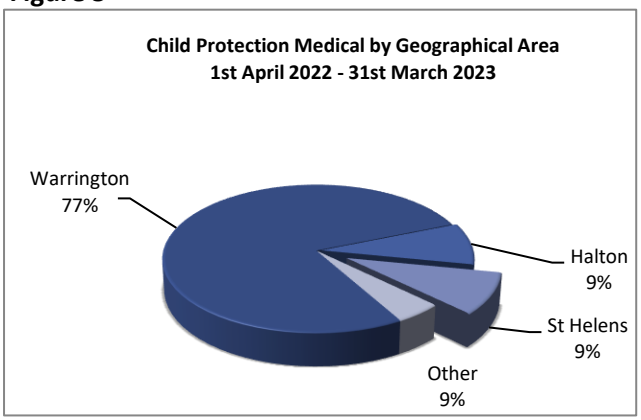
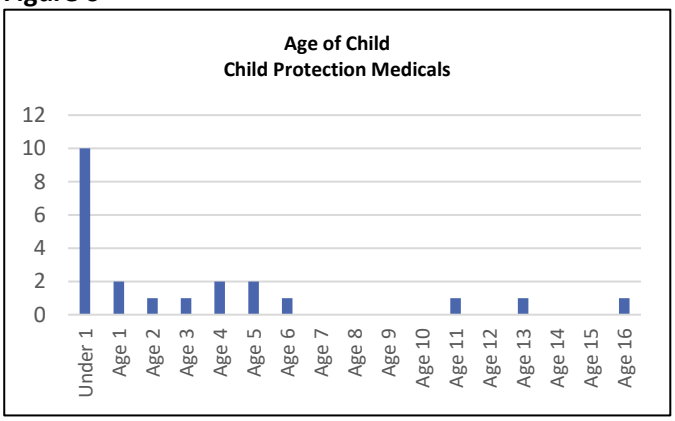


Figure 6



Pathways to harm, pathways to protection: a triennial analysis of serious case reviews 2011-2014, (Brandon et al 2016) identified that "Infancy remains the period of highest risk for serious and fatal child maltreatment; there is a particular risk of fatality for both boys and girls during infancy." This is replicated within the activity seen in **Figure 6.**

6.1.6 Child Death

Working Together to Safeguard Children 2018 Chapter 5 sets the functions and processes of the Child Death Overview Panel (CDOP), which includes the collection and collation of data following the death of a child and subsequent recommendations following data analysis.

The Sudden Unexpected Death in Childhood (SUDIC) proforma & guidelines was updated in 2021. This guidance provides a framework for the investigation and care of families after an unexpected death of an infant or child. Due to confidentially and ongoing investigations / meetings the causes of deaths cannot be documented within this annual report. Bereavement support is offered to the family and the staff involved in any child death incident. Following relevant multi-agency meetings, feedback and learning is presented internally to the Mortality Review Group. **Figure 7** demonstrates the number cases which have required WHH input.

Figure 7

	2017/2018	2018/2019	2019/2020	2020/2021	2021/2022	2022/2023
Number of deaths pronounced at WHH	5	15	3	8	5	6
Total number of child deaths requiring further information sharing / input from WHH	12	22	19	24	10	12

6.1.7 Safeguarding Unborns and their families

Safeguarding within midwifery is constantly changing and becoming more complex. Research and experience indicate that very young babies are extremely vulnerable to abuse and that work carried out in the ante-natal period to assess risk and to plan intervention will help to minimise harm. In 2021/2022 the number of women with identified vulnerabilities who are being supporting through their pregnancy has remained fairly static as detailed in **Figure 8**. There has been a decrease of 51 out of area (wigan, Manchester, St Helens) women which accounts for the overall decrease. Consistent with the previous year's data mental health continues to be the most prevalent reason for concern (48%). WHH provides a peri-natal mental health service to support the increasing demand which included the recruitment of a specialist midwife for mental health. There has been a significant increase in women accessing maternity care with concerns of domestic abuse (130 increased to 158). The Safeguarding Children Team provide a robust channel of communication with external partners and ensure that patient records and care plans are up to date in readiness for delivery of the baby. The data below in **Figure 9** provides detailed information regarding the number of special circumstance forms comments and from which geographical area the patients are from.

Figure 8

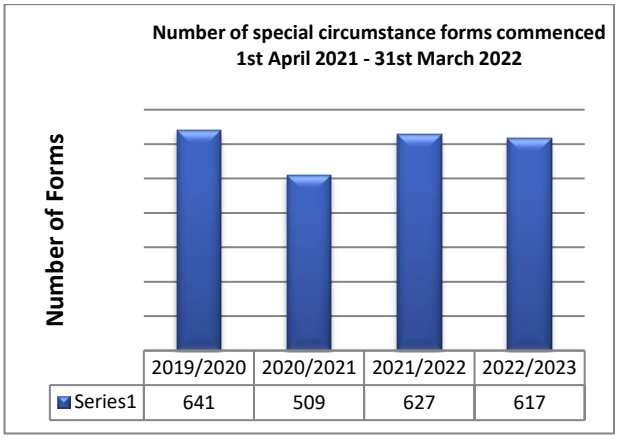
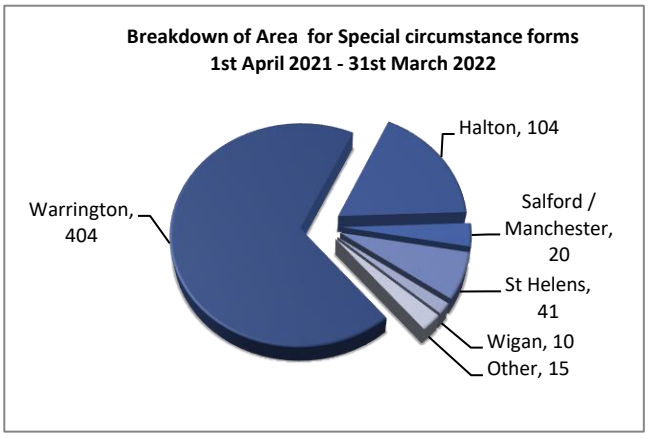


Figure 9



Each midwifery referral is reviewed and categorised by a safeguarding practitioner. Warrington Safeguarding Partnership Continuum Tool identifies four areas of vulnerability, risk and need to assist practitioners to identify the most appropriate service response for children, young people and their families.

A review of the data evidences the significant change in the complexity of cases. Figure 10 provides an overview of the midwifery cases over the last 3 years. In 2020/2021, 129 women and their unborns were identified as requiring statutory / specialist services whereas in 2022/2023 this had increase to 204 which is an increase of 58%. The table below also provides an explanation of each level.

Figure 10

Area of Vulnerability	Warrington Safeguarding Partnership Continuum Tool – description and colour code	20/21	21/22	22/23
Universal	No emerging concerns. Services are available to everybody and can be accessed by anyone without additional support. Universal provision is fluid throughout all the levels.	201	183	50
Universal Plus	Providing support as soon as a problem emerges. Usually a single agency response and coordination is usually by the service/ agency who knows the family well. An Early Help Assessment is the recommended tool to identify needs	117	209	243
Partnership Plus	Multiple and complex concerns apparent which require a multi-agency and targeted approach. Early Help assessment is essential and lead professional identified to support.	46	82	117
Statutory / Specialist	Complex and acute needs likely to require statutory or specialist intervention under the Children's Act 1989 and where a Children's Social Care assessment is required. This includes children with complex health needs and disabilities.	129	140	204

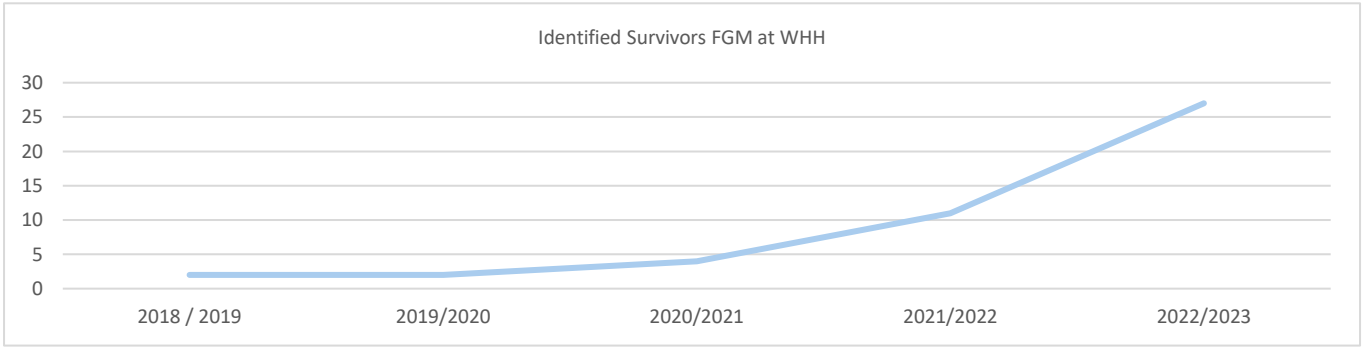
6.1.8 Female Genital Mutilation (FGM)

Female Genital Mutilation (FGM) is illegal in England and Wales under the FGM Act 2003 ("the 2003 Act"). It is a form of child abuse and violence against women. FGM comprises all procedures involving partial or total removal of the external female genitalia for non-medical reasons. The duty to mandatory report all FGM cases in under 18 years old came into effect in October 2015.

The National Female Genital Mutilation - April 2019 to March 2020 Annual Report identified there were 6,590 individual women and girls who had an attendance where FGM was identified. These accounted for 11,895 total attendances reported at NHS trusts and GP practices where FGM was identified. Nationally the number of total attendances during 2019-20 has remained broadly stable.

Screening for FGM is a routine part of midwifery booking. Within this reporting period, twenty-seven survivors of FGM have been identified via WHH midwifery services. This is an increase of 170% (10 in 21/22 versus 27 in 22/23) (**Figure 11)**. The appropriate pathways were followed and relevant agencies notified to ensure the safety of the unborn and any siblings was assessed.

Figure 11



The Female Genital Mutilation (FGM) Enhanced Dataset (SCCI 2026) is submitted on a quarterly basis. The dataset supports the Department of Health's FGM Prevention Programme by presenting a national picture of the prevalence of FGM in England.

6.2 Safeguarding Adults at Risk

The Safeguarding Adult team activity results from concerns raised internally from WHH wards and departments and from external agencies.

When compared to the previous year there has been a 28% overall increase of safeguarding adult activity across the whole of the adult safeguarding portfolio. When the data is compared from 2019 to 2023 this represents an increase of 97.3%. The safeguarding adult team receive ICE notifications under five categories, safeguarding adults, domestic abuse (where only adults are identified), learning disabilities, DoLS and Prevent. The activity generated from the ICE referrals is explained in **Figure 12, 12a** and **12b** below.

The recruitment of a Learning Disability (LD) and Autism Nurse Specialist has enabled a clear focus on developing existing pathways further, ensuring patients with a Learning Disability and or Autism diagnosis are appropriately escalated and supported. The table below demonstrates that the support required from the LD/Autism specialist Nurse has increased by 47% in year.

6.2.1 Safeguarding Adults Notifications

Figure 12

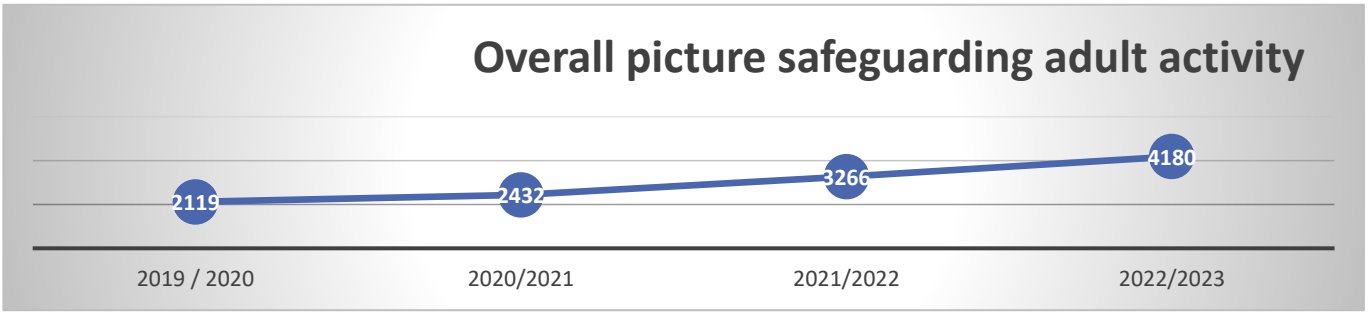
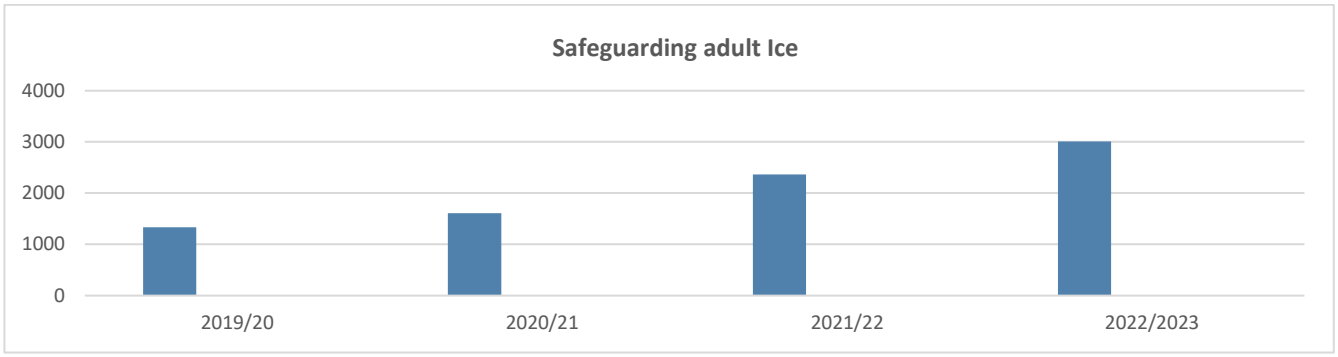


Figure 12a

ICE Notifications to the adult's team	Safeguarding Adult ICE	DA Adult Only Cases	LD In-Patients	Prevent	DoLS	Overall increase effect
2019/2020	1336	116	142	0	525	2119
2020/2021	1611	116	158	1	480	2432
2021/2022	2364	153	198	4 cases	547	3266
2022/2023	3009	136	291	2	742	4180
% change 21/22 to 22/23	↑27%	↓11%	↑47%	↓2 Cases	↑36%	↑ 28%
% change 2019/2020 to 2022/2023 = 4 years	↑ 125%	↑ 17%	↑ 105%	Fluctuating picture	↑ 38%	↑ 97.3%

Figure 12b



The information detailed in the charts above (**Figure 12** and **12a**) describes adult safeguarding activity from 2019. As the data demonstrates, the overall activity of referrals to the safeguarding team has significantly increased year on year.

6.2.2 Mental Capacity Act (MCA) / Deprivation of Liberty Safeguards (DoLS)

All DoLS applications are notified to the CQC in line with statutory guidance. During the reporting period there has been a 41% increase in the number of DoLS applied for. Court of Protection cases are also contributed to by the Safeguarding Team. **Figure 13** demonstrates the number of DoLS applied for in the reporting period with comparison to previous years. This has continued to increase.

Figure 13

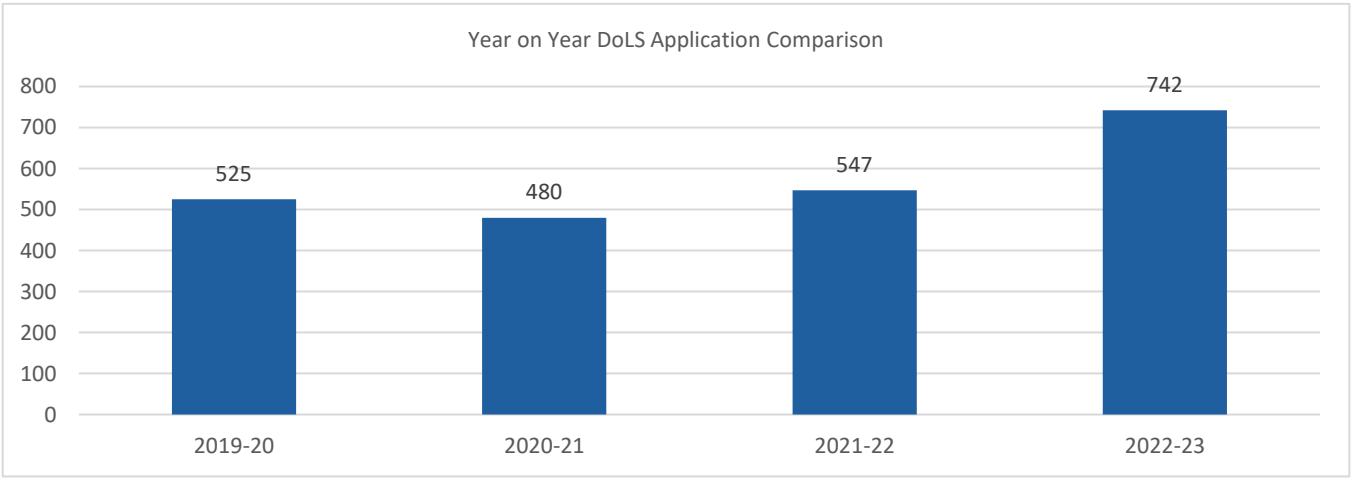
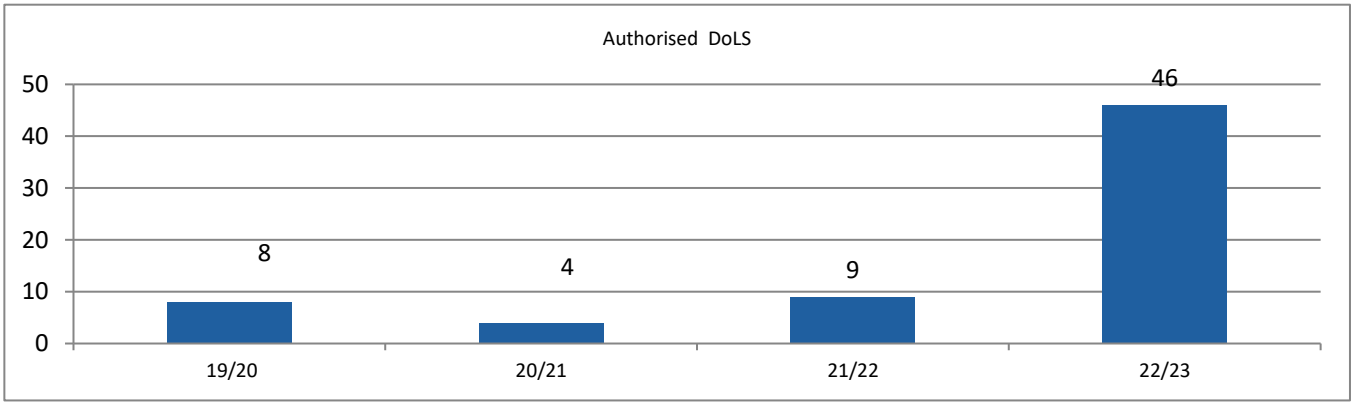


Figure 14 (below) describes the number of DoLS applications authorised by Local Authorities. This also demonstrates a significant increase. This can be attributed to Court of Protection cases and a higher number of complex patients.

Figure 14



6.2.3 Liberty Protection Safeguards (LPS)

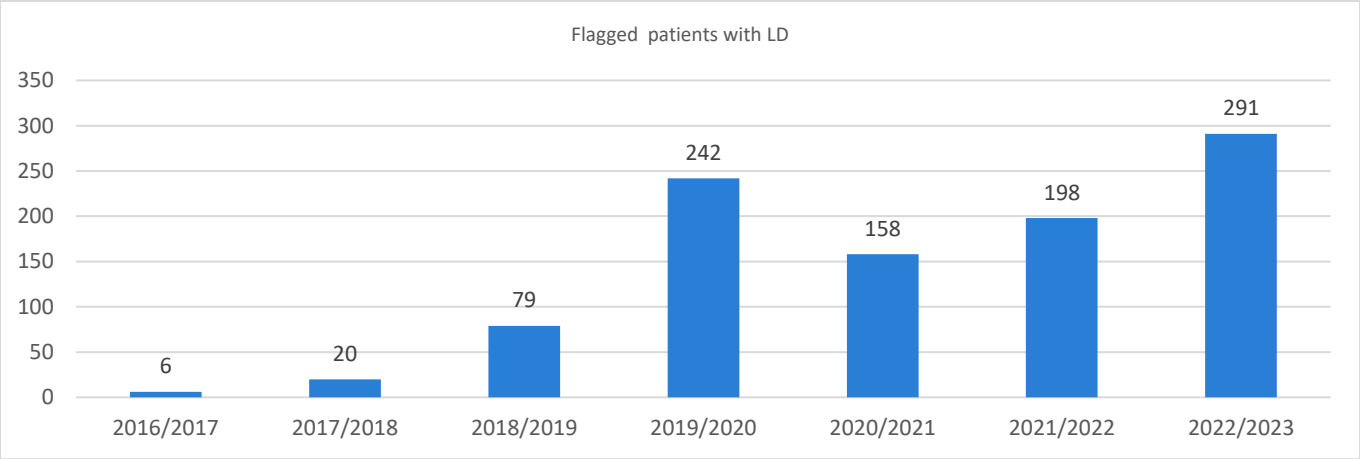
During the reporting year WHH have continued with preparations for the implementation of Liberty Protection Safeguards (LPS). The Law that replaced the Deprivation of Liberty Safeguards (DoLS) received Royal Ascent in May 2019 and it was originally due to be implemented in October 2020, but this was delayed due to the COVID-19 pandemic. An LPS draft Code of Practice was submitted for consultation between March and July 2022, with the implementation date still awaited. On 5th April 2023, The Department of Health and Social Care (DHSC) announced that the implementation of the LPS has been formally paused, though is still anticipated. Preparatory work continues utilising a system approach. Training has been implemented to support WHH teams with the preparation and implementation of LPS, including MCA and DoLS. WHH have also temporarily recruited an MCA Trainer and Professional Development Practitioner.

In the reporting year policies and procedures have been reviewed and updated, tools have been devised that better support staff with their MCA/DoLS practice which has included the development of specific tools within the Lorenzo electronic records so that MCA/DoLS processes can be recorded within the patient electronic record. This will allow the DoLS applications to be shared directly from the patients records when the documents go live.

6.2.4 Learning Disability/Autism

There are 1.5 million people believed to have a learning disability in the UK equating to 2.16% of adults and 2.5% of children (Office for National Statistics (2020). The chart below describes the activity associated to patients with LD who required admission to WHH during 2016/17 which was prior to the introduction of the alert process to the current reporting year, 2022/2023. The increase in the number of patients notified to the Safeguarding team has notably increased with an in-year increase of 47%. In 22/23 there were 291 patients with LD who required admission to WHH in comparison to the previous year, which was 198, this can be seen in **Figure 15** below.

Figure 15



LeDeR, the national mortality review program is supported by WHH safeguarding team and Mortality Review Group (MRG). Lessons from LeDeR reviews are relayed to WHH via the MRG newsletter.

National Health Service Improvement (NHSI) published Learning Disability Improvement Standards for NHS Trusts in 2018. The document highlights four overarching areas for improvement; with three of those areas being key to Acute Hospital's.

1. Respecting and protecting rights (5 improvement measures)
2. Inclusion arrangements (5 improvement measures)
3. Workforce (4 improvement measures)

An action plan for improvement is in place and monitored via the internal Learning Disability Steering Group. In line with equality standards, WHH are required to ensure reasonable adjustments are made to support access to health care for people with an LD diagnosis. Alongside the appointment of an LD Specialist Nurse, a program of training has supported staff.

In 2022/2023 significant pieces of work have been undertaken to support the Learning Disability action plan including:

- Recruitment of LD and Autism Specialist Safeguarding Nurse
- Review and update of LD and Autism Steering Group
- Virtual tours of outpatient's departments
- Daily Makaton sign updates via trust wide safety brief
- LD and Autism Champions
- WHH collaborate with local partnerships – Warrington Learning Disability and Walton Lea Partnership

6.3 Domestic Abuse – Children and Adults

There are 2.4 million victims of domestic abuse a year aged 16 to 74 (two-thirds of whom are women) and more than one in ten of all offences recorded by the police are domestic abuse related. WHH, working with the Domestic Abuse Partnership Board, takes its role in helping to prevent domestic abuse and offering support for victims very seriously. WHH supported the development of the Warrington Domestic Abuse Strategy and continues to support the progress of the priorities set. The strategy sets out intentions for the next three years whereby we aim to create sustainable change across the system through continued partnership work.

In comparison to the previous year the number of referrals has decreased to 258 (was 285 in 2021/2022) which equates to 9% / 27 referrals (**Figure 16**). As demonstrated in **Figure 17**, the geographical split of referrals remains Warrington and Halton being the highest.

Figure 16

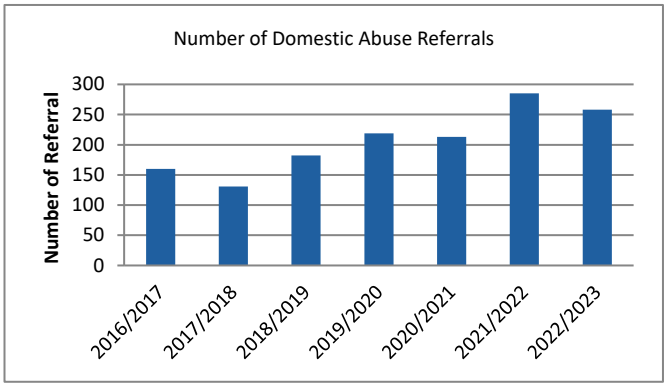
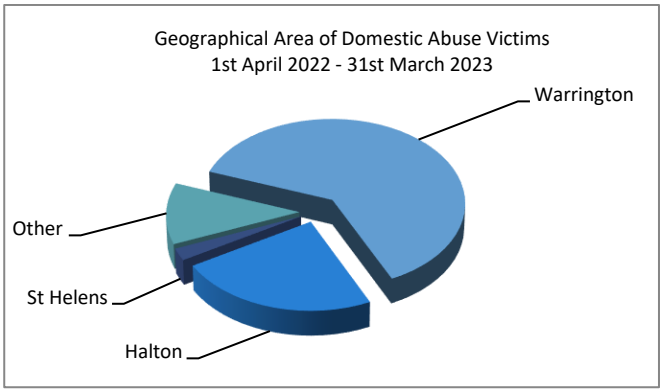


Figure 17



Key statistics for WHH include:

- 258 domestic abuse cases identified
- 10% victims were identified as men
- 48% of cases were referred to the children's team as they had children / unborns in the family
- 52% of cases were referred to the adult's team as they were adult only cases
- 46% cases were referred on to the appropriate MARAC (Multi -Agency Risk Assessment Conference)

7 Incident Reporting

DATIX incidents are responded to in a timely manner in collaboration with the appropriate Clinical Business Unit (CBU). Comparable data shows an increase in reporting safeguarding children's incidents by 4% (96 incidents in 21/22 versus 110 in 22/23). The highest reporting category being that an element of the WHH Safeguarding Children policy has not been followed. **See Figure 18** for breakdown of the top 5 themes. Some DATIX fall under more than one category. Adult safeguarding incidents have increased by 93% (90 incidents in 20/21 versus 174 incidents in 21/22) as noted in **Figure 19.** Each category and theme identified has associated actions monitored at the Safeguarding Committee. An analysis of incident data will be undertaken to understand the appropriateness of referral and the themes in greater detail.

Figure 18

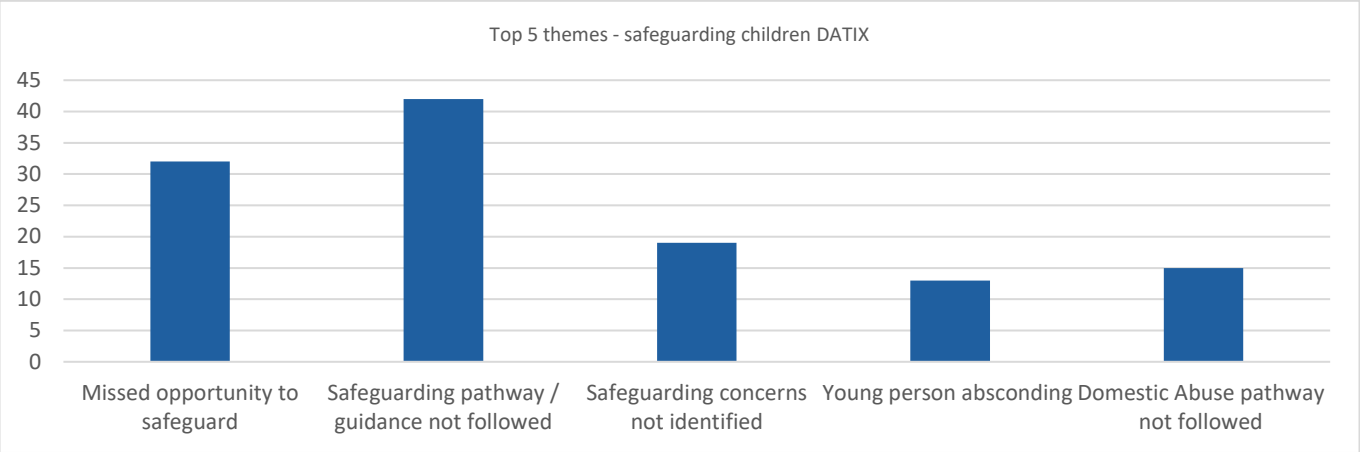
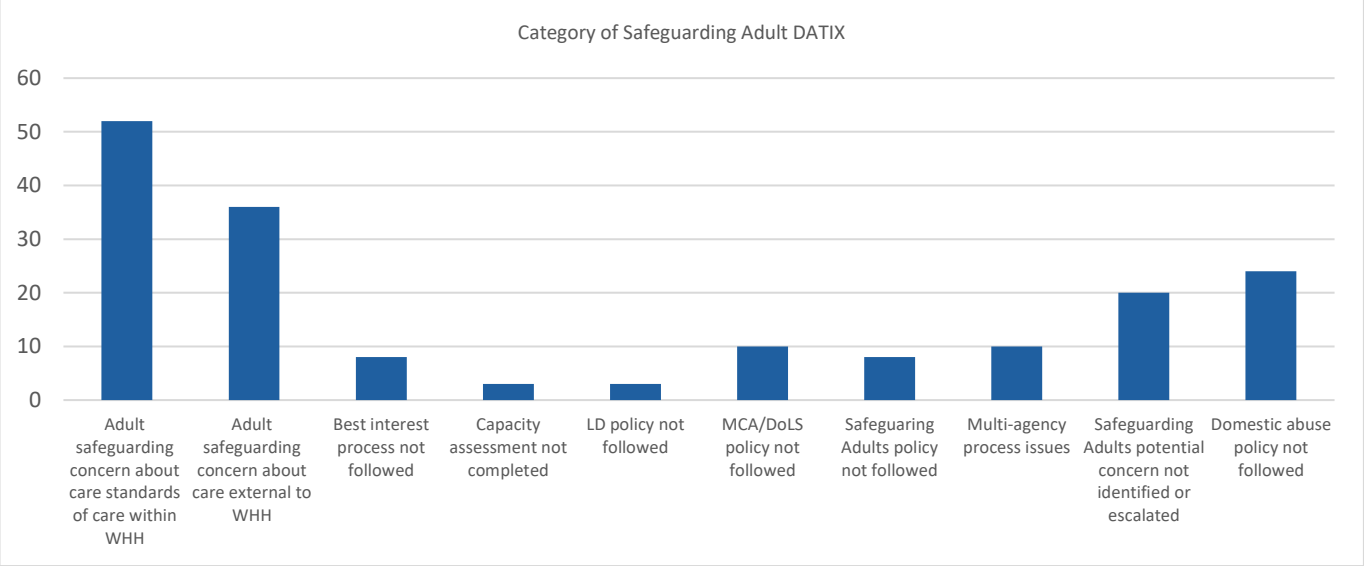


Figure 19



8. Safeguarding Training

8.1 Training Compliance

The table below **(figure 19)** provides an update on the training compliance from April 2022 to March 2023. All levels of training have increased in compliance across this reporting period. As demonstrated in **Figure 20**, safeguarding adult and child training is compliant with the exception of level 3 training. In quarter 3, this training (with the exception of level 3 child training) has been moved to a system of e-learning. This has been a positive measure and has been welcomed by staff. Departments are focusing upon improvement in level 3 training though there is a smaller cohort that require this. Trajectories are in place. Domestic Abuse, Learning Disability and Autism training commenced in February 2021 with the current trajectories on target for 2024 (3-year training plan).

Figure 20

Training – 1st April 2022 – 31st March 2023	Number of people to be trained	Number of people trained	Compliance
DoLS	2713	2431	89.51%
MCA	2805	2529	90.16%
WRAP	1813	1718	94.76%
Prevent Basic Awareness	4446	3928	88.35%
Safeguarding Children Level 1	1747	1580	90.44%
Safeguarding Children Level 2	2215	1761	79.50%
Safeguarding Children Level 3	475	314	66.11%
Adult safeguarding level 1 Face to face	1663	1420	85.39%
Adult safeguarding level 1 eLearning	1663	1521	91.46%
Adult safeguarding level 2 Face to face	1672	1308	78.23%
Adult safeguarding level 2 eLearning	1672	1453	86.90%
Adult safeguarding level 3	1103	532	48.23%
LD level one (this data is indicative of the training commenced in February 2021)	1420	1092	76.90%
LD level two (this data is indicative of the training commenced in February 2021)	2969	1965	66.18%
Autism level one (this data is indicative of the training commenced in February 2021)	1391	1118	80.37%
Autism level two (this data is indicative of the training commenced in February 2021)	2970	1950	65.66%
Domestic Abuse Level 1 (this data is indicative of the training commenced in February 2021)	4446	3776	84.93%
Domestic Abuse Level 2 (this data is indicative of the training commenced in February 2021)	2022	1286	63.06%
Domestic Abuse Level 3 (this data is indicative of the training commenced in February 2021)	2934	861	29.35%

9. Learning and Improving

9.1 Safeguarding Reviews

Safeguarding Practice Reviews / Local Learning Reviews

A Local Child Safeguarding Practice Review (LCSPR) is a locally conducted multi-agency review in circumstances where a child has been abused or neglected, resulting in serious harm or death, and/or there is cause for concern as to the way in which agencies have worked together to safeguard the child. The purpose of a review is to establish whether there are lessons to be learned about the way in which local professionals and agencies work together to safeguard children; identify what needs to be changed and, as a consequence, improve inter-agency working to better safeguard and promote the welfare of children.

The statutory guidance for Serious Child Safeguarding Reviews was updated in 2018, see Working Together to Safeguard Children 2018. Previously, these types of reviews were called Serious Case Reviews (SCRs).

WHH have supported the Warrington Safeguarding Children Partnership (WSP) and Halton Children and Young People Safeguarding Partnership (HCYPSP) with a total of 4 reviews. Any actions that arise from the reviews are monitored and tracked through the safeguarding committee.

Safeguarding Adult Reviews (SAR) / Domestic Homicide Reviews (DHR)

The Local Authority has a duty to investigate when an adult at risk comes to harm as a result of abuse or neglect. The purpose of a review is to establish whether there are lessons to be learned about the way in which local professionals and agencies work together to safeguard adults, identify what needs to be changed and as a consequence, improve inter-agency working to better safeguard and promote the welfare of adults. Statutory guidance laid out in the Care Act (2014) explains that the Local Authority should investigate where a concern meets this statutory guidance under section 42 of the Act. Where necessary a Serious Adult Review (SAR) is conducted in cases that meet section 44 of the Act, this happens where multi-agency involvement has contributed to the patients serious harm or death. Where death is the result of domestic abuse a Domestic Homicide Review is undertaken. At the time of writing WHH are supporting 5 reviews.

9.2 Mortality Review

The Mortality Review Group (MRG) meets monthly and has safeguarding representation to facilitate safeguarding oversight of the cases reviewed. In cases where issues/concerns are found learning is shared and used to update training. All patients who have passed away in the Trust who have a Learning Disability or were on DoLS when they passed away receive a Standard Judgement Review (SJR). The medical examiners review all deaths and those with identified learning are taken to MRG. Patients who have and LD, Autism diagnosis and those that passed away whilst on DoLS receive an additional review conducted by the safeguarding adult Lead Nurse and Safeguarding Adult named Dr that focuses on safeguarding, MCA and DoLS, mental health and LD/Autism practice and care delivery. Learning from this is shared at MRG and with the wider Trust via MRG newsletters and Safeguarding Committee. The LeDeR process is recognised by the MRG, completed SJRs contribute to the overall LeDeR review process. Child death cases are presented quarterly.

10. Prevent

Responsibilities under the Home Office Prevent Strategy were placed on a statutory footing from July 2015 with the introduction of the Counter Terrorism and Security Act 2015. Following a change announced in 2019 Prevent training is no longer reported via the Home Office and prevent trainers are no longer required to register with the Home Office. Instead, prevent activity and compliance is reported quarterly via NHS digital.

In line with National guidance, WHH Lead Nurse Adult Safeguarding is the prevent lead who attends regional and local prevent meetings ensuring that important information and learning is shared via Safeguarding Committee. Following the increase in terror activity in 2017 the Home Office instructed all Trusts of a requirement to achieve 85% training compliance with 3 yearly updates. WHH are currently above the required training target with 93% compliance.

A new arrangement across the Cheshire footprint has been implemented with partners from across Cheshire and Merseyside joining forces to share information and review radicalisation issues. The role of the Pan-Cheshire channel panel has been audited since the last annual report, to ensure the function complies with statutory guidance. The group were congratulated on their work. WHH is represented at the Pan-Cheshire Channel panel by the Lead Nurse Adult Safeguarding and relevant information for sharing is disseminated via Safeguarding Committee. WHH assurance data is reported on a quarterly basis in line with the statutory requirements.

11. Allegations against Staff

11.1 Children

All allegations of abuse of children by those who work with children must be taken seriously. Allegations against any person, who works with children, whether in a paid or unpaid capacity, cover a wide range of circumstances.

This procedure must be applied when there is such an allegation or concern that a person who works with children, has:

- Behaved in a way that has harmed a child or may have harmed a child.
- Possibly committed a criminal offence against or related to a child.
- Behaved towards a child or children in a way that indicates he or she may pose a risk of harm to children.

11.2 Adults

All allegations of abuse of adults by staff who are caring for patients using our services are taken seriously. Allegations against WHH staff, agency staff and those who come to our attention who work in other agencies are supported using WHH policy and the national PiPoT guidance.

This guidance is applied when:

- An allegation of assault to a patient has been made about a staff member
- A member of staff has been found to have committed a criminal offence related to an adult at risk
- Staff on staff assault or abuse
- A member of staff has accessed patient records inappropriately

There are currently no open cases requiring the support of the Local Authority Designated Officer (LADO) or PIPPOT (People in Position of Trust).

12. Achievements

The Safeguarding Team were nominated and chosen finalists in the WHH Thank You Awards under the category of Supporting Excellence.

(paragraph to be added here from the nomination booklet)

13. Assurance Statement

Whilst this Annual Report provides many examples of the positive and inspiring progress made in 2022/2023, it is important to prepare for the challenges ahead. Partnership working will continue to raise awareness and find solutions to tackling emergent and persistent safeguarding issues for health such as self-neglect and all age exploitation. Work continues to embed the Mental Capacity Act/Deprivation of Liberty Safeguards into practice will continue, as will promoting a culture of 'Making Safeguarding Personal' and 'Think Family'.

QUALITY ASSURANCE COMMITTE

AGENDA REFERENCE:	**QAC/23/07/153**			
SUBJECT:	**Infection Prevention and Control Board Assurance Framework Compliance Report**			
DATE OF MEETING:	11 July 2023			
AUTHOR(S):	Lesley McKay, Associate Chief Nurse, Infection Prevention + Control			
EXECUTIVE DIRECTOR SPONSOR:	Kimberley Salmon-Jamieson, Chief Nurse + Deputy Chief Executive			
LINK TO STRATEGIC OBJECTIVE:	SO1 We will.. Always put our patients first delivering safe and effective care and an excellent patient experience. SO2 We will.. Be the best place to work with a diverse and engaged workforce that is fit for now and the future. SO3 We will ..Work in partnership with others to achieve social and economic wellbeing in our communities.			
EXECUTIVE SUMMARY	To provide the Quality Assurance Committee with assurance on actions in place to meet legislative requirements relating to the prevention and control of infection linked directly to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.			
PURPOSE: (please select as appropriate)	Information	Approval	To note X	Decision
RECOMMENDATIONS:	The Quality Assurance Committee is asked to receive the report			
PREVIOUSLY CONSIDERED BY:	**Committee**			
	Agenda Ref.			
	Date of meeting			
	Summary of Outcome			
NEXT STEPS: ***State whether this report needs to be referred to at another meeting or requires additional monitoring***	**Submit to Trust Board**			
FREEDOM OF INFORMATION STATUS (FOIA):	**Release in Full**			
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None			

Infection Control Sub-Committee

SUBJECT	IPC Board Assurance Framework Covid-19	AGENDA REF:	QAC/23/07/153

1. BACKGROUND/CONTEXT

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

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

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

Legislative requirements relating to Covid-19 include: -

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

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

This assessment has been made against version 1.11 of the Infection Prevention and Control Board Assurance Framework published in September 2022.

The Board Assurance Framework was revised and an updated version published in April 2023, which incorporates the National Infection Control Manual for England. Future assessments will be carried out using the updated assessment template biannually and an action plan will be devised to address gaps in assurance/areas of concern.

2. KEY ELEMENTS

Please see Appendix 1 for compliance assessment.

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

3. ACTIONS REQUIRED/RESPONSIBLE OFFICER

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

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

4. IMPACT ON QPS?

- **Q**: Visiting restrictions have been lifted and returned to pre-pandemic visiting times

- **P**: Risk to staff health and wellbeing from anxiety associated with the unknown situation and risk of infection of self and family members. Risk from continuous high pressure/demand on healthcare services. Staff absence due to infection or vulnerability status

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

5. MEASUREMENTS/EVALUATIONS

- Incident reporting
- IPC BAF action plan monitoring
- Environmental action plan monitoring
- Learning from Covid-19 action plan
- Nosocomial case monitoring and outbreak detection and reporting

6. TRAJECTORIES/OBJECTIVES AGREED

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

7. MONITORING/REPORTING ROUTES

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

8. TIMELINES

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

9. ASSURANCE COMMITTEE

- Infection Control Sub-Committee

10. RECOMMENDATIONS

The Quality Assurance Committee is asked to receive the report.

APPENDIX 1 Infection Prevention and Control Board Assurance Framework Compliance Assessment 06 2023

1. Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks their environment and any other users may pose to them.				**RAG**
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure that:				
A respiratory plan incorporating respiratory seasonal viruses that includes: - point of care testing (POCT) methods for infectious patients known or suspected to have a respiratory infection to support patient triage/ placement according to local needs, prevalence, and care services	Triage tool in ED: Molecular Point of Care Testing for Covid-19. Seasonal respiratory testing SOPs Adult and Paediatric (including Influenza A/B; RSV and Covid-19) for patients attending ED with respiratory symptoms.			
- segregation of patients depending on the infectious agent taking into account those most vulnerable to infection e.g., clinically immunocompromised	ED triage and placement according to respiratory/non-respiratory presentation. Liaison with Patient Flow on Covid status to ensure appropriate isolation or cohorting on admission Immunosuppressed patient isolation Guidelines in addition to consideration in the SOPs			
- a surge/escalation plan to manage increasing patient/staff infections	Respiratory infection capacity escalation plan discussed and agreed at Event Planning meetings	Demand for side rooms exceeds capacity	Liaison with Patient Flow Team throughout each day to optimise side room use, based on infection transmission risks and positive results	
- a multidisciplinary team approach is adopted with hospital leadership, operational teams estates & facilities, IPC Teams, and clinical and non-clinical staff to assess and plan for creation of	Additional side room capacity created with pods inserted in - ED x1 - ICU x5 - B18 x4			

APPENDIX 1 Infection Prevention and Control Board Assurance Framework Compliance Assessment 06 2023

1. Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks their environment and any other users may pose to them.				**RAG**
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure that:				
adequate isolation rooms/cohort units as part of the plan	Additional side rooms created on Wards - A2 - A3 - A6 - A9 - C21 Escalation plan includes cohorting			
Organisational /employers risk assessments in the context of managing infectious agents are: - based on the measures as prioritised in the hierarchy of controls, - applied in order and include elimination; substitution, engineering, administration and PPE/RPE - communicated to staff - further re-assessed where there is a change or new risk identified e.g., changes to local prevalence	Risk assessments in place for all locations in the Trust based on hierarchies of control with template approved at Tactical meetings			
The Completion of risk assessments have been approved through local governance procedures, for example Integrated Care Systems	All completed risk assessments are reviewed by the Head of Safety and Risk at WHH			
Risk assessments are carried out in all areas by a competent person with the skills, knowledge, and experience to be able to	All completed risk assessments are reviewed by the Head of Safety and Risk at WHH			

APPENDIX 1 Infection Prevention and Control Board Assurance Framework Compliance Assessment 06 2023

1. Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks their environment and any other users may pose to them.				**RAG**
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure that:				
recognise the hazards associated with infectious agents				
Ensure that transfers of infectious patients between care areas are minimised and made only when necessary for clinical reasons	Patients are allocated to wards based on speciality requirements	Operational pressures can impact on allocation to speciality area	Operational and Patient Flow teams work cohesively to minimise patient transfers as far as reasonably practicable	
Resources are in place to monitor and measure adherence to the NIPCM. This must include all care areas and all staff (permanent, flexible, agency and external contractors)	IPC annual audit programme Hand hygiene audit programme Standard Precautions Audit Covid-19 AGP/non-AGP audits	Robust plan for decontamination audits	Work in progress to implement decontamination audits with the medical devices co-ordinator	
The application of IPC practices within the NICM is monitored, e.g., 10 elements of SICPs	IPC annual audit programme Standard Precautions Audits Hand hygiene audit programme Standard Precautions Audit Covid-19 AGP/non-AGP audits			
The IPC Board Assurance Framework is reviewed, and evidence of assessments are made available and discussed at Trust board	Bimonthly review Board meeting agendas Board meeting minutes			
The Trust Board has oversight of incidents/ outbreaks and associated action plans	- Information on outbreaks included in daily executive summary and discussed at the daily Senior Executive Oversight Group Meeting - Outbreak email circulation list - Quarterly DIPC reports include details on incidents/outbreaks			

APPENDIX 1 Infection Prevention and Control Board Assurance Framework Compliance Assessment 06 2023

1. Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks their environment and any other users may pose to them.				**RAG**
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure that:				
The Trust is not reliant on a single respirator mask type and ensures that a range of predominantly UK made FFP3 masks are available to users as required	Fit Testing programme in place and includes a plan to ensure that staff are fit tested for a minimum of 2 types of UK manufactured mask and there is no more than 25% compliance with a single respirator	Fit testing compliance data at 61% November 2022 (for 2 masks) Requirement to repeat Fit test 2 yearly Need to ensure no more than 25% compliance on one type of mask Fit tester retraining plan to maintain competency Records in ESR are currently in the property register section	CBU Leads contacted to drive improvements in Fit testing Review to move records to staff training section to prompt follow-up of fit testing and to allow continued compliance figure monitoring.	

2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections				**RAG**
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure that:				
The Trust has a plan in place for the implementation of the National Standards of Healthcare Cleanliness and this plan is monitored at board level. B0271-national-standards-of-healthcare-cleanliness-2021.pdf (england.nhs.uk)	Task and Finish Group established with Action Plan in place for implementation. Progress included in IPC quarterly reports to QAC / Trust Board The Commitment to cleanliness charter has been approved, signed, and is displayed in all areas with	Agreement on roles and responsibilities for cleaning Rectification process and timescales for cleaning standards improvement when score falls below	Plan to agree and sign off by January 2023 Draft plan awaiting sign off with rectification timescale to be agreed	

APPENDIX 1 Infection Prevention and Control Board Assurance Framework Compliance Assessment 06 2023

2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections				**RAG**
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure that:				
	information on Functional risk categories. Star ratings are displayed	minimum level for the functional risk category Efficacy audits Use of IT for auditing (not mandated – but good practice)	Plan drafted to review by functional risk categories (1 – 4) with a multi-disciplinary team IT system is under review to interface with the Estates system	
The organisation has systems and processes in place to identify and communicate changes in the functionality of areas/rooms	Communications team are involved in changes of functionality and ensure information is cascaded and signage updated and displayed			
Cleaning standards and frequencies are monitored in clinical and non-clinical areas with actions in place to resolve issues in maintaining a clean environment.	Robust audit programme with timely feedback for corrective action as per the national cleanliness standards	Rectification process and timescales for cleaning standards improvement when score falls below minimum level for the functional risk category	Draft plan awaiting sign off with rectification timescale to be agreed	
Enhanced/Increased frequency of cleaning should be incorporated into the environmental decontamination schedules for patient with known/suspected infections as per the NIPCM (Section 2.3) or local policy and staff are appropriately trained	Additional cleaning of outbreak areas including frequently touched surfaces Use of chlorine-based disinfectants implemented Use of HPV for terminal decontamination Adherence to COSHH			

2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections				**RAG**
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure that:				
	Colour coded cleaning equipment Terminal cleaning guidelines			
Manufacturers' guidance and recommended product 'contact time' is followed for all cleaning/disinfectant solutions/products.	Information on contact time is included in the decontamination policy Staff training on chlorine-based disinfectants and dilution and usage posters for disinfection SOP for HPV decontamination with equipment used by trained personnel			
For patients with a suspected/known infectious agent the frequency of cleaning should be increased particularly in: - patient isolation rooms - cohort areas - donning & doffing areas – if applicable - 'Frequently touched' surfaces e.g., door/toilet handles, chair handles, patient call bells, over bed tables and bed/trolley rails - where there may be higher environmental contamination rates, including toilets/commodes particularly if patients have diarrhoea and/or vomiting	Colour coded cleaning in place - Twice daily cleaning in place - Ring the bell it's time for Clinell campaign - Domestic staff record when they have cleaned areas - Enhanced cleaning – all areas, including non-clinical, supplied with desk wipes - Domestic staff will time cleaning activity when areas are vacant - Increased cleaning included in ICU Isolation pod SOP - Review of guidance to reduce			

APPENDIX 1 Infection Prevention and Control Board Assurance Framework Compliance Assessment 06 2023

2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections				**RAG**
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure that:				
The responsibility of staff groups for cleaning/decontamination are clearly defined and all staff are aware of these as outlined in the National Standards of Healthcare Cleanliness	National Cleaning Standards Action Plan	Roles and responsibilities under review and will be on a recurring annual schedule for review or updated sooner where significant changes are required	Plan to agree and sign off by January 2023	
A terminal clean of inpatient rooms is carried out: - when the patient is no longer considered infectious - when vacated following discharge or transfer (this includes removal and disposal/or laundering of all curtains and bed screens) - following an AGP if clinical area/room is vacated (clearance of infectious particles after an AGP is dependent on the ventilation and air change within the room).	- Terminal cleaning and decontamination polices in place and include guidance on environmental disinfectant for decontamination of the environment - The Head of Facilities is a member of the Infection Control Sub-Committee - Terminal cleaning standards sign off checklist - Ventilation Group and Ventilation Policy	Ventilation and air changes per hour in all areas is not unknown	Discussion on down time following areas where AGPs are performed based on air changes/hour where known and time extended in areas where mechanical ventilation is not available	

NHS England » Infection prevention and control boardassurance framework

APPENDIX 1 Infection Prevention and Control Board Assurance Framework Compliance Assessment 06 2023

2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections				**RAG**
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure that:				
Reusable non-invasive care equipment is decontaminated: - between each use - after blood and/or body fluid contamination - at regular predefined intervals as part of an equipment cleaning protocol - before inspection, servicing, or repair equipment.	- Included in Decontamination Policy which incorporates single use and single patient use guidance - Green I am clean indicator tape for items cleaned/ decontaminated at ward level Cleaning monitoring audits - Blood and body fluid spillage guidelines - Policy and certification process to confirm cleaning prior to service inspection or repair - Dynamic mattresses are cleaned off site by contractual arrangements			
Compliance with regular cleaning regimes is monitored including that of reusable patient care equipment	Robust audit programme according to functional risk categories with timely feedback for corrective action as per the national cleanliness standards			
Ventilation systems, should comply with HTM 03:01 and meet national recommendations for minimum air changes https://www.england.nhs.uk/publication/specialised-ventilation-for-healthcare-buildings/	Trust wide audit	Some areas below HTM standards	Requirement for Estate overview discussed at Ventilation Group and action plan to be developed to address non-compliant areas	
Ventilation assessment is carried out in conjunction with organisational estates teams and or specialist advice from ventilation group	The Trust is supported by an Appointed Authorising Engineer/ Ventilation.			

NHS England » Infection prevention and control boardassurance framework

2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections				**RAG**
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure that:				
and or the organisations, authorised engineer and plans are in place to improve/mitigate inadequate ventilation systems wherever possible	Guidance sought from the appointed Authorising Engineer/Ventilation on all capital projects with sign off of plan			
Where possible air is diluted by natural ventilation by opening windows and doors where appropriate	'Give fresh air to show you care' campaign in warmer weather			

3. Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance				**RAG**
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				

Arrangements for antimicrobial stewardship are maintained and a formal lead for AMS is nominated
- NICE Guideline NG15 https://www.nice.org.uk/guidance/ng15 is implemented – Antimicrobial Stewardship: systems and processes for effective antimicrobial medicine use
- the use of antimicrobials is managed and monitored:
  - to optimise patient outcomes
  - to minimise inappropriate prescribing
  - to ensure the principles of Start Smart, Then Focus are followed https://www.gov.uk/government/pu
	- Consultant Microbiologist is formally nominated as lead for AMS
	- NICE Guidance is implemented
	- Antimicrobial Management Steering Group in place – meet quarterly
	- Daily (weekdays) Ward Round in Critical Care
	- Ward based Pharmacist support
	- Prescribing advice available by telephone (in and out of hours 24/7)			

3. Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance				**RAG**
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
blications/antimicrobial-stewardship-start-smart-then-focus	- Pharmacist prescribing support on all inpatient wards - Infection Control Doctor presentations to Medical Cabinet - Formulary reviewed as evidence/ guidelines are updated - C difficile outliers ward rounds - Quarterly Point Prevalence audits with concerns discussed at Medical Cabinet and Infection Control Sub-Committee - Antimicrobial Stewardship is included in the IPC Strategy 2022 – 2023 - Participation in World Antibiotic Awareness Week in November each year			
Contractual reporting requirements are adhered to, and boards continue to maintain oversight of key performance indicators for prescribing including: - total antimicrobial prescribing; - broad-spectrum prescribing; - intravenous route prescribing; adherence to AMS clinical and organisational audit standards set by NICE: https://www.nice.org.uk/guidance/ng15/resources	- Mandatory reporting of HCAIs has continued to be completed timely - Prescribing data is available on fingertips			

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3. Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance				**RAG**
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
- resources are in place to support and measure adherence to good practice and quality improvement in AMS. This must include all care areas and staff (permanent, flexible, agency and external contractors)	- DIPC reports HCAI data at Trust Board include antimicrobial audit data			

4. Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion.				**RAG**
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
IPC advice/resources/information is available to support visitors, carers, escorts, and patients with good practices e.g., hand hygiene, respiratory etiquette, appropriate PPE use	Information available on Trust website Signage displayed on - Hand hygiene - Catch it, bin it kill it - Poster display where there are outbreaks			
Visits from patient's relatives and/or carers (formal/informal) should be encouraged and supported whilst maintaining the safety and wellbeing of patients, staff, and visitors	Visiting restrictions lifted and returned to pre-pandemic visiting times 1st June 2022			
National principles on inpatient hospital visiting and maternity/neonatal services will remain in place as an absolute minimum	National Guidance implemented - Visitors with symptoms of infection are advised not to visit			

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4. Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion.				**RAG**
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
standard. national guidance on visiting patients in a care setting is implemented.	- Two visitors per bed (additional if interpreter support is required) - Face coverings as per local risk assessment/dependant on outbreak/prevalence - Compassionate visiting considerations at end of life			
Patients being accompanied in urgent and emergency care (UEC), outpatients or primary care services, should not be alone during their episode of care or treatment unless this is their choice.	Restrictions lifted and returned to pre-pandemic guidance on 1st June 2022			
Restrictive visiting may be considered appropriate during outbreaks within inpatient areas This is an organisational decision following a risk assessment and should be communicated to patients and relatives.	Visiting may be restricted during outbreaks. Next of Kins informed of ward outbreaks and risks.			
There is clearly displayed, written information available to prompt patients' visitors and staff to comply with handwashing, respiratory hygiene, and cough etiquette. The use of facemasks/face coverings should be determined following a local risk assessment	Signage across the Trust including at entrances and in public toilets: - Face masks - Hand washing - Social distancing suspended signage from ceilings on all corridors and at entrances/exits		Every action counts campaign signage – roll out plan in place Leaflets on face mask wearing provided January 2022	

4. Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion.				**RAG**
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
	- PPE/ mask stations located at entrances/exits alongside alcohol-based hand gels - Facemasks no longer required, and guidance implemented from 13th June 2022 with personal choice to wear a face covering supported			
If visitors are attending a care area with infectious patients, they should be made aware of any infection risks and offered appropriate PPE	PPE provided at all Trust entrances and entrances to wards Ward staff assist visitors with PPE where required			
Visitors, carers, escorts who are feeling unwell and/or who have symptoms of an infectious illness should not visit Where the visit is considered essential for compassionate (end of life) or other care reasons (e.g., parent/child) a risk assessment may be undertaken, and mitigations put in place to support visiting.	Visitor Risk assessment Visiting restrictions lifted and returned to pre-pandemic visiting times following Guidance on 1st June 2022 The IPC Team give advice to support visiting in compassionate situations			
Visitors, carers, escorts should not be present during AGPs on infectious patients unless they	FFP3 Fit testing for visitors to ICU			

4. Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion.				**RAG**
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
are considered essential following a risk assessment e.g., carer/parent/guardian.				
Implementation of the supporting excellence in infection prevention and control behaviours Implementation Toolkit has been adopted where required C1116-supporting-excellence-in-ipc-behaviours-imp-toolkit.pdf (england.nhs.uk)	Campaign posters received and roll- out plan devised	Images of WHH staff selected for campaign use Wellbeing support area established	Roll out completed January 2022	

5. Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people				**RAG**
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
All patients are risk assessed, if possible, for signs and symptoms of infection prior to treatment or as soon as possible after admission, to ensure appropriate placement and actions are taken to mitigate identified infection risks (to staff and other patients).	Infection risk assessments are completed on all patients at admission and updated in light of emerging infections/specimen results Electronic Patient records are flagged with known infection risks			
Signage is displayed prior to and on entry to all health and care settings instructing patients with respiratory symptoms to inform receiving reception staff, immediately on their arrival (see NIPCM).	Signage displayed at all main entrances Information is available on the Trust website			

5. Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people				**RAG**
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
The infection status of the patient is communicated prior to transfer to the receiving organisation, department or transferring services ensuring correct management /placement	- SBAR transfer form in place - Electronic Patient Records are flagged with infection alerts - Infection assessment on x-ray referral forms	Limited number of side rooms	Liaison with Patient Flow Team throughout each day to optimise side room use, based on infection transmission risks	
Triaging of patients for infectious illnesses is undertaken by clinical staff based on the patients' symptoms/clinical assessment and previous contact with infectious individuals, the patient is placed /isolated or cohorted accordingly whilst awaiting test results. This should be carried out as soon as possible following admission and a facemask worn by the patient where appropriate and tolerated.	- Senior ED staff triage patients and liaise with Patient Flow Team - Advice on use of face mask if tolerated is in place			
Patients in multiple occupancy rooms with suspected or confirmed respiratory infections are provided with a surgical facemask (Type II or Type IIR) if this can be tolerated	- Use of facemasks can be recorded in Electronic patient record			
Patients with a suspected respiratory infection are assessed in a separate area, ideally a single room, and away from other patients pending their test result and a facemask worn by the patient where appropriate and tolerated (unless in a single room/isolation suite).	ED segregation of respiratory non-respiratory areas			

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5. Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people				**RAG**
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
Patients with excessive cough and sputum production are prioritised for placement in single rooms whilst awaiting test results and a facemask worn by the patient where appropriate and tolerated only required if single room accommodation is not available.	Prioritisation for side rooms is based on suspected/known diagnosis	Demand for side rooms exceeds capacity	Liaison with Patient Flow Team throughout each day to optimise side room use, based on transmission risks	
Patients at risk of severe outcomes of infection receive protective IPC measures depending on their medical condition and treatment whilst receiving healthcare e.g., priority for single room protective isolation	Isolation Policy Isolation of immunocompromised patient s policy Side room optimisation with IPC and Patient Flow using side room isolation tool and transmission-based precautions			
If a patient presents with signs of infection where treatment is not urgent consider delaying this until resolution of symptoms providing this does not impact negatively on patient outcomes	Virtual Ward Pathways		Consultant decision to proceed if urgent	
The use of facemasks/face coverings should be determined following a local risk assessment.	Step down of universal masking in June 2022 Masks worn during outbreaks of respiratory infections			
Patients that attend for routine appointments who display symptoms of infection are managed appropriately, sensitively, and according to local policy.	Staff are advised not to attend routine appointments if unwell			

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5. Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
Staff and patients are encouraged to take up appropriate vaccinations to prevent developing infection	Influenza campaign Covid-19 booster campaign			
Two or more infection cases linked in time, place and person trigger an incident/outbreak investigation and are reported via reporting structures.	Major Outbreak of Infection Policy Reporting to UKHSA in place			

6. Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
IPC education is provided in line with national guidance/recommendations for all staff commensurate with their duties.	IPC Mandatory training programme in line with Core Skills Framework Level 1 and Level 2 training	Level 2 clinical IPC training 84% at the end of May 2023.	Trajectories set by CBUs with less than 85% compliance. 2 taught sessions per week and eLearning option	
Training in IPC measures is provided to all staff, including the correct use of PPE	Fit Testing programme UK HSA training videos shown during mandatory training sessions Aide memoire posters on donning and doffing are displayed in all clinical areas			

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6. Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection				**RAG**
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
	Hand hygiene technique is displayed on all soap dispensers Training for Helping Hands staff IPC Team out of hours advice IPCN and Consultant Microbiologist Departmental visits to provide support			
All staff providing patient care and working within the clinical environment are trained in hand hygiene technique as per the NIPCM and the selection and use of PPE appropriate for the clinical situation and on how to safely put it on and remove it (NIPCM);	Mandatory IPC Training package Hand hygiene training strategy with rotation of UV light boxes for testing hand hygiene technique PPE Champions (58), training and cascaded roving training on donning and doffing of PPE			
Adherence to national guidance on the use of PPE is regularly audited with actions in place to mitigate any identified risk	PPE audits in place Concerns identified are addressed at the time of audit Increased auditing schedule during outbreaks Standard PPE Audit tool implemented for use during outbreaks			

6. Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection				**RAG**
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
Gloves and aprons are worn when exposure to blood and/or other body fluids, non-intact skin or mucous membranes is anticipated or in line with SICP's and TBP's.	Standard precautions and PPE guidelines			
Hand hygiene is performed: - before touching a patient. - before clean or aseptic procedures. - after body fluid exposure risk. - after touching a patient; and - after touching a patient's immediate surroundings.	Weekly hand hygiene audits in inpatient areas			
The use of hand air dryers should be avoided in all clinical areas. Hands should be dried with soft, absorbent, disposable paper towels from a dispenser which is located close to the sink but beyond the risk of splash contamination (NIPCM)	- Hand air dryers not in place in clinical areas - Access to hand hygiene facilities (stock of liquid soap, hand gel and paper towels is included in the auditing template) - Removal of hand driers in public toilets (none in clinical areas) has taken place as part of the environmental action plan - Hand towel dispensers have been installed and waste collection schedule put in place			

6. Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
Staff understand the requirements for uniform laundering where this is not provided for onsite	Guidance included in Uniform Policy and Covid-19 PPE booklet. Scrub suit provided for use in place of uniforms which are laundered by the Trust during the pandemic			

7. Provide or secure adequate isolation facilities				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
Clear advice is provided; and the compliance of facemask wearing for patients with respiratory viruses is monitored (particularly when moving around the ward or healthcare facility) providing it can be tolerated and is not detrimental to their (physical or mental) care needs.	Patient information leaflet circulated in January 01/2022 promoting use of face masks for in patients Signage on display advising use of face masks Facemasks no longer required for patients, and guidance implemented from 13th June 2022 Use of Facemasks included in TB Guidance			
Patients who are known or suspected to be positive with an infectious agent where their treatment cannot be deferred, care is provided following the NIPCM.	Isolation Policy Immunosuppressed Patient Guidelines			

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7. Provide or secure adequate isolation facilities				**RAG**
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
Patients are appropriately placed i.e.; infectious patients are ideally placed in a single isolation room If a single/isolation room is not available, cohort patients with confirmed respiratory infection with other patients confirmed to have the same infectious agent.	Isolation Policy Immunosuppressed Patient Guidelines Respiratory Pathway SOPS (Adult and Paediatric			
Standard infection control precautions (SIPC's) are applied for all, patients, at all times in all care settings	Standard Precautions Policy Standard Precautions Audit Tool			
Transmission Based Precautions (TBP) may be required when caring for patients with known/ suspected infection or colonization	Isolation Policy Immunosuppressed Patient Guidelines Respiratory Pathway SOPS (Adult and Paediatric			

8. Secure adequate access to laboratory support as appropriate				**RAG**
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
Laboratory testing for infectious illnesses is undertaken by competent and trained individuals.	Training on swabbing technique provided verbally and by video and competency assessment tool launched Training provided on use of point of care molecular testing equipment			

8. Secure adequate access to laboratory support as appropriate				**RAG**
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
	UKAS accredited laboratory with Quality Control checks in place			
Patient testing for infectious agents is undertaken promptly and in line with national guidance	Swabbing SOP in place Quadplex testing (Influenza A/B RSV – in addition to Covid-19) for patients presenting with respiratory symptoms Legionella and Pneumococcal antigen testing			
Staff testing protocols are in place for the required health checks, immunisations, and clearance	Health Clearance Policy			
There is regular monitoring and reporting of the testing turnaround times, with focus on the time taken from the patient to time result is available	Local data available on testing turnaround times			
Inpatients who go on to develop symptoms of infection after admission are tested/retested at the point symptoms arise. COVID-19 Specific	Testing requirement included in the Respiratory testing SOP			
Patients discharged to a care home are tested for SARS-CoV-2, 48 hours prior to discharge (unless they have tested positive within the previous 90 days), and result is communicated to receiving organisation prior to discharge.	Discharge screening in place with results shared accordingly prior to patient discharge			

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8. Secure adequate access to laboratory support as appropriate				**RAG**
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
Coronavirus (COVID-19) testing for adult social care services - GOV.UK (www.gov.uk) For testing protocols please refer to: COVID-19: testing during periods of low prevalence - GOV.UK (www.gov.uk) C1662_covid-testing-in-periods-of-low-prevalence.pdf (england.nhs.uk)	Discharge to care home SOP in place including process to check results prior to discharge Additional of Lateral Flow Device testing prior to discharge to Care Homes if prior covid positive test within <90 days. PCR testing for negative patients remains in place. Lateral Flow Device testing for patients who require on going social care and no history OF Covid-19			

9. Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections				**RAG**
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
Resources are in place to implement, measure and monitor adherence to good IPC and AMS practice. This must include all care areas and all staff (permanent, flexible, agency and external contractors).	Access to: - PPE - Hand hygiene products Auditing programme			
Staff are supported in adhering to all IPC and AMS policies.	Mandatory IPC training Microguide antibiotic prescribing App Local training Single Point Lessons			

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9. Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections				**RAG**
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
Policies and procedures are in place for the identification of and management of outbreaks of infection. This includes the documented recording of an outbreak.	Major Outbreak of Infection Guidelines			
All clinical waste and infectious linen/laundry used in the care of known or suspected infectious patients is handled, stored and managed in accordance with current national guidance as per NIPCM	- Waste handling, segregation, and disposal guidelines - Laundry Policy - Waste segregation included in mandatory training - All waste bins have colour coded lids and signage to denote waste category			
PPE stock is appropriately stored and accessible to staff when required as per NIPCM	- Stock control in place - In and out of hours access protocol in place - National distribution to maintain stock levels			

10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection				**RAG**
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
Staff seek advice when required from their IPCT/occupational health department/GP or employer as per their local policy	SOP for staff Covid-19 testing Occupational Health and Wellbeing available to provide advice on attendance at work where there are concerns about other infections			

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10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection				**RAG**
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
Bank, flexible, agency, and locum staff follow the same deployment advice as permanent staff.	Bank, agency, and locum staff follow the same deployment advice as permanent staff			
Staff understand and are adequately trained in safe systems of working commensurate with their duties.	IPC Mandatory training Level 1 and Level 2. Contractor information leaflet PPE Donning and Doffing training			
A fit testing programme is in place for those who may need to wear respiratory protection.	Fit testing programme is in place			
Where there has been a breach in infection control procedures staff are reviewed by occupational health. Who will: - lead on the implementation of systems to monitor for illness and absence. - facilitate access of staff to treatment where necessary and implement a vaccination programme for the healthcare workforce as per public health advice. - lead on the implementation of systems to monitor staff illness, absence, and vaccination. - encourage staff vaccine uptake.	Outbreak meeting discussions on exposed staff Datix reports on workplace exposure incidents Vaccination and Post exposure prophylaxis treatment will be co-ordinated if advised by UKHSA according to pathogen			
Staff who have had and recovered from or have received vaccination for a specific respiratory pathogen continue to follow the	IPC policy Respiratory Infection SOPs			

10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection				**RAG**
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
infection control precautions, including PPE, as outlined in NIPCM	Staff seasonal influenza vaccination programme commenced in September 2022			
A risk assessment is carried out for health and social care staff including pregnant and specific ethnic minority groups who may be at high risk of complications from respiratory infections such as influenza or severe illness from COVID-19. ○ A discussion is had with employees who are in the at-risk groups, including those who are pregnant and specific ethnic minority groups. ○ that advice is available to all health and social care staff, including specific advice to those at risk from complications. ○ Bank, agency, and locum staff who fall into these categories should follow the same deployment advice as permanent staff. ○ A risk assessment is required for health and social care staff at high risk of complications, including pregnant staff.	- An integrated self-risk assessment tool has been produced for all staff to identify if they are 'at-risk'. - Following identification (through the tool or the personal information held on individuals), and a subsequent detailed risk assessment is completed for all staff who are within an 'at-risk' group - Individual letters have been sent to BAME members of staff, outlining support available - Named midwife contact within Maternity Department provides advice for pregnant staff - All staff who are considered clinically extremely vulnerable are supported by robust workforce support and the Trust are in the process of having one to one discussion to agree support and adjustments			

10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection				**RAG**
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
	- All staff working at home have been provided with a 'working from home pack', including access to mental health support - Enhanced Occupational Health Service to 7 days per week with additional staffing both administration and clinical. Service resumed to 5 day working - An enhanced wellbeing offer has been developed, linked to learning from Wuhan, Italy, and the British Psychological Society - Electronic system in place for Covid-19 Workforce risk assessment - Access to face-to-face counselling - Wellbeing Wednesday emails			
Testing policies are in place locally as advised by occupational health/public health.	Health Clearance Policy			
NHS staff should follow current guidance for testing protocols: C1662_covid-testing-in-periods-of-low-prevalence.pdf (england.nhs.uk)	Asymptomatic staff testing for Covid-19 paused Protocol in place for return-to-work Lateral Flow Device Testing clearance			

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

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10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection				**RAG**
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
All staff required to wear an FFP3 respirator should be fit tested to use at least two different masks	Fit testing programme in place	Fit testing compliance data against 2 masks at 61% November 2022	CBU Leads contacted to drive improvements in Fit testing	
Those who fail a fit test, there is a record given to and held by employee and centrally within the organisation of repeated testing on alternative respirators or an alternative is offered such as a powered hood	- Spreadsheet with Fit testing details included	Data not held on ESR	Action in place to review use of ESR for recording Fit Testing records	
That where fit testing fails, suitable alternative equipment is provided. Reusable respirators can be used by individuals if they comply with HSE recommendations and should be decontaminated and maintained according to the manufacturer's instructions	- Alternative respiratory protection is offered i.e., powered hood - Staff are redeployed to green pathway areas or amber areas where aerosol generating procedures are not performed - Provision of specialist PPE equipment is recorded including advice on decontamination of re-usable PPE			
Members of staff who fail to be adequately fit tested: a discussion should be had, regarding re deployment opportunities and options commensurate with the staff members skills and experience and in line with nationally agreed algorithm	- Alternative respiratory protection is offered i.e., powered hood - Staff are redeployed to green pathway areas or amber areas where aerosol generating procedures are not performed			

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10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection				**RAG**
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
	- Provision of specialist PPE equipment is recorded including advice on decontamination of re-usable PPE			
A documented record of this discussion should be available for the staff member and held centrally within the organisation, as part of employment record including Occupational health.	Provision of specialist PPE equipment is recorded	Documented evidence of discussion and central holding of this record	Process under review to capture this data	
A documented record of this discussion should be available for the staff member and held centrally within the organisation, as part of employment record including Occupational health.	- Provision of specialist PPE equipment is recorded	- Documented evidence of discussion and central holding of this record	- Process under review to capture this data	
Boards have a system in place that demonstrates how, regarding fit testing, the organisation maintains staff safety and provides safe care across all care settings. This system should include a centrally held record of results which is regularly reviewed by the board.	- Records in ESR are currently in the property register section - Compliance with Fit testing is monitored at Infection Control Sub-Committee and reported to QAC and Trust Board	Training records being added to ESR under compliance Fit testing compliance data against 2 masks at 61% November 2022 Requirement to repeat Fit test 2 yearly Need to ensure no more than 25% compliance on one type of mask Fit tester retraining plan to maintain competency	CBU Leads contacted to drive improvements in Fit testing Review to move records to staff training section to prompt follow-up of fit testing and to allow continued compliance figure monitoring.	

10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection				**RAG**
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
Staff who have symptoms of infection or test positive for an infectious agent should have adequate information and support to aid their recovery and return to work.	- A COVID-19 Occupatinal Health advice line has been created, to provide a range of advice and guidance to the workforce - The OH Service has also developed the co-ordination and advice service for staff testing (for symptomatic staff) - Enhanced Occupational Health Service to 7 days per week with additional staffing both administration and clinical. Service returned to 5 days - Occupational Health and Wellbeing advise staff of test results and provide further wellbeing support as and when required - Retesting is in place as appropriate and is set out in Staff Testing SOP - Occupational Health e-mail to staff and their manager with return-to-work guidance	- Test and Trace Service hours of operation	- Notifications from Test and Trace are received in the Control Room and forwarded to the Occupational Health and Infection Control Teams for action	

APPENDIX 2 Action Plan for IPC BAF 06 2023

Ref No	Action required	Target / review date	Date met	Supporting action	Lead	Supported by	Evidence/ Current position	RAG status
Criterion 1 Systems are in place to manage and monitor the prevention and control of infection								
1	Resources are in place to monitor and measure adherence to the NIPCM. This must include all care areas and all staff (permanent, flexible, agency and external contractors) The application of IPC practices within the NICM is monitored, e.g., 10 elements of SICPs	**Mar 23**	**June 23**	Revision to audit tools and programme to include all elements in the NICM and all areas of the Trust	IPCT		Audit tool revised and implemented in June 2023	
2	The Trust is not reliant on a single respirator mask type and ensures that a range of predominantly UK made FFP3 masks are available to users as required	**Mar 24**		Adherence to resilience principles to ensure no > 25% reliance on a single type of FFP3 mask Recording fit testing in ESR	IPCT		Revision to baseline assessment of staff requiring Fit Testing. Fit Testing programme in place	
Criterion 2 Provide and maintain a clean and appropriate environment								
3	A systematic review of ventilation and risk assessment is undertaken to support location of patient care areas for respiratory pathways	**Mar 24**		Requirement for discussion on audit findings at Ventilation Group and plan to agree actions	ADE	IPCT ICD	Site audits completed Action plan required to address areas of non-compliance Capital bids required	
Criterion 3 Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance								
Criterion 4 Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion.								

APPENDIX 2 Action Plan for IPC BAF 06 2023

Ref No	Action required	Target / review date	Date met	Supporting action	Lead	Supported by	Evidence/ Current position	RAG status
Criterion 5 Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people								
Criterion 6 Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection								
Criterion 7 Provide or secure adequate isolation facilities								
Criterion 8 Secure adequate access to laboratory support as appropriate								
Criterion 9 Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections – Nil Concerns								
Criterion 10 Have a system in place to manage the occupational health needs and obligations of staff in relation to infection								
4	All staff required to wear an FFP3 respirator should be fit tested to use at least two different masks	**Mar 24**		Continuous Fit Testing Programme in place	DCN		Figures reported to Trust Board	

RAG Legend	
Action not commenced	
Action in progress	
Action completed	

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

APPENDIX 2 Action Plan for IPC BAF 06 2023

Completed actions

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

APPENDIX 2 Action Plan for IPC BAF 06 2023

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

Quality Assurance Committee

AGENDA REFERENCE:	**QAC/23/07/152**
SUBJECT:	**Director of Infection Prevention and Control Annual Report**
DATE OF MEETING:	11 July 2023
AUTHOR(S):	Lesley McKay, Associate Chief Nurse, Infection Prevention + Control
EXECUTIVE DIRECTOR SPONSOR:	Kimberley Salmon-Jamieson, Chief Nurse + Deputy Chief Executive
LINK TO STRATEGIC OBJECTIVE:	SO1: We will... Always put our patients first delivering safe and effective care and an excellent patient experience. SO2: We will ... Be the best place to work with a diverse and engaged workforce that is fit for now and the future. SO3: We will ... Work in partnership with others to achieve social and economic wellbeing in our communities.
EXECUTIVE SUMMARY	This report outlines the arrangements, activities and achievements of the Trust relating to infection prevention and control for the April 2022 to March 2023 year. The Covid-19 pandemic continued to place high demands on the Infection Prevention and Control Team (IPCT) and had an impact of achieving the annual work plan as activity was redirected in response to the pandemic. There were: - • 47 Covid-19 outbreaks • 282 Hospital onset/probable healthcare associated cases • 381 Hospital onset/definite healthcare associated cases Total HCAI case numbers for 2022/23 are comparable with similar sized Trusts when benchmarked using UK Health Security Agency data. Totals for HCAIs were: - • 55 Clostridium difficile cases – 18 cases over threshold • 3 MRSA bacteraemia cases – 2 cases unavoidable • 21 MSSA bacteraemia cases – no threshold • 67 E. coli bacteraemia cases – 10 cases over threshold • 22 Klebsiella bacteraemia cases – 3 cases over threshold • 4 P. aeruginosa bacteraemia cases – 2 cases under threshold HCAI prevention plans are in place to prevent healthcare associated infections. Gratitude is extended to all members of the IPCT for working at an exemplar level throughout the year. Collaboration and successful

	engagement with colleagues across the Trust have contributed to the successes detailed within this report. This report builds on previous annual reports submitted to the Board of Directors to give a full year account of infection prevention and control activity.			
PURPOSE: (please select as appropriate)	Information	Approval	To note X	Decision
RECOMMENDATIONS:	The Quality Assurance Committee is asked to receive and note the report.			
PREVIOUSLY CONSIDERED BY:	**Committee**	Infection Control Sub-Committee		
	Agenda Ref.	ICSC/23/06/063		
	Date of meeting	15/06/2023		
	Summary of Outcome	Submit to Quality Assurance Committee		
NEXT STEPS: ***State whether this report needs to be referred to at another meeting or requires additional monitoring***	Submit to Trust Board			
FREEDOM OF INFORMATION STATUS (FOIA):	Release in Full			
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None			

Quality Assurance Committee

SUBJECT	Infection Prevention and Control DIPC Annual Report	AGENDA REF:	QAC/23/07/152

Table of Contents

1. BACKGROUND/CONTEXT

Executive Summary

Organisation

Warrington and Halton Teaching Hospitals NHS Foundation Trust, sits within the mid-Mersey region in the northwest of England, providing healthcare services to Warrington, Runcorn, Widnes, and surrounding areas. The Trust has 3 hospitals across two sites, circa 520 beds, an operating budget of £261 million and employs over 4,400 staff.

The Trust's mission is to be 'outstanding for our patients, our communities and each other', with a vision that 'we will be a great place to receive healthcare, work and learn'. Good infection prevention and control practices are a fundamental part of this mission and vision. Effective prevention and control of infection is part of everyday practice and is embedded at all levels of this organisation.

Infection Prevention & Control Strategy and Annual Work Plan

The Infection Prevention and Control Strategy was launched in June 2022 with three objectives: -

- prevention of healthcare associated infections
- strengthening antimicrobial stewardship
- commitment to cleanliness

The Infection Prevention and Control Team (IPCT) worked towards delivery of the annual work plan. The Covid-19 pandemic had an impact on completion of all elements as efforts were appropriately re-directed.

A robust annual work plan (appendix 1) which is linked to the Infection Prevention and Control Strategy, has been devised for the 2023/24 financial year,. The work plan includes attendance at other committee meetings to ensure integration of infection prevention and control across the organisation; compliance with all mandatory surveillance requirements; monitoring of environmental cleanliness standards; audits of practice/policies; policy/guideline reviews and a programme of education and awareness raising events.

Covid-19 Pandemic

The Covid-19 pandemic continued to present challenges. Timely and integrated working took place between the operational and Infection Prevention and Control Teams to ensure safe patient placement. The Trust complied with recommendations for reporting outbreaks of hospital onset cases as detailed below: -

- 47 Covid-19 outbreaks
- 282 Hospital onset/probable healthcare associated cases
- 381 Hospital onset/definite healthcare associated cases

Code of Practice on Prevention of Healthcare Associated Infections

The Code of Practice on Prevention of Healthcare Associated Infections, which is linked to Regulation 12 of the Health and Social Care Act (2008), was updated in December 2022. The Trust is working towards full compliance with the 10 criterions. Revised assessment against the updated Code of Practice shows : -

- 7 are fully compliant
- 3 have minor non-compliances

These minor non-compliances relate to old estate i.e., lower number of side room facilities, in a small number of areas and lower ratio of hand washing sinks to patient number than current guidance.

The annual Patient Led Assessment of the Care Environment (PLACE) occurred in November 2022 and achieved cleanliness scores above 99% for both sites.

Healthcare Associated Infections

NHS standard contracts include a quality requirement to minimise rates of C. difficile and Gram-negative bloodstream infections (GNBSI) to thresholds set by NHS England (NHSE). The approach to learning from HCAI events is being revised to align with the Patient Safety Incident Response Framework and cases are no longer submitted to commissioners for review. Trust apportioned healthcare associated infection (HCAI) figures include hospital onset/healthcare associated (HOHA) and community onset/healthcare associated (COHA) cases. The Trust apportioned cases are detailed below: -

Table 1 HCAI Data and Thresholds

Organism	Trust Apportioned (HOHA/COHA)	Total	Trust threshold
C. difficile	44 HOHA: 11 COHA	**55**	37
E. Coli bacteraemia	40 HOHA: 27 COHA	**67**	57
Klebsiella Spp. bacteraemia	14 HOHA: 8 COHA	**22**	19
MRSA bacteraemia	2 HOHA: 1 COHA	**3**	Zero avoidable
MSSA bacteraemia	16 HOHA: 5 COHA	**21**	No threshold
P. aeruginosa bacteraemia	4 HOHA: 0 COHA	**4**	6

Collaborative working with the Quality Academy continued with targeted work on patient hydration to prevent GNBSI. Actions in place to prevent C. difficile include; hand hygiene (staff and patients), environmental cleanliness and antimicrobial stewardship.

This report outlines the arrangements, activities, and achievements during the 2022/23 financial year. The report builds on previous annual reports submitted to the Board of Directors to give a full year account of infection prevention and control activity.

Kimberley Salmon-Jamieson
Chief Nurse/Deputy Chief Executive
Director of Infection Prevention and Control (DIPC)
June 2023

Acknowledgements

Lesley McKay	Associate Chief Nurse Infection Prevention and Control/Associate DIPC
Dr Zaman Qazzafi	Consultant Medical Microbiologist/ Infection Control Doctor/Deputy DIPC
Jacqui Ward	Lead Pharmacist in Antimicrobial Stewardship
Kate Rainbird	Interim Lead Pharmacist in Antimicrobial Stewardship
Julie McGreal	Head of Facilities
Claudine Reynolds	Lead Nurse Medical Care CBU

2. KEY ELEMENTS

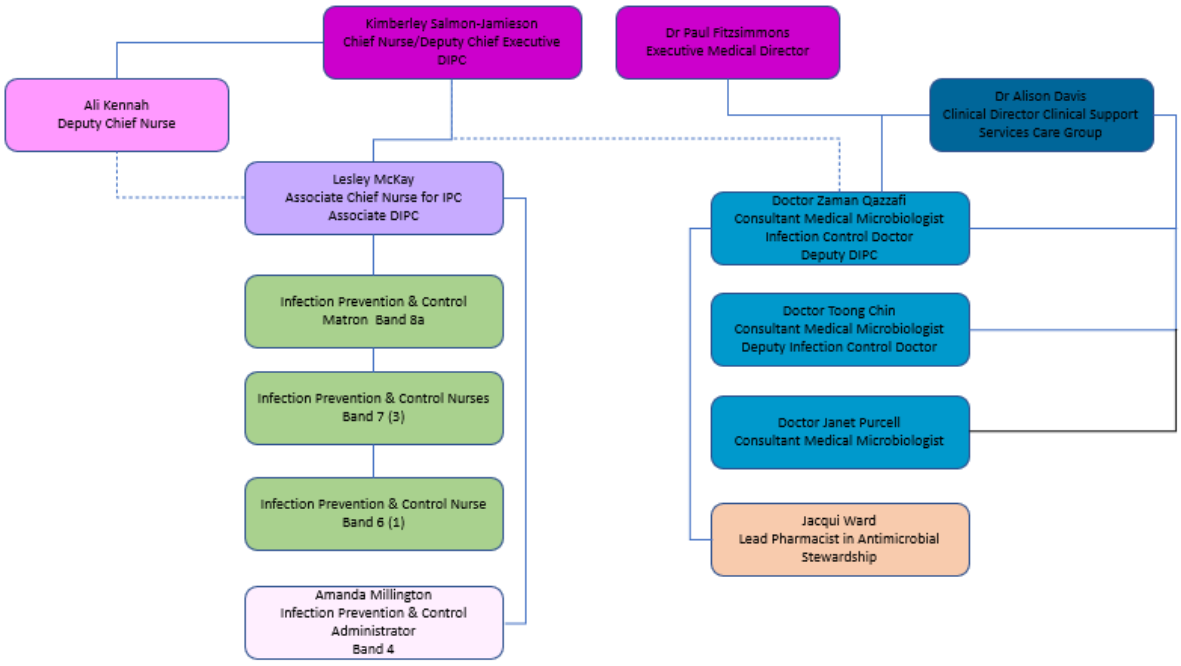
Description of Infection Control Arrangements

Infection Prevention and Control Team

The Infection Prevention and Control Team (IPCT) meet fortnightly. Meeting frequency was affected as efforts were redirected to respond to the continued Covid-19 pandemic.

The Team is structured as per figure 1.

Figure 1. Infection Prevention and Control Team Structure with Professional Reporting Line



Staff turnover included 3 nursing staff member changes.

- Matron
  - Louise Meikle (until February 2023)

- Infection Prevention and Control Nurses: -
  - Aalifha Mariadhas Margaret
  - Chantelle Jackson (until October 2022)
  - Joanne Oldfield (until December 2022)
  - Louise Bale (from September 2022)

Infection Control Sub-Committee

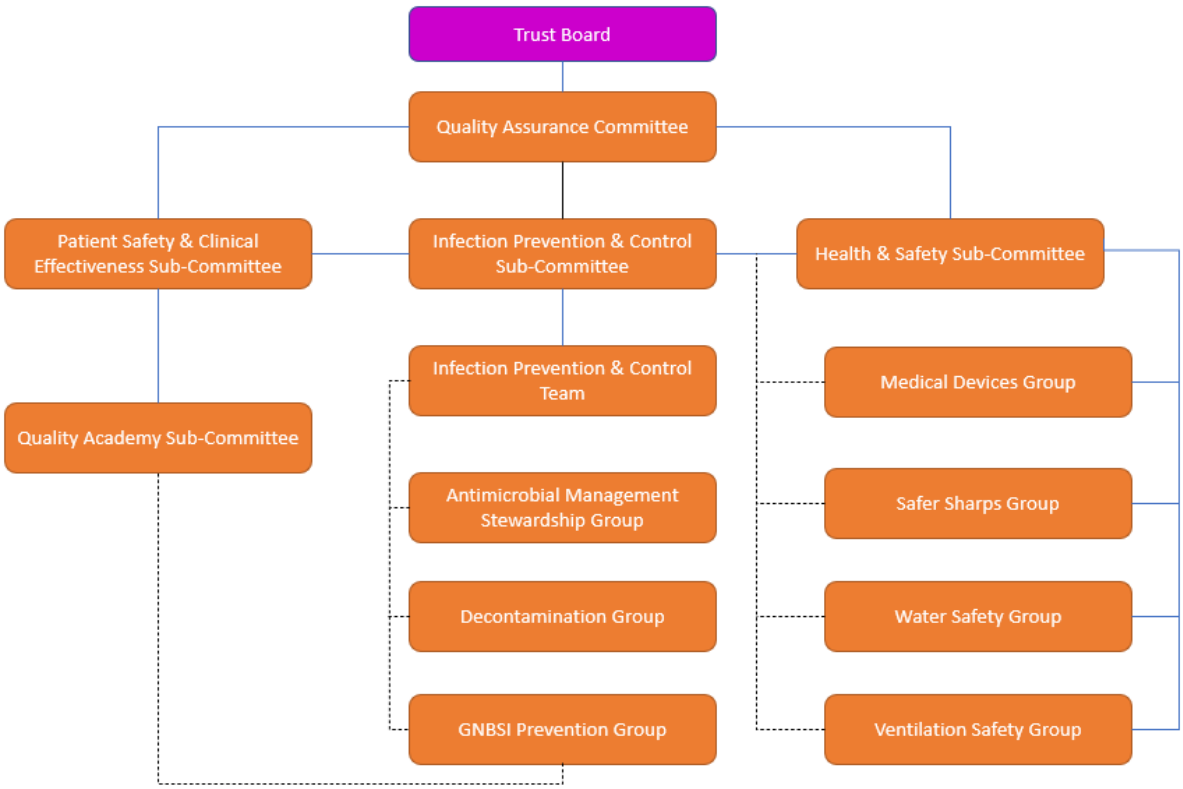
The Consultant Medical Microbiologist/Infection Control Doctor/Deputy DIPC chairs the Infection Control Sub-Committee. The committee met twelve times during the year.

Membership comprises of the Chief Nurse/Deputy CEO/DIPC, Operational IPCT, Lead Nurses or Matron from each Clinical Business Unit (CBU), Estates and Facilities Managers, Lead Allied Health Professional and an Occupational Health and Wellbeing representative.

The Lead Nurses for each CBU and the Lead for Allied Health Professionals and Estates and Facilities representatives, submit reports at each meeting as a standing agenda item. This allows the Infection Control Sub-Committee to give assurance to the Quality Assurance Committee and Trust Board of Directors on activity within the Trust, compliance with the Code of Practice is maintained and that there is a programme of continuous improvement.

High level briefing papers are submitted by the Infection Control Sub-Committee Chair to the Health and Safety Sub-Committee and the Patient Safety and Clinical Effectiveness Sub-Committee. The reporting line to Trust Board is detailed in figure 2.

Figure 2 Reporting Line to Trust Board



There are links to the Drugs and Therapeutics Committee via: -

- Consultant Medical Microbiologists
- Lead Pharmacist in Antimicrobial Stewardship
- Antimicrobial Management Stewardship Group

DIPC Reports to Trust Board

Reports and high-level briefing papers, which included compliance assessments against the Covid-19 Board Assurance Framework, key performance indicators, HCAI surveillance data, outbreak/incident details and root cause analysis/post infection review findings were submitted to the Quality and Assurance Committee with onward reporting to Trust Board: -

- IPC Board Assurance Framework Compliance Report/Action Plan – April 2022
- IPC Board Assurance Framework Compliance Report/Action Plan – July 2022
- IPC Board Assurance Framework Compliance Report/Action Plan – September 2022

- IPC Board Assurance Framework Compliance Report/Action Plan – November 2022
- IPC Board Assurance Framework Compliance Report/Action Plan – January 2023

- IPC Healthcare Associated Infection Report Q1 – August 2022
- IPC Healthcare Associated Infection Report Q2 – December 2022
- IPC Healthcare Associated Infection Report Q3 – February 2022
- IPC Healthcare Associated Infection Report Q4 – May 2023

- DIPC Annual Report – July 2022

Annual work plan

The IPCT work plan was developed to give assurance that each element of the Code of Practice for Prevention of Healthcare Associated Infections, which underpins the Health and Social Care Act (2008) linked to Regulation 12, is adhered to and that appropriate evidence of compliance is available.

This work plan is underpinned by action plans for key performance indicators/mandatory healthcare associated infections and a programme of audit that provides evidence of policy/guideline compliance. Progress against planned activity was impacted by the volume of Covid-19 cases and effort to update trust guidance in line with frequently updated Covid-19 guidance. The annual work plan has been revised for 2023/24 and is included at appendix 1.

Covid-19

Activity to respond to the Covid-19 pandemic continued. The pandemic escalation plan was in place with nominated wards utilised to cohort patients with different respiratory infections to maintain patient safety.

National guidance, which initially included molecular and PCR testing, was followed for patients with respiratory symptoms until guidance was revised and the Trust moved to lateral flow device testing.

Admissions with Covid-19 peaked in April and July and hospital onset cases rose in line with these increases.

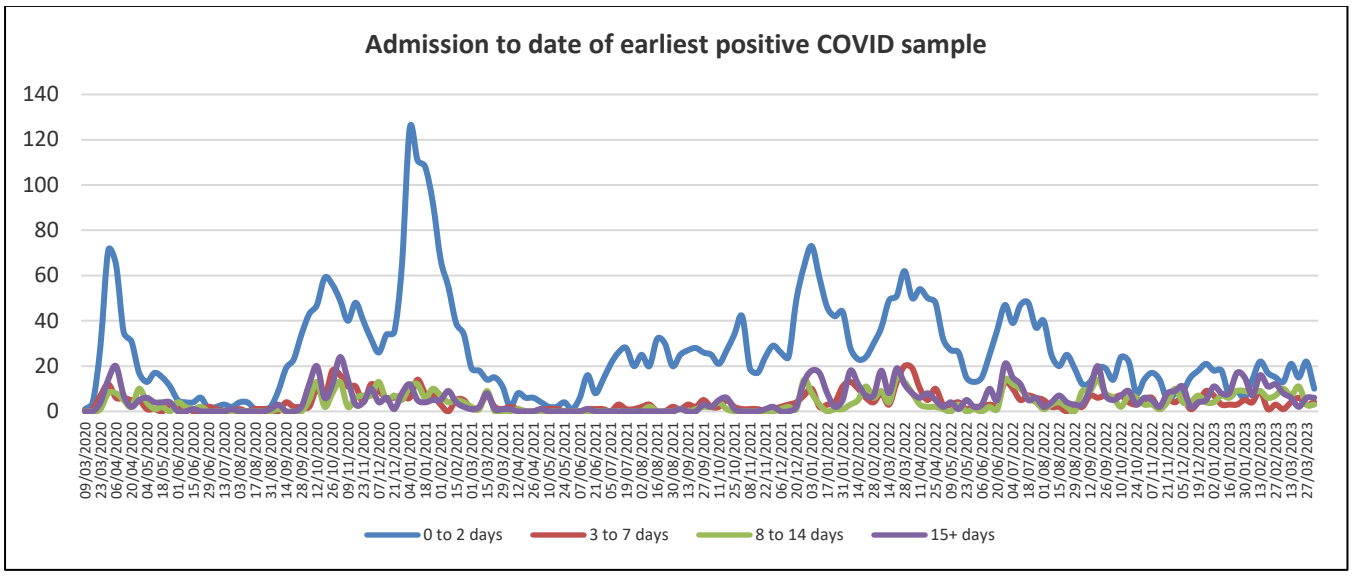
Covid-19 Nosocomial cases

The Trust reported hospital onset Covid-19 cases as per NHSE definitions of:

- Hospital onset/probable healthcare associated cases (days 8-14) = 282
- Hospital onset/definite healthcare associated cases (>15 days) = 382

Figure 3 shows inpatient cases according to NHSE definitions.

Figure 3 Covid-19 Cases by NHSE definitions



Discharge to Care Home screening continued to ensure risk of introducing Covid-19 was minimised.

The following documents were developed and revised/updated throughout the year as per new/updated national guidance being published: -

- Clinical and non-clinical areas Covid-19 risk rating for patients
- Clinical and non-clinical areas Covid-19 risk rating for staff
- Covid-19 contact letter
- Respiratory viruses testing approach
- Risk assessment for meeting rooms
- HOCI daily cluster outbreak reporting proforma
- Clinical and non-clinical Area Covid-19 risk rating for staff previously identified as CEV
- Updates to face mask guidance for Covid-19 and social distancing
- SOP Covid-19 Lateral Flow Device testing for patients
- SOP for contractors and external representatives visiting Trust premises
- SOP for reusable PPE decontamination and maintenance
- Covid-19 Self-Isolation and Routine Testing SOP
- Hospital onset Covid-19 investigation and outbreak management SOP
- Hospital Onset Covid-19 Infection (HOCI) Assurance Checklist
- Cross site working SOP (Therapies)
- Non-elective Patient Respiratory Virus Testing, Placement, and Infection Control Precautions SOP (several revisions)

The programme of Fit Testing of Face Filtering Piece (FFP) 3 respirators, carried out by appropriately trained staff, continued throughout the year. Where it has not been possible to successfully fit test some members of staff, alternative specialist respiratory protective equipment has been provided for these staff. Where re-usable PPE was supplied, written guidance on maintenance and decontamination was provided.

Covid-19 Outbreaks

The IPCNs conducted surveillance of cases to detect Covid-19 clusters. Where outbreaks were declared, Outbreak Control Groups were established. A total of 47 Covid-19 outbreaks were reported to external partners including: - NHSE, UK Health Security Agency, Integrated Care Board Sub-Groups for Warrington and Halton, Care Quality Commission (CQC) and the northwest incident control centre (NW. ICC) as per NHSE guidance.

Challenges to managing Covid-19 included: -

- Old estate – limited side/break rooms/offices
- Patients movements
- Poorly ventilated bays/wards
- Bed pacing <2 metres
- 'Presenteeism' – coming to work despite having symptoms
- Return to open visiting

Action taken included: -

- Increased uptake of Lateral Flow Device Testing
- Repeated communications and updates on Covid-19 IPC precautions
- Staff vaccination programme
- Streaming of patients to Covid/non-Covid wards timely as far as reasonably practicable

Board Assurance Framework Covid-19

The Infection Prevention and Control (IPC) Board Assurance Framework (BAF), linked to the Code of Practice on prevention of HCAIs, was updated by NHSE several times during the year as evidence about Covid-19 emerged. Compliance assessments were undertaken bimonthly throughout the year and submitted to the Trust Board of Directors. An action plan is in place for minor gaps in assurance which include fit testing staff against two different FFP3 masks and natural rather than mechanical ventilation in inpatient areas.

Covid-19 Recovery

The IPCT provided support to the Planned Care Group CBUs with advice on safe restoration of elective services, appropriate precautions, and risk assessments. The IPCNs continued to provide an out of hours on call service with text message alerting of confirmed Covid-19 results to ensure timely management of cases.

Health and Social Care Act (2008) compliance assessment

Compliance assessment against the 10 criteria, specified in the *Health and Social Care Act 2008 Code of Practice for preventions and control of infections and related guidance* (updated in December 2022) are carried out biannually. Revised assessment against the updated Code of Practice shows : -

- 7 are fully compliant
- 3 have minor non-compliances

The CQC uses this code to assess registered provider compliance with the cleanliness and infection control requirement set out in the regulations. Compliance with the revised Code of Practice and areas requiring further action are detailed in table 2.

Table 2 Compliance with the Code of Practice on prevention of HCAIs

Criterion	*Assessment*	*Action required/in progress*
1. Systems to manage and monitor the prevention and control of infection.	*Partially compliant*	*Solution being sought to obtain surveillance software, requirement is being escalated to Quality Assurance Committee and executive team*
2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.	*Partially compliant*	*Upgrades to some hand washing sinks required (design and location). Audit of handwashing facilities scheduled with Estates Team* Ventilation systems review to ensure all comply with HTM 03 01
3. Ensure appropriate antibiotic use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance.	*Compliant*	
4. Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/medical care in a timely fashion.	*Compliant*	
5. Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people.	*Compliant*	
6. Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection.	*Compliant*	
7. Provide or secure adequate isolation facilities.	*Partially compliant*	*Continuous liaison with the Patient Flow Team to optimise use of side rooms for appropriate patient isolation*
8. Secure adequate access to laboratory support as appropriate.	*Compliant*	
9. Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections.	*Compliant*	
10. Providers have a system in place to manage the occupational health needs of staff in relation to infection.	*Compliant*	

Healthcare Associated Infection Statistics

The Trust participates in mandatory reporting of Healthcare Associated Infections (HCAI). There are 3 HCAI prevention action plans, linked to mandatory reporting requirements which were reviewed 3 times per annum. RCA investigations undertaken for Trust apportioned Clostridioides (Clostridium) difficile (C. difficile) cases supported review of an action plans to promote learning from cases.

C. difficile

The Trust reported 82 C. difficile toxin positive cases with 55 cases apportioned to the Trust: -

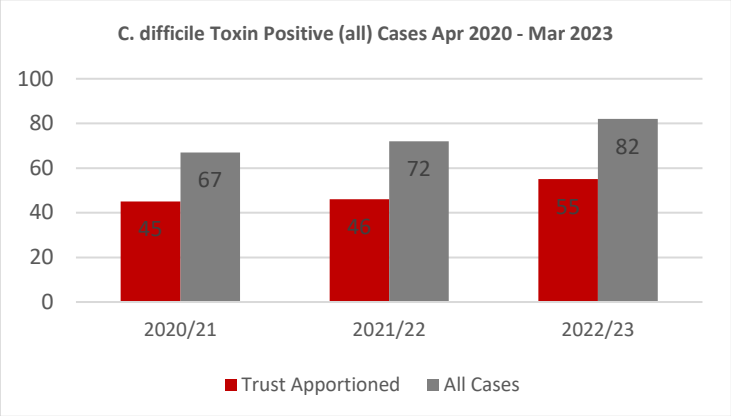
- hospital onset/healthcare associated = 44
- community onset/healthcare associated = 11

} 55 Trust apportioned cases

- community onset indeterminate association = 12
- community onset community associated = 15

The NHSE threshold for C. difficile was set at 37 cases or less (which includes both hospital onset/healthcare associated, and community onset/healthcare associated cases). The Trust was 18 cases over threshold with a total of 55 cases. A comparison with previous year's data is displayed in figure 4.

Figure 4 C. difficile Toxin Positive Cases (all) April 2020 – March 2023

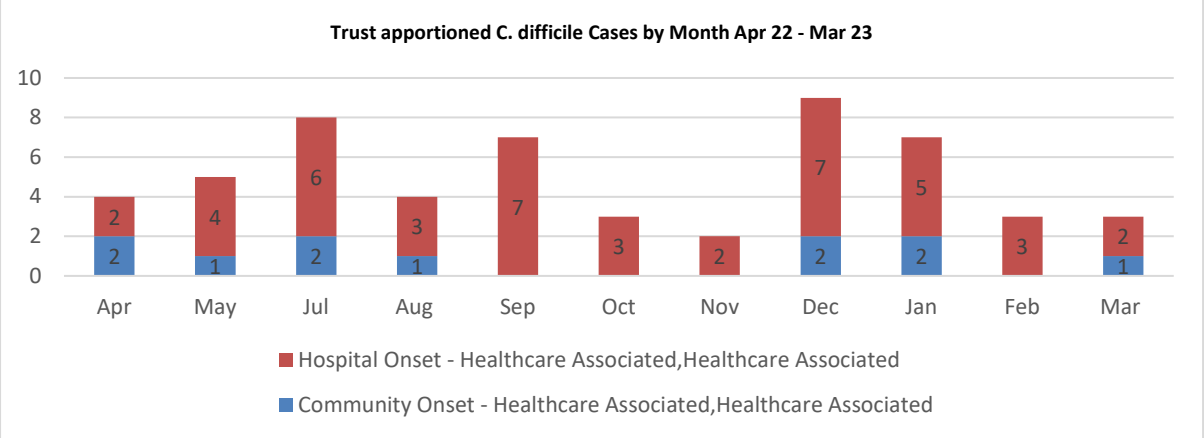


The IPCT focussed activity on C. difficile prevention by: -

- Surveillance of cases/monitoring for periods of increased incidences
- Antimicrobial Management Stewardship Group
- Hand hygiene awareness raising events
- Multi-disciplinary team review of patients with Trust apportioned C. difficile
- Promoting improvements to standards of environmental hygiene
- Use of hydrogen peroxide vapour for environmental decontamination

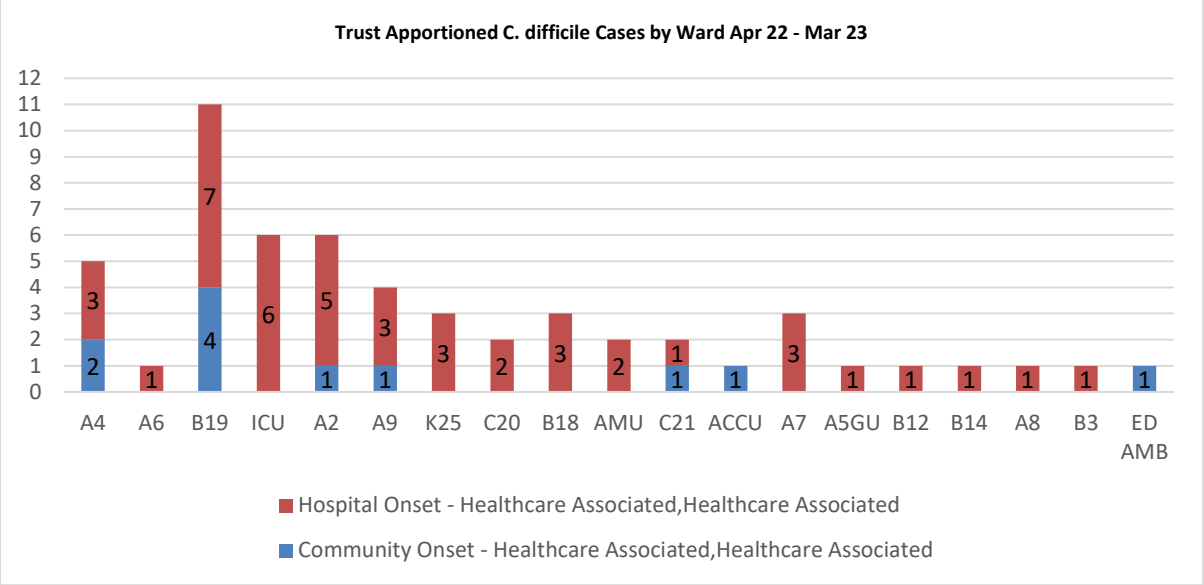
Figure 5 shows C. difficile toxin positive Trust apportioned (HOHA/COHA) cases by month.

Figure 5 Trust Apportioned HOHA/COHA C. difficile Toxin Positive Cases by Month



HOHA cases by location when the sample was taken and COHA cases by the discharging ward are displayed in figure 6. The location the specimens were obtained from is not necessarily where the infection was acquired as patients may have been on the ward/department for less than 48 hours when tested.

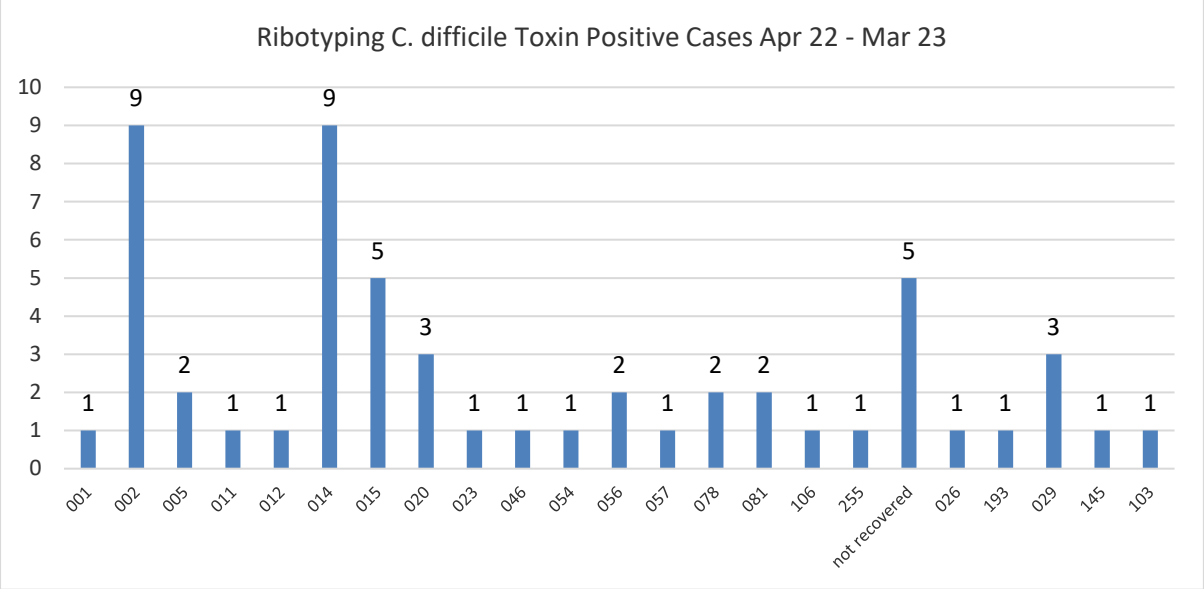
Figure 6 Trust Apportioned HOHA/COHA C. difficile Toxin Positive Cases by Location



All Trust apportioned C. difficile cases undergo RCA investigation, completed by Ward Managers with input from the patients' Consultants'. Completed investigations are reviewed internally. There was a delay in completing RCA reviews due to the Covid-19 pandemic and a recovery plan is in place to ensure completion.

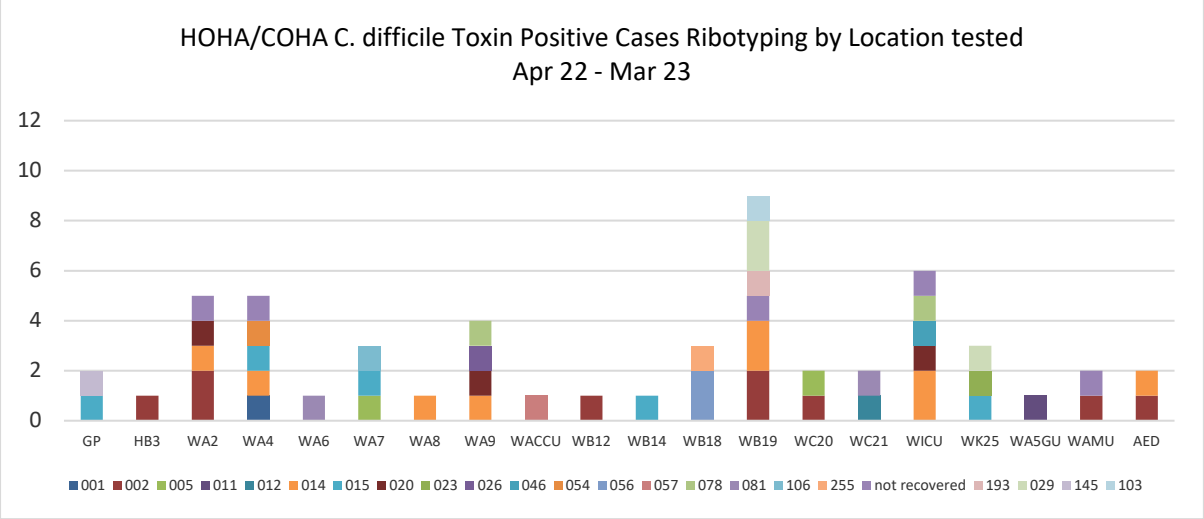
All Trust apportioned C. difficile toxin positive isolates are submitted for ribotyping. From the 55 isolates, 22 different ribotypes were identified. C. difficile was not recovered from 5 of the samples. Results are shown in figure 7 and demonstrate 002 and 014 ribotypes are seen more frequently.

Figure 7 HOHA/COHA C. difficile Toxin Positive Ribotyping Results



Ribotyping results by ward are shown in figure 8. Whilst Ward B19 has had a higher number of cases, ribotyping results differed indicating the cases were not linked.

Figure 8 C. difficile Toxin Positive Ribotyping Results by Location



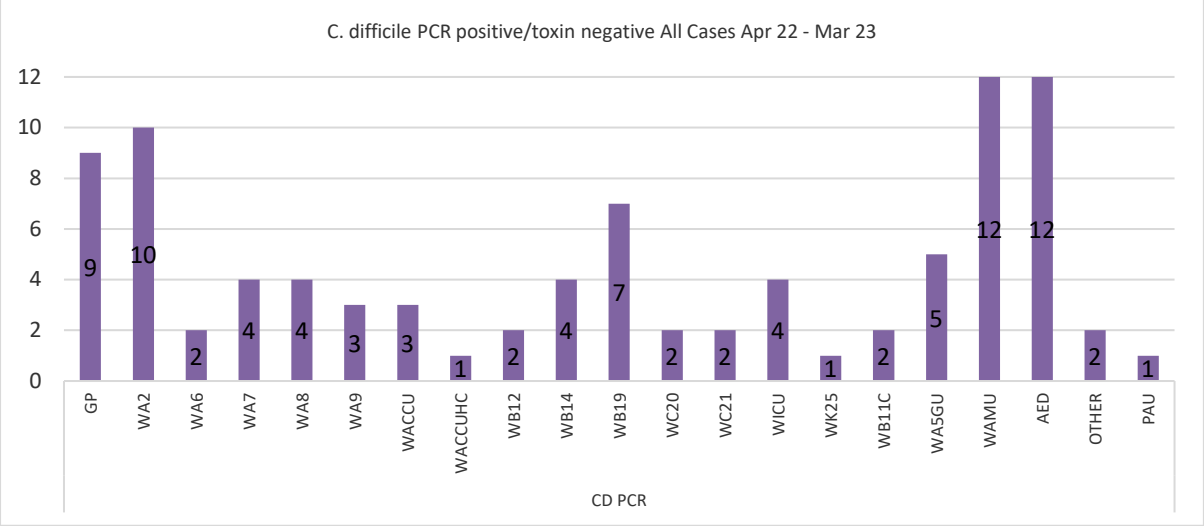
C. difficile (Toxin Negative/PCR Positive)

Diagnostic testing methods for C. difficile infection distinguishes between patients who are colonised with C. difficile (toxin negative/PCR positive), and those with C. difficile toxins present. Presence of toxins indicates infection is more likely.

The IPCT conduct local surveillance on the patients who are C. difficile toxin negative/PCR positive. These patients are at a higher risk of developing C. difficile infection than non-colonised patients. Inpatients falling into this category are reviewed and patients exhibiting symptoms are nursed in isolation and treatment advice provided.

Figure 9 shows the results for all patients (no apportionment) who were C. difficile toxin negative/PCR positive and location at the time of testing.

Figure 9 C. difficile PCR Positive/Toxin Negative cases (all) by Location Tested



Meticillin resistant *Staphylococcus aureus* (MRSA*)* bacteraemia

The Trust reported four MRSA bacteraemia cases.

- hospital onset/healthcare associated = 2
- community onset/healthcare associated = 1
- community onset community associated = 1

} 3 Trust apportioned cases

Data for comparison with earlier financial years is shown in figure 10.

Figure 10 MRSA bacteraemia cases (all) April 2020 – March 2023

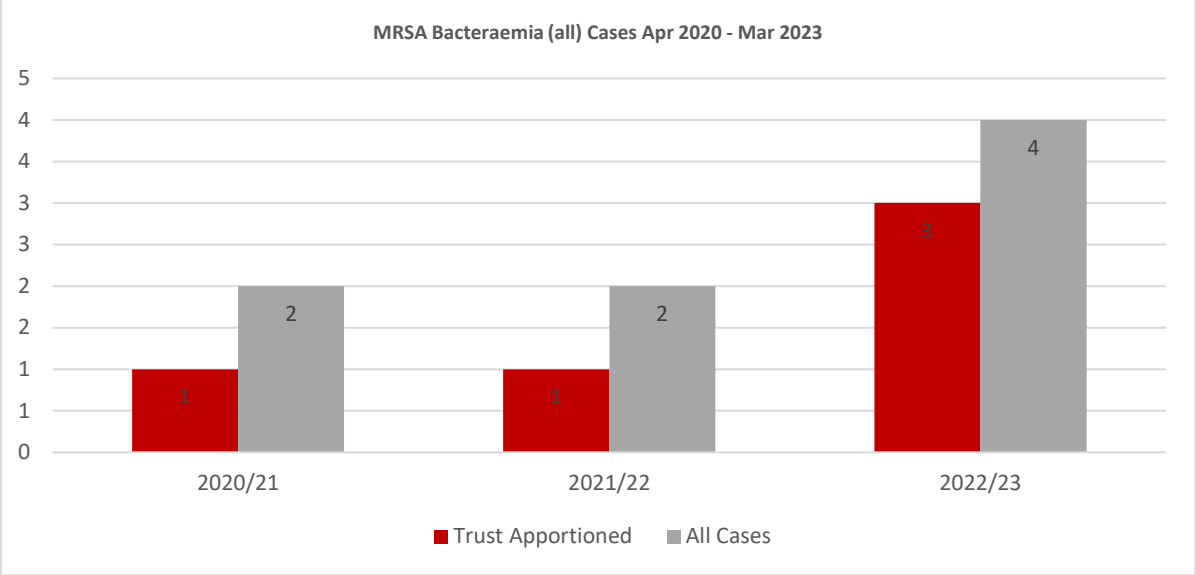
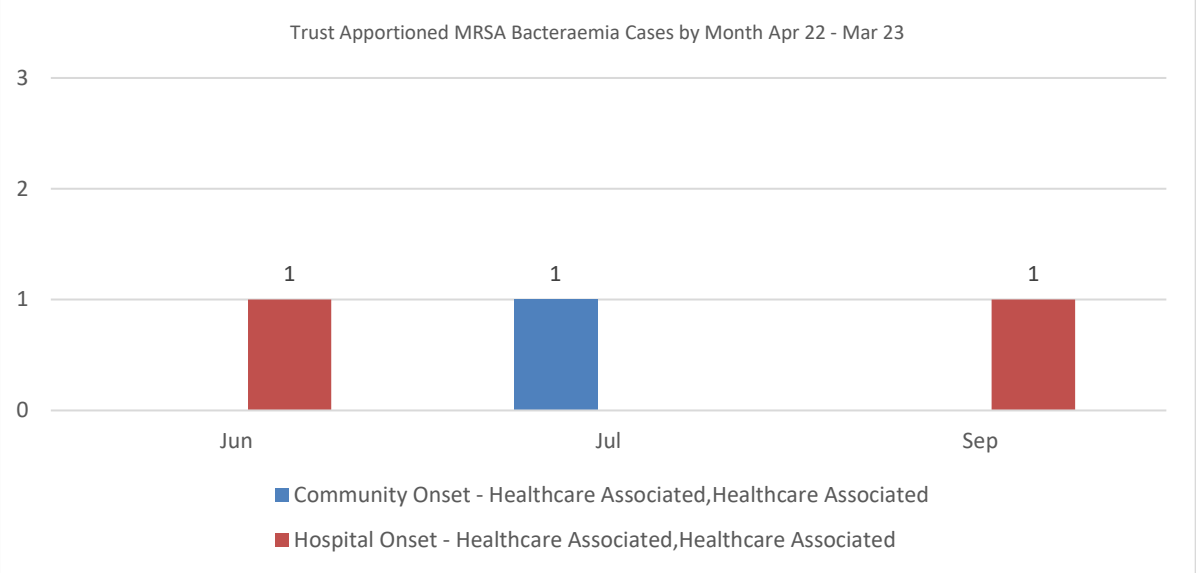


Figure 11 shows the Trust apportioned MRSA bacteraemia case identified within the financial year.

Figure 11 Trust Apportioned MRSA Bacteraemia Cases by Month



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

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

Case 2 - Household contact a carrier of MRSA. This case was considered unavoidable.

Case 3 – Nil learning identified, Likely unavoidable.

Annual threshold exceeded by 1 avoidable cases.

Next steps include: -

- Drive compliance with ANTT training
- Audit compliance with MRSA screening policy for assurance

Meticillin sensitive *Staphylococcus aureus* (MSSA) bacteraemia

The Trust reported 57 cases of MSSA bacteraemia (36 community onset and 21 Trust apportioned).

- hospital onset/healthcare associated = 16
- community onset/healthcare associated = 5
- community onset/community associated = 36

} 21 Trust apportioned cases

This was a decrease 8 Trust apportioned cases from the previous financial year.

Thresholds for the reduction of MSSA bacteraemia have not been set. Data for comparison with previous financial years is shown in figure 12.

Figure 12 MSSA bacteraemia cases (all) April 2020 – March 2023

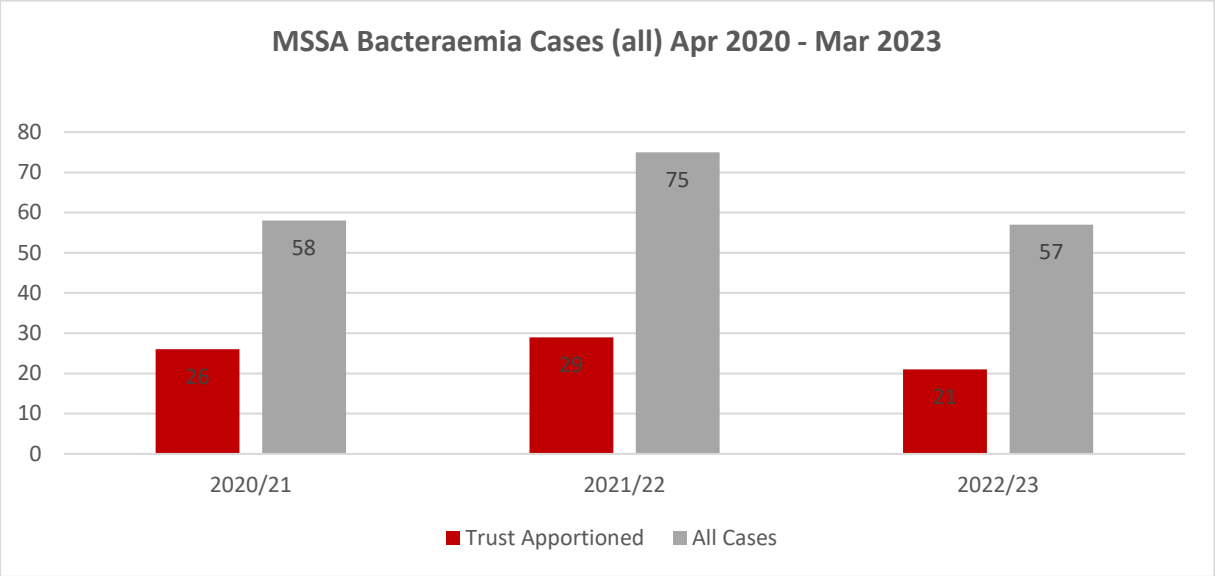


Figure 13 shows the Trust apportioned MSSA bacteraemia cases by month.

Figure 13 Trust Apportioned MSSA bacteraemia cases by month

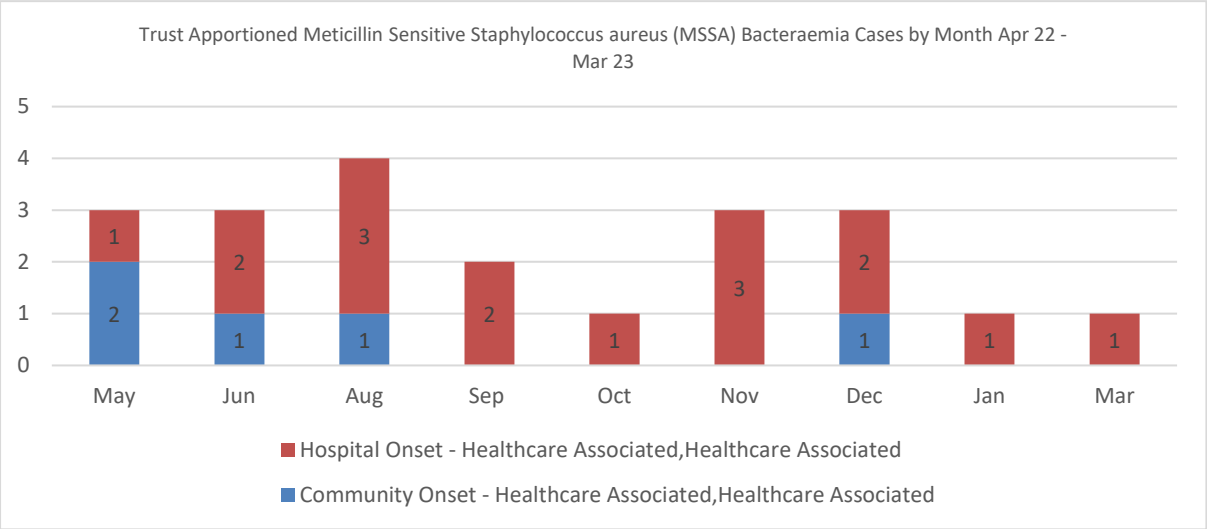


Figure 14 shows the patients location at the time the specimen was obtained for HOHA cases and discharging ward for COHA cases.

Figure 14 Trust Apportioned MSSA Bacteraemia Cases by Location

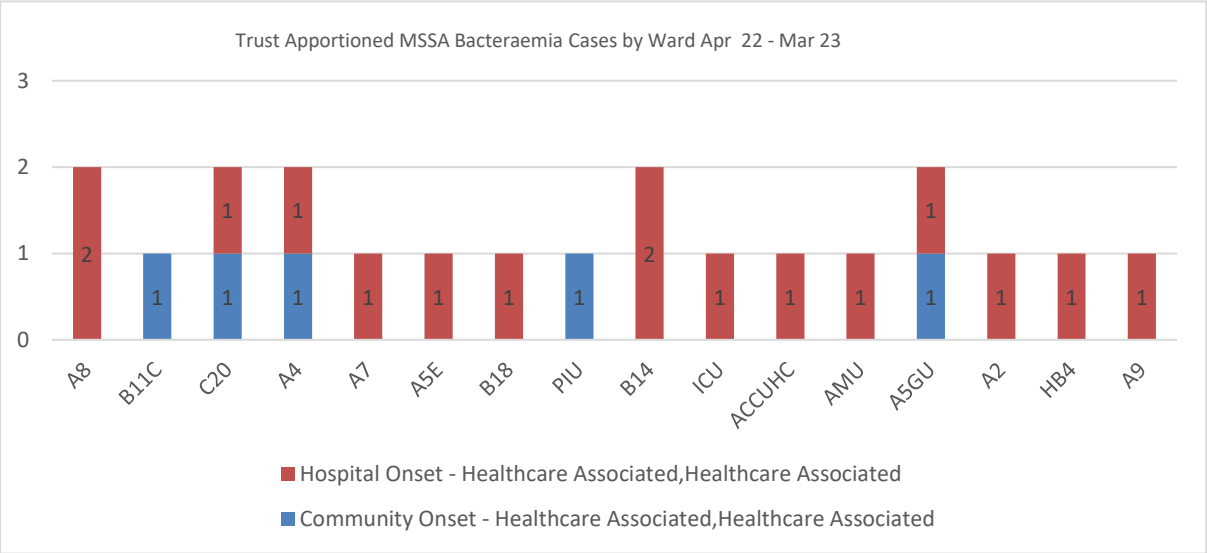
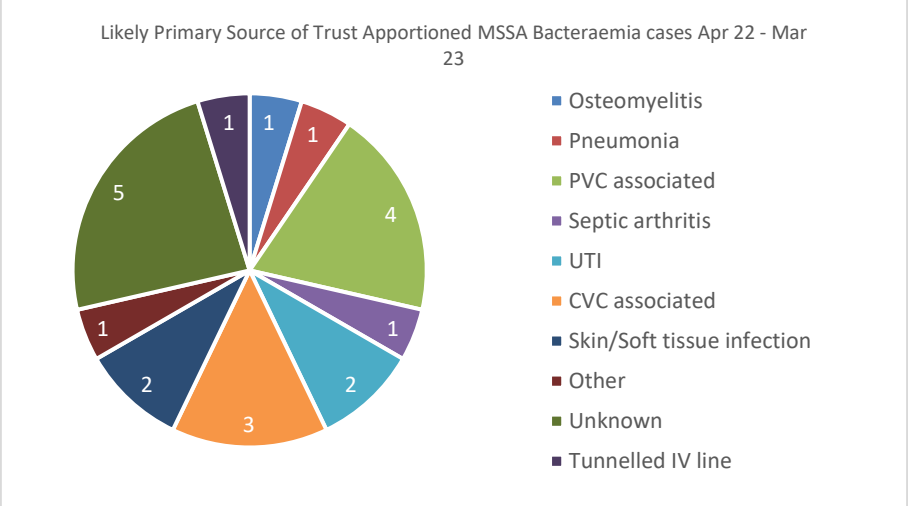


Figure 15 shows the likely primary sources of the Trust apportioned cases.

Figure 15 Likely Primary Source of Trust Apportioned MSSA Bacteraemia Cases



An action plan is in place that sets out the work required to prevent the risks of MRSA/MSSA bacteraemia cases.

Gram Negative Bloodstream Infection (GNBSI)

The national target to reduce GNBSI (E. coli; Klebsiella spp. and Pseudomonas aeruginosa) published in the Tackling Antimicrobial Resistance 5-year plan (January 2019) remains in place. This publication recommends a systematic approach to preventing infections. NHSE publish quality requirements for Trusts to minimise GNBSI and set thresholds for providers.

The IPCT continued work with the Quality Academy to focus on hydration, continence management, reducing usage of urinary catheters and improving care, hand hygiene (including patients) and urinary tract infection detection/management.

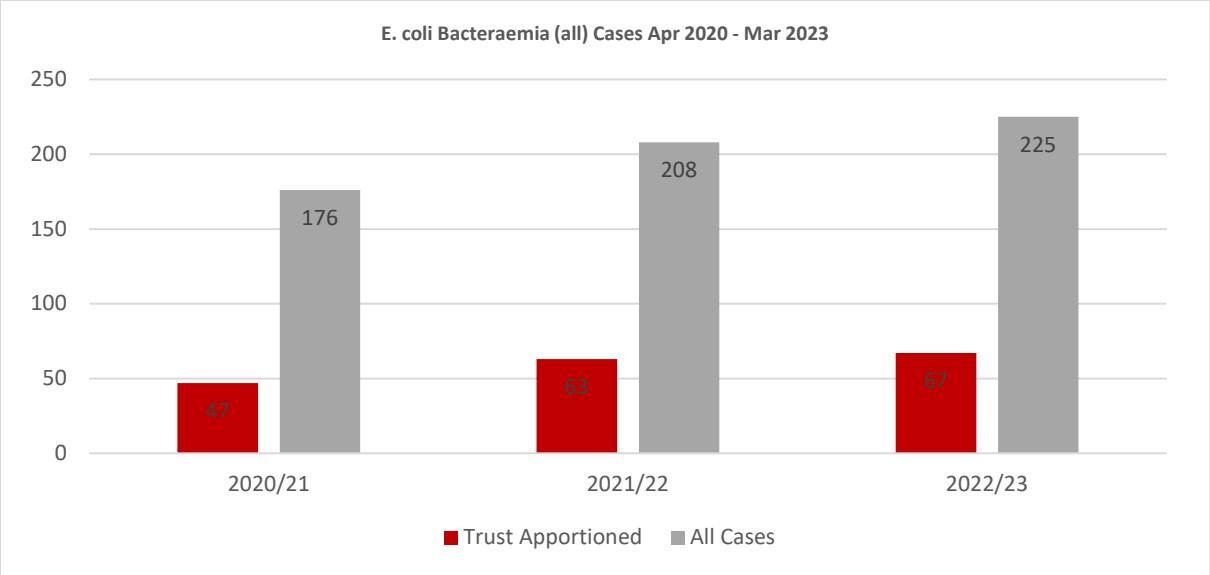
The Urinary Tract Infection pathway was revised and relaunched at a Grand Round in May.

Figure 16 GNBSI Grand Round

E. coli bacteraemia Cases

Data for comparison with previous financial years is shown in figure 17 .

Figure 17 E. coli bacteraemia cases (all) April 2020 – March 2023



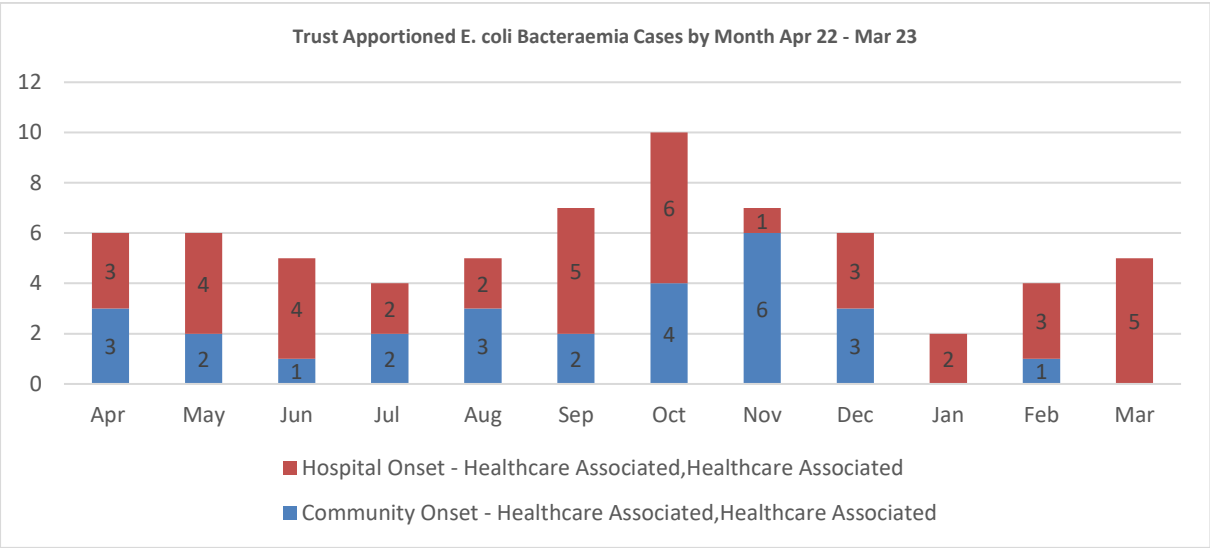
The Trust reported a total of 225 E. coli bacteraemia cases, 67 of these were Trust apportioned cases. The threshold of 57 cases set by NHSE was exceeded by 10 cases.

- hospital onset/healthcare associated = 40
- community onset/healthcare associated = 27
- community onset community associated = 158

} 67 Trust apportioned cases

Figure 18 shows trust apportioned cases by month.

Figure 18 Trust Apportioned E. coli Bacteraemia Cases by Month



The Trust apportioned E. coli bacteraemia cases by location where specimen was taken for HOHA cases and location discharged from for COHA cases are shown in figure 19.

Figure 19 Trust apportioned E. coli Bacteraemia Cases by Location

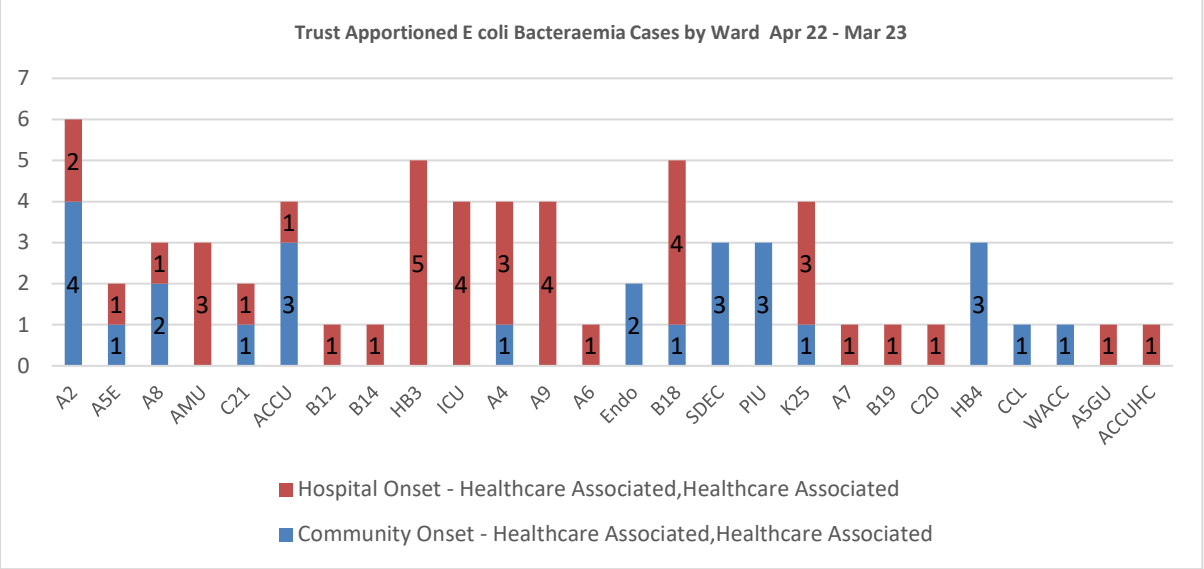
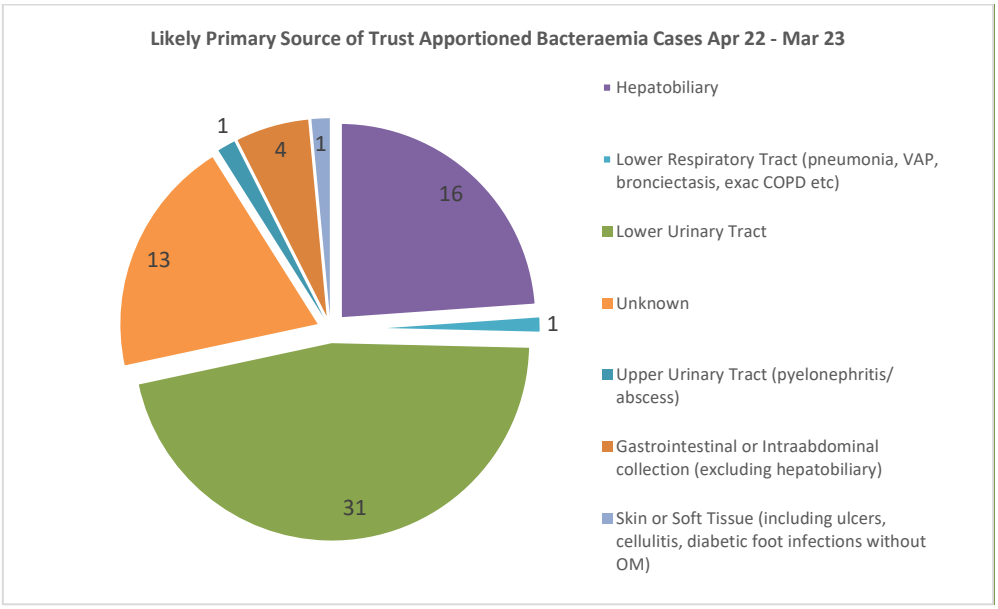


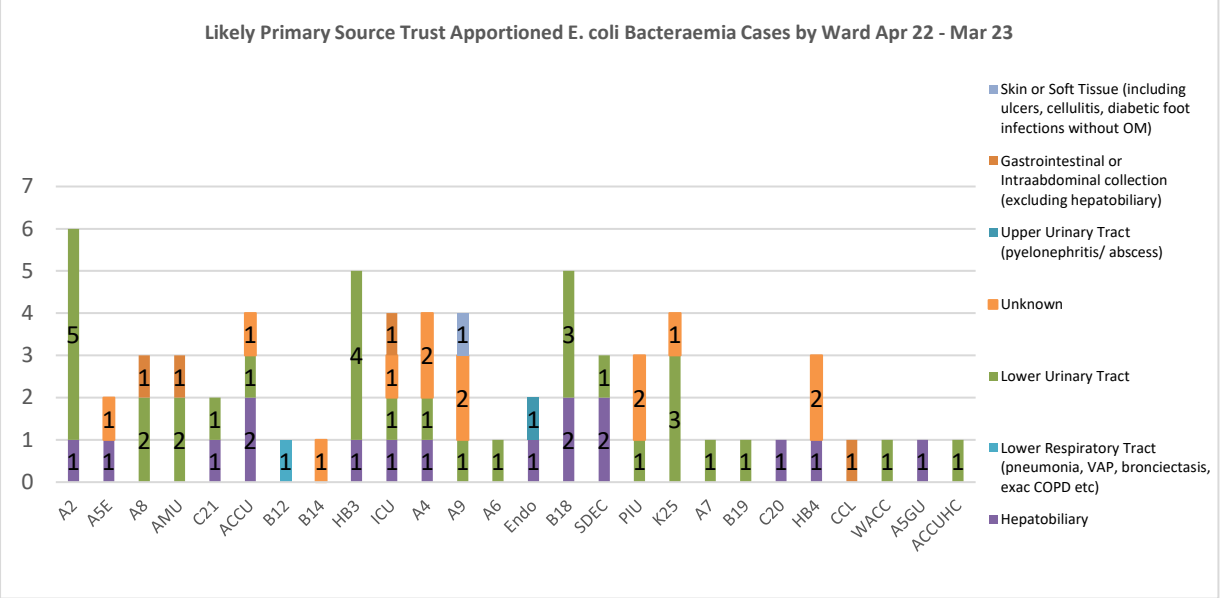
Figure 20 shows the likely primary sources of the Trust apportioned cases.

Figure 20 Likely primary sources Trust apportioned E. coli Cases



A breakdown of Trust apportioned cases to show likely primary source by location is shown in figure 21.

Figure 21 Trust Apportioned Cases - Likely Primary Source by Location



The IPCT continued to work with the Quality Academy and Clinical Business Units (CBUs) to prevent GNBSI cases. Further work is scheduled to work with wards with higher UTI associated cases and the Gastroenterology consultants for prevention of hepatobiliary cases.

Klebsiella spp. Bacteraemia

A comparison with previous year's data is shown in figure 22.

Figure 22 Klebsiella spp. bacteraemia (all) April 2020 – March 2023

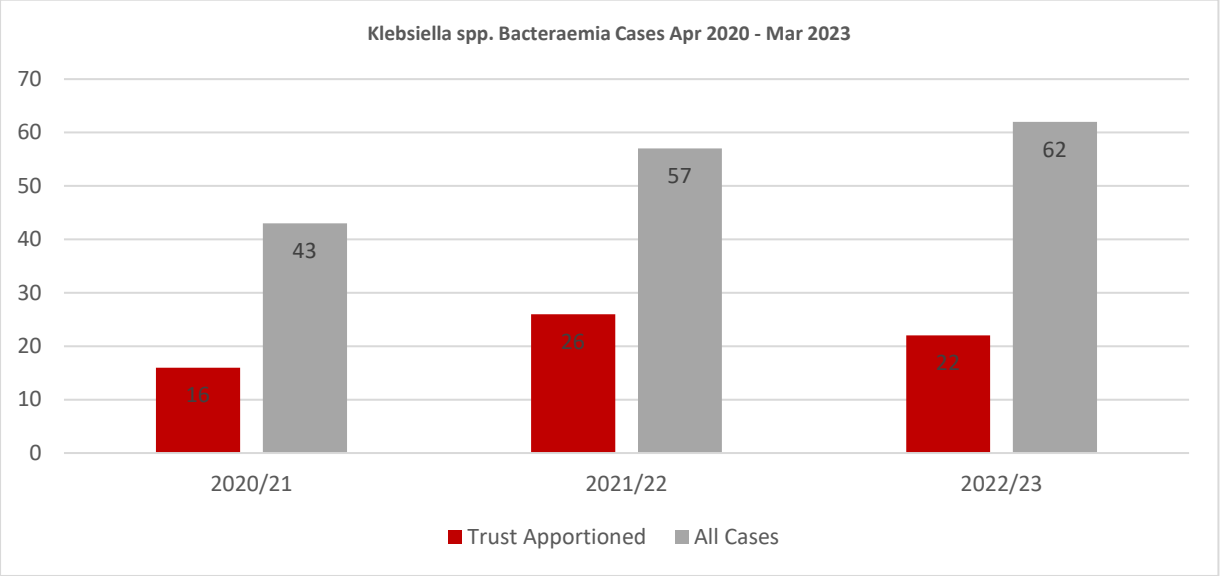


Figure 23 shows trust apportioned cases reported each month.

Figure 23 Trust Apportioned Klebsiella spp. Bacteraemia Cases by Month

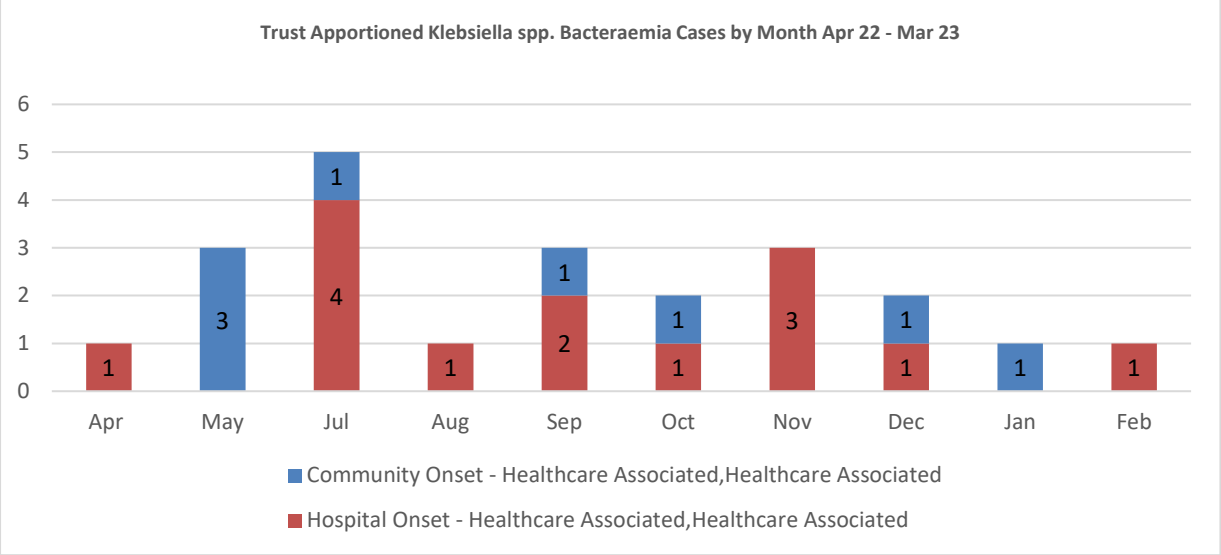


Figure 24 shows Trust apportioned Klebsiella bacteraemia cases by location where specimen was taken for HOHA cases and location discharged from for COHA cases.

Figure 24 Trust Apportioned Klebsiella Bacteraemia Cases by Ward Location

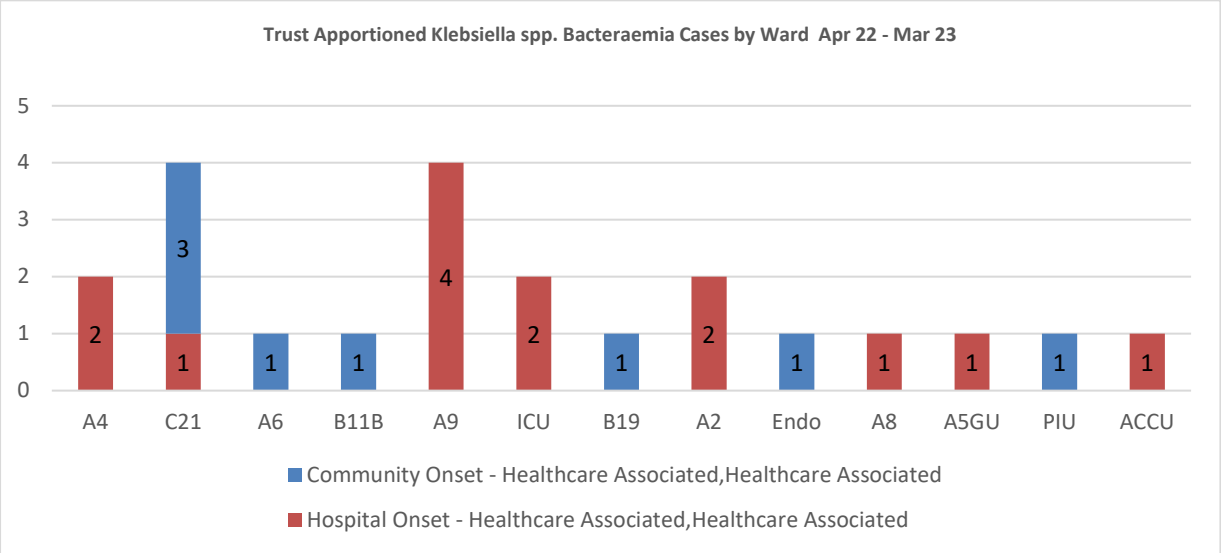
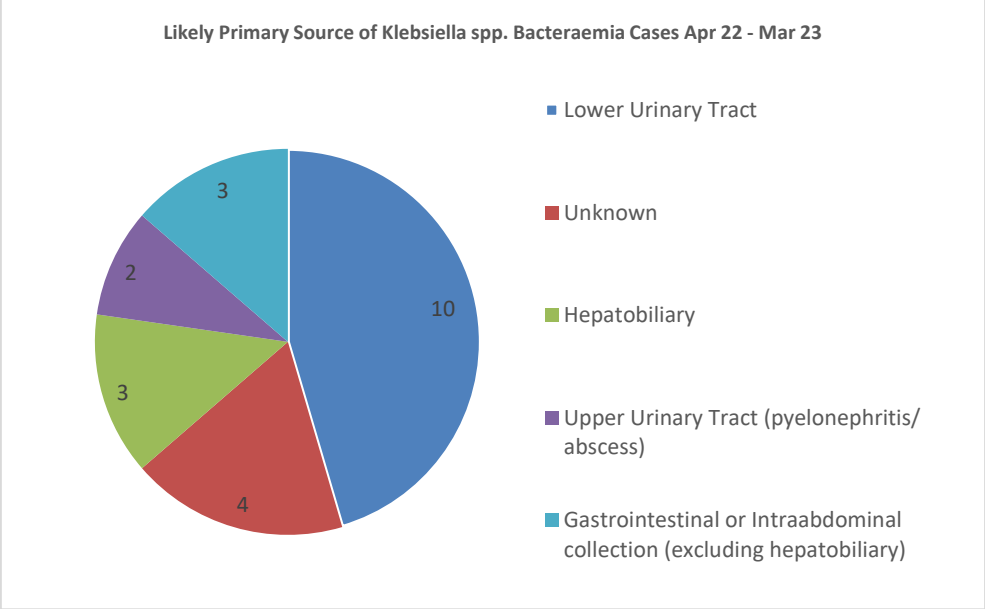


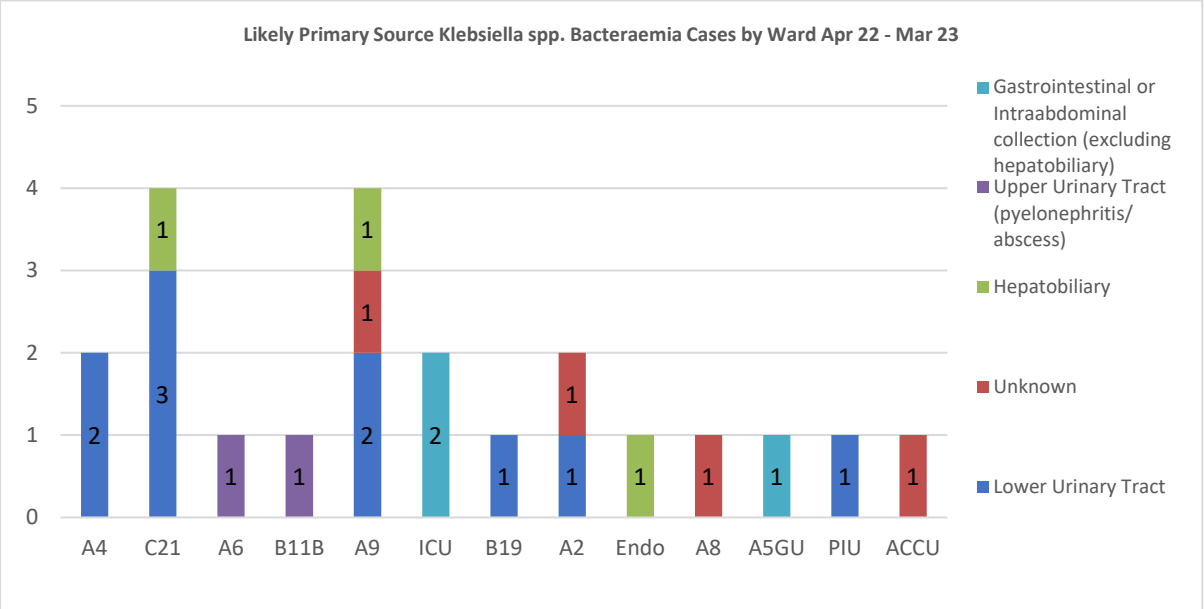
Figure 25 shows the likely primary sources of the Trust apportioned cases.

Figure 25 Likely primary sources of the 26 Trust apportioned cases



A breakdown of Trust apportioned cases to show likely primary source by location is shown in figure 26.

Figure 26 Trust Apportioned Cases - Likely Primary Source by Location



Pseudomonas aeruginosa bacteraemia

A comparison with previous year's data is shown in figure 27.

Figure 27 Pseudomonas aeruginosa bacteraemia cases April 2020 – March 2023

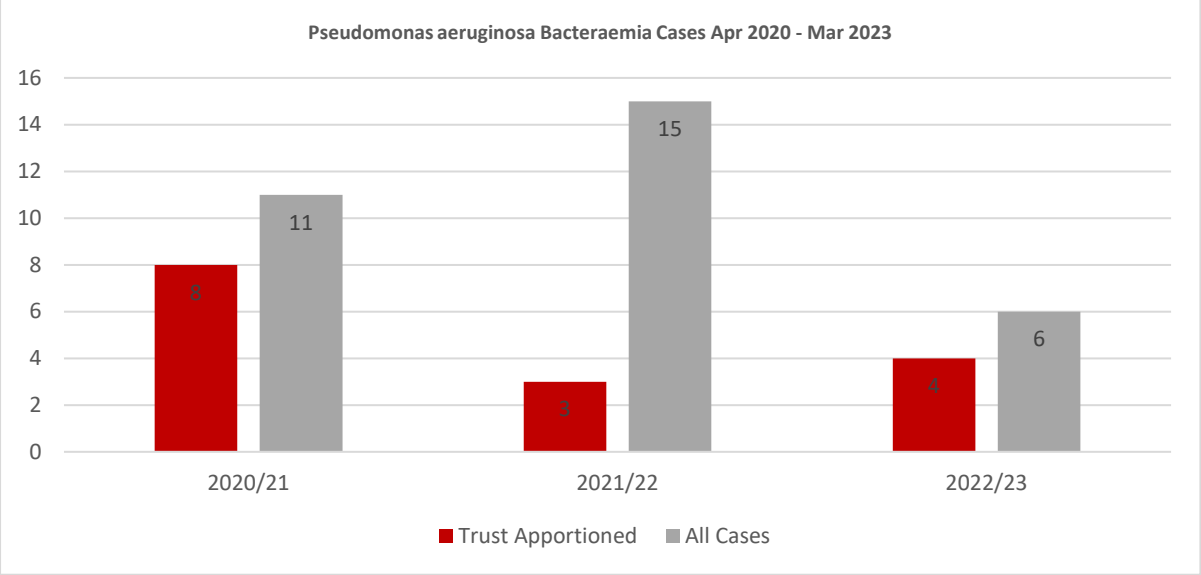


Figure 28 displays the Trust apportioned cases reported by month.

Figure 28 Trust Apportioned Pseudomonas aeruginosa Bacteraemia Cases by Month

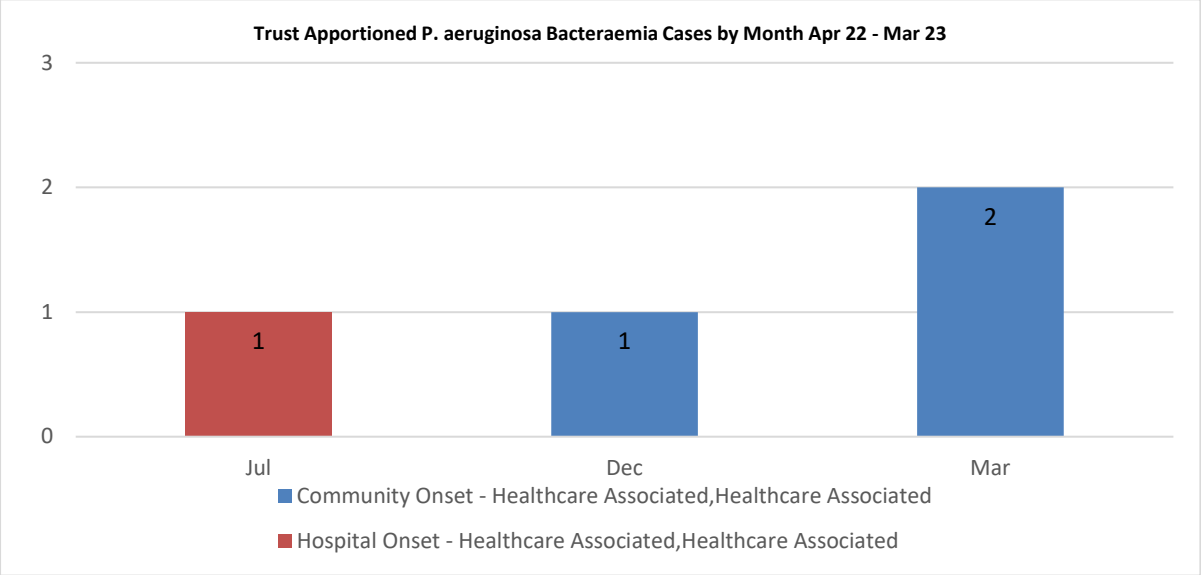
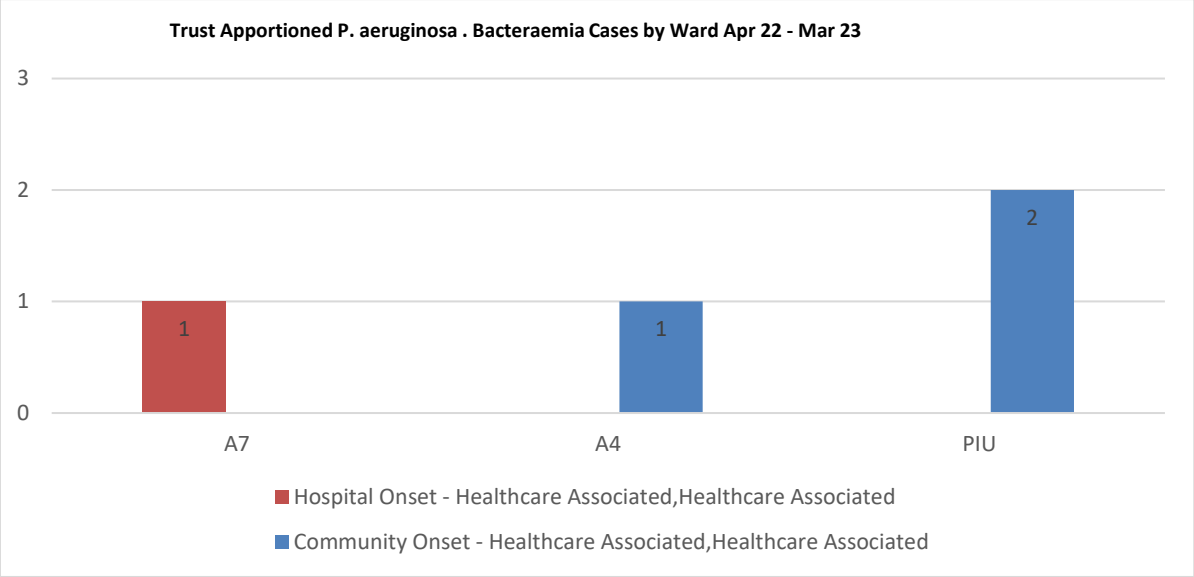


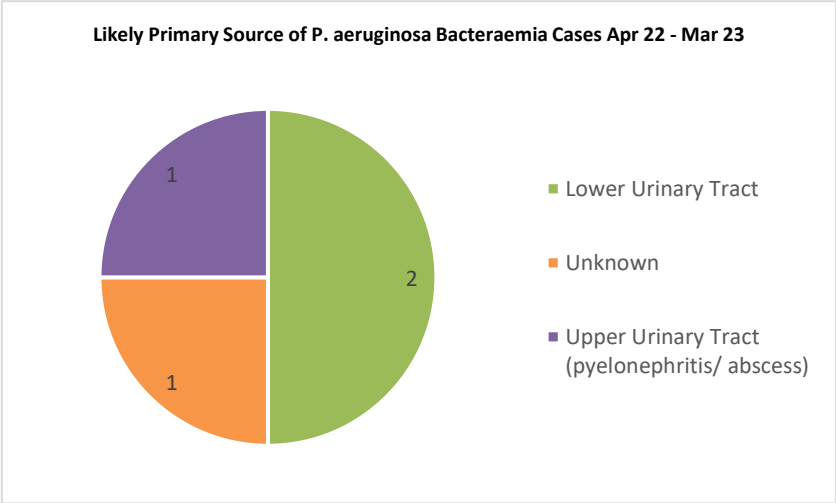
Figure 29 show Trust apportioned Pseudomonas aeruginosa bacteraemia cases by location where specimen was taken for HOHA cases and location discharged from for COHA cases.

Figure 29 Pseudomonas aeruginosa bacteraemia cases by location



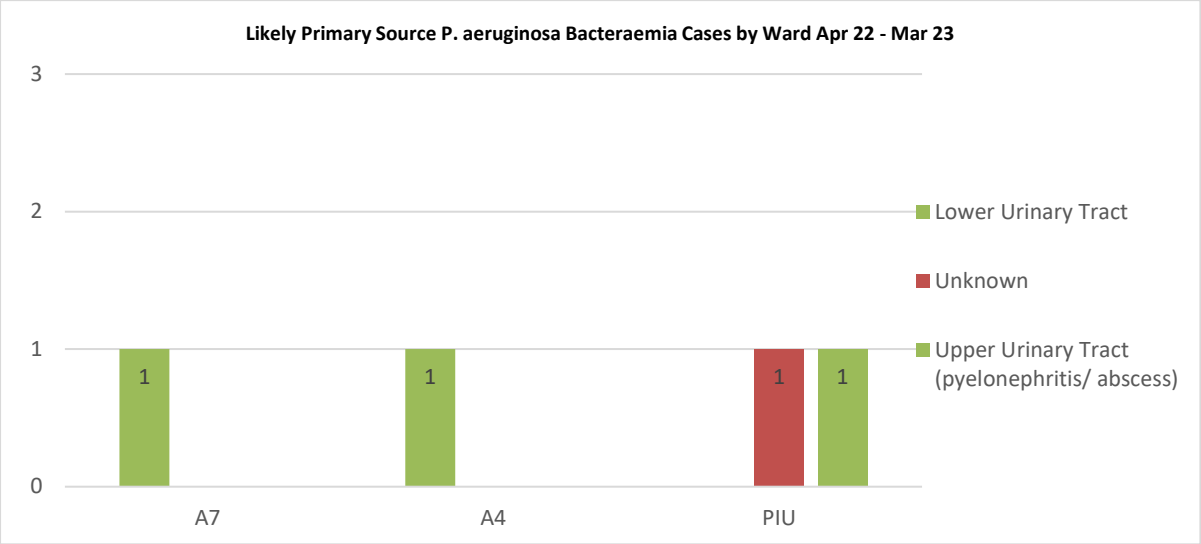
A breakdown of Trust apportioned cases to show likely primary source is shown in figure 30.

Figure 30 Likely Primary Sources of Trust Apportioned Cases



A breakdown of Trust apportioned cases to show likely primary source by location is shown in figure 31.

Figure 31 Trust Apportioned P. aeruginosa Bacteraemia Cases Likely Primary Source by Location



GNBSI prevention activity has recommenced with action that includes: -

- patient hydration
- reduction in use of urinary catheters
- improvements to care of urinary catheters
- competency assessments incorporating ANTT
- patient hand hygiene strategy

Information on all mandatory reported HCAIs is circulated weekly with up-to-date information on cases and learning from reviews. Dashboards are circulated monthly after data validation. Work is in progress with CBUs to ensure completion of action plans from HCAI incidents.

Incidents/outbreak reports

Surgical Site Infection Orthopaedics

The UK Health Security Agency (UKHSA) identified WHH as an outlier with an increase in arthroplasty (hip and knee replacement) surgical site infections (0.9%). The situation was reviewed with findings and action taken including: -

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

S. Pyogenes (Group A Streptococcus)

Challenges associated with an increase in patient admissions with S. pyogenes, (Group A Streptococcus) including invasive disease. Good collaboration was in place with the DIPC, IPC Team, Paediatric Department, Pharmacy, and the Microbiology Laboratory. Rapid testing for S. pyogenes

was introduced to support safe management of available antibiotics (national shortage) and effective treatment of patients presenting with suspected infections.

Respiratory Syncytial Virus

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

Hand Hygiene and Aseptic Protocols

Audits of compliance with the hand hygiene policy are undertaken weekly at ward and department level. The average compliance rate for the year was 98%. Overall results by month are shown in table 3.

Table 3 Trust wide hand hygiene audit results by month

Month	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
Compliance	98%	99%	99%	98%	99%	98%	99%	99%	98%	98%	98%	98%

The IPC team have joined an initiative spearheaded by NHSE to invite patients to comment on staff compliance with hand hygiene using quick response (QR) codes.

Decontamination

All surgical instruments are decontaminated off site by a company that provides decontamination services for several Trusts within the region. There is a programme of internal and external validation. The Trust is compliant with Department of Health and NHS Estates guidance. The terms of reference for the Decontamination Group have been revised and meetings are held quarterly.

A report from the Healthcare Safety Investigation Branch (HSIB) hsib-report-decontamination-of-surgical-instruments.pdf (hsib-kqcco125-media.s3.amazonaws.com) into decontamination of surgical instruments was shared with the decontamination service provider. A response was provided in June 2022, indicating a review of safety observations was in progress to move the service from compliant with guidelines/manufacturers recommendations to an improved standard.

Domestic Services

Management Arrangements

Warrington and Halton Hospitals Domestic Team are employed as an in-house service and are part of the Trust Estates and Facilities Team. The team is led by a Head of Facilities and on a day-to-day basis managed by a Support Services Manager on each site.

The Domestic Team provide 24 hour, 7 days per week cover, this includes out of hours support by the Portering Team at Halton. The team are also supported by 'as and when' staff who cover vacancies and partially cover annual leave and sickness and have been supported by an agency during the pandemic.

The Domestic Task Team at Warrington provides a valuable service, dealing with emergency leaks/spills, routine and emergency curtain changes, terminal cleans, and any cleaning required following infection outbreaks. They also form the core team progressing deep cleans in clinical areas. The Trust also uses a number of hydrogen peroxide fogging machines to assist with decontamination of the environment. This is operated by the Task Team.

Budget Allocation

The budget allocation for domestic services was £5.1 million with 157.55 whole time equivalent (WTE) staff.

Cleaning Arrangements

In line with the national specifications for cleanliness in the NHS, the functional groups are divided into levels of cleaning intensity, based on the risks associated with inadequate cleaning in that specific area with recommended rectification timescales:

FR1 98%: Assessment within 20 minutes and task completed at the next scheduled clean or within 2 hours (if the area is accessible) whichever is the soonest.
Areas include: - A&E, ICU, All Theatres, Birthing Suite, Neonatal, A5 elective, Cantreat, Urgent Care PACU

FR2 95%: Assessment within 20 minutes and task completed a the next scheduled clean or within 4 hours whichever is the soonest.
Areas include: All wards not above, Angio, Endoscopy, Day case, TSSU, Ophthalmic Day case, Nest, UCC, Xray, Renal Dialysis, GUM, Blood rooms

FR3 90%: Assessment within 1 hour and task completed at the next scheduled clean or within 12 hours whichever is the soonest.
Areas include: Orthodontics, Mortuary

FR4 85%: Assessment within 1 hour and task completed at the next scheduled clean or within 72 hours whichever is the soonest.
Areas include: CT, Pharmacy, MRI, Ultrasound, Radiology Day Case, Breast screening, Blood rooms, Surgery Pre-op, Occupational Health, Main linen store, entrances and exits, OPD, Daresbury, Halton Eye clinic, SAU, X Ray, Anti-Coagulation, ANDU, Physio, Surgical Appliances, Gynae Clinic, Pathology lab, Childrens OPD, Vascular lab, Clinical skills, Delamere Centre, ECG, Audiology, Cardiology, Diabetic drop in, Occupational Therapy, Cardiac rehab

FR5 80%: Assessment within 24 hours and task completed at the next scheduled clean or within 96 hours whichever is the soonest.
Areas include: Medical Engineering, Chapel, Main Receptions, linen and waste cupboards, equipment store

FR6 75%: Assessment within 24 hours and task completed at the next scheduled clean or within 120 hours whichever is the soonest.
Areas Include: Offices, Medical Records, Stores, Drs Mess

Monitoring Arrangements

There is a dedicated Monitoring Team within Facilities, who monitor standards of cleanliness within clinical and non-clinical areas at both sites. This team is led by a Facilities Manager to ensure there is no conflict of interest. The team are all trained to British Institute of Cleaning Science BICS standard.

The monitoring of ward kitchens is undertaken by the Catering Department, who monitor cleanliness and food hygiene standards. A schedule is in place to routinely monitor ward kitchens. Any serious breaches of food hygiene are dealt with immediately. An annual inspection of ward kitchens is also carried out by the Local Authority's Environmental Health Team.

The monitoring programme complies with the Department of Health Specifications, covering domestic cleaning, patient equipment, and estates issues. The monitoring frequency is dictated by the grading of areas, which are as follows: -

FR1 Areas Weekly
FR2 Areas Monthly
FR3 Areas Every 2 Months
FR4 Areas Every 3 Months
FR5 Areas Every 6 Months
FR6 Areas Every 12 Months

Copies of the monitoring reports are circulated to the Lead Nurses, Matrons, Ward Managers, Support Service Managers and Estates, to address any remedial action required.

Ward Housekeepers are responsible for ensuring any actions on Monitoring forms are dealt with promptly. If there are any specific areas of concern, this is reviewed, and focus is given to address the issue. When necessary, the frequency of monitoring is increased to address any problem areas and during periods of increased incidence of infection.

Terminal Cleaning

Terminal cleaning is carried out by the Task team on request by a Ward when there is an infection or when a patient has been discharged outside normal working domestic hours.

Table 4 Terminal Cleans

Terminal cleans	**A**	**M**	**J**	**J**	**A**	**S**	**O**	**N**	**D**	**J**	**F**	**M**	**Total**
2021/2022	427	525	630	768	781	552	675	808	816	890	591	787	**8250**
2022/2023	698	491	522	578		405	471	457	642	462	392	404	**5522**

Table 5 Curtain changes:

Curtain changes	A	M	J	J	A	S	O	N	D	J	F	M	**Total**
2021/2022	95	95	119	101	94	101	143	131	144	224	227	158	**1632**
2022/2023	208	158	164	186		134	261	265	441	211	268	232	**2528**

Table 6 HPV Cleans:

HPV Cleans	A	M	J	J	A	S	O	N	D	J	F	M	**Total**
2021/2022	37	30	37	51	29	44	75	64	72	88	100	77	**704**
2022/2023	74	51	48	42	-	14	34	26	21	18	23	29	**380**

CLEANLINESS SCORES

The 2022/23 cleanliness monitoring scores (Domestic only) for Very high risk and high-risk clinical areas were as follows:

VHR (FR1)

- Warrington: 99%
- Halton: 99%

HR (FR2)

- Warrington 97%
- Halton 97%

PLACE (Patient Led Assessments of the Care Environment)

PLACE assessments are conducted annually and provide a non-clinical appraisal of healthcare settings with patient representatives making up 50% of the assessment teams. This year the assessment was carried out in November 2022 on both sites with results published in March 2023 and the scores for cleanliness shown in table 7.

Table 7 PLACE Results

Site Name	Cleanliness Score %
HALTON HOSPITAL	99.72%
WARRINGTON HOSPITAL	99.27%

Corporate Reporting

A monthly report is submitted by Facilities to the Infection Control Sub-Committee regarding cleanliness standards scores, number of terminal cleans/curtain changes, process audits for cleaning hand wash sinks and PPE, ward kitchen monitoring, linen, pest control and waste.

Training

The Domestic Staff receive specific theoretical and practical cleaning training as part of their induction, which includes infection control elements including the use of FFP3 Masks and this is supported by subsequent refresher training.

Random process audits are carried out to ensure that staff follow the correct procedure and wear the correct personal protective equipment (PPE) when cleaning hand washing sinks. Staff competency audits are also carried out to ensure that domestics are working in accordance with their training and the Trust Cleaning Standards Policy and Cleaning manual.

Clinical Access/Responsibility

The domestic staff are centrally managed by the Facilities team; however, the Ward Managers and the Housekeepers are able to direct the domestic staff based on each ward regarding day-to-day priorities. There is also close liaison with the Matrons, who have a specific responsibility for cleanliness standards for their Clinical Business Unit.

Facilities also have a close working relationship with the Ward Housekeepers and attend their monthly meetings to share concerns or offer support as and when required. The Domestic Task Team at Warrington liaises closely with the Infection Prevention and Control Team and Estates when responding to terminal/deep cleans on the Wards.

National Standards of Cleanliness

In April 2021 new standards were launched. The new standards replace the National Standards for Cleanliness in the NHS (2007) and reflect modern methods of cleaning, infection prevention and control and emphasis transparency to assure patients, the public and staff that safe standards of cleanliness have been met.

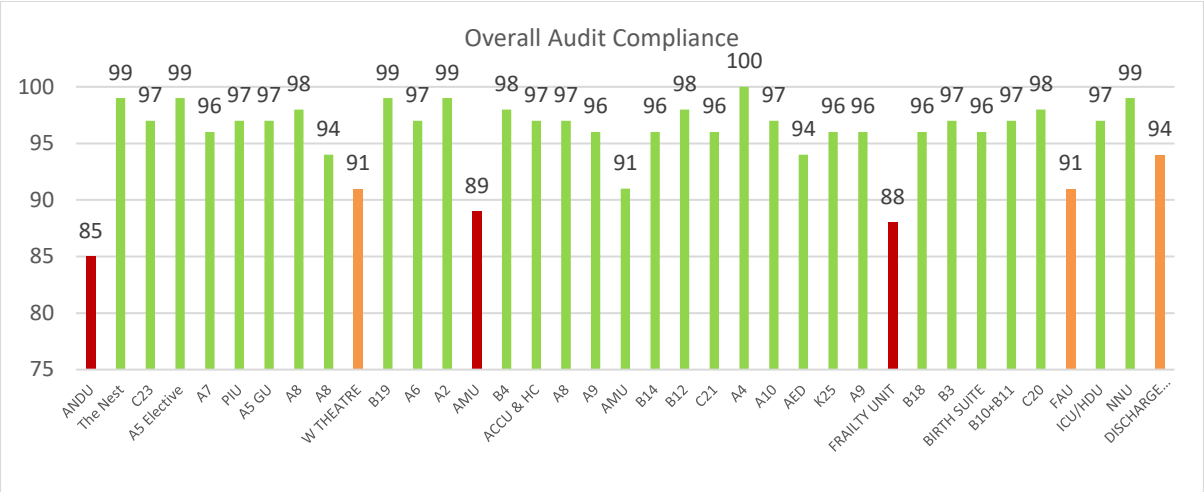
The Trust appointed a Task and Finish Group for the introduction of the new standards which was led by Facilities and IPC, focussing on the need for a collaborative approach. We have now been working to the new recommendations since November 2022 following briefings to Domestic Assistants, Ward Housekeepers, and the Cleanliness Monitoring Team. Some of the main changes have been the introduction of the new FR (frequency of audits), amendments to timelines of audited areas, staffing responsibilities between Domestic Assistants and Nursing, the introduction of rectification timelines and the introduction of star ratings to individual departments.

Audit

The aim of the audit programme is to measure compliance with Infection Prevention & Control policies/guidelines and standards in the patient care environment. This audit programme contributes to providing assurance that infection control policies are followed, and risks are effectively managed within the Trust.

The audits are carried out by the IPCNs using an approved Infection Prevention and Control audit tool. The audit tool has a total of 14 components however these are not all relevant in all areas of the Trust. A rolling programme of audit is in place to cover all in-patient areas. The audit plan was reduced due to the on-going Covid-19 pandemic. Additional audits are completed outside of the rolling programme when infection incidents occur.

Figure 32 Infection Control Audit Results



Reports on findings are fed back to the nurse in charge of the clinical area at the time of the audit. This is followed up by a written report within one week of the audit. The manager of the clinical area is responsible for producing an action plan to address areas for improvement.

High Impact Interventions

The CBUs have continued a rolling programme of audit to assess compliance with the Department of Health's High Impact Interventions Toolkit. Audit scores are mostly in the region of 90-100%. The results are discussed at the Infection Control Sub-Committee and fed back to the ward teams. Action plans are produced by wards and departments for areas where care improvements are required.

An increase in auditing frequency is requested when scores are below accepted standards. Matrons are directed to provide assurance that the audits drive improvements rather than being a monitoring process.

Antimicrobial Prescribing

From 1st April 2022-31st March 2023, 72 joint Consultant Medical Microbiologist and Antimicrobial Pharmacist ward rounds were conducted.

This was an increase in the number of ward rounds carried out compared to the previous year where there were 59 joint Consultant Medical Microbiologist and Antimicrobial Pharmacist ward rounds. Additional Pharmacists have been trained to cover the antibiotic ward round to build resilience within the service and there are plans to extend this training further when staffing allows. A Band 5 Pharmacy Technician was recruited in November 2022 to assist the Lead Antimicrobial Pharmacist with Stewardship Responsibilities. Unfortunately, recruitment of a Band 7 Pharmacist has so far been unsuccessful due to challenges with recruitment of Pharmacists at this grade nationally.

The weekly Outpatient Parenteral Antimicrobial Therapy (OPAT) Multi-Disciplinary Team (MDT) has continued.

This year we have also continued the additional weekly antibiotic MDT on ward A9 due to persistent low compliance with the antimicrobial formulary (identified in the quarterly point prevalence audit).

A Consultant Microbiologist attends B19 on Mondays to review antimicrobial prescribing in patients who have a diagnosis or history of *C. difficile* infection. They also attend the AMU board round on Fridays (when staffing allows) to review patients prescribed antimicrobials and establish individualised treatment plans for the weekend.

Joint Consultant Medical Microbiologist and Antimicrobial Pharmacist Ward Rounds

UK Health Security Agency's (formerly Public Health England) Antimicrobial Stewardship Toolkit, states that improving antimicrobial prescribing and stewardship is dependent on strong clinical leadership. They recommend that antimicrobial quality improvement should be done in collaboration with a Consultant Medical Microbiologist/infectious diseases specialist and the Antimicrobial Pharmacist.

Within the Trust, we aim to undertake two joint Consultant Medical Microbiologist and Pharmacist ward rounds each week at Warrington hospital. These ward rounds target patients who are prescribed specific "target antimicrobials", wards with higher rates of antimicrobial prescribing or wards where there are concerns about compliance with the Trust antimicrobial formulary (picked up through the quarterly antimicrobial point prevalence audit) or higher incidence of HCAIs.

"Target antimicrobials" are antimicrobials that we have determined locally require closer monitoring than other antimicrobials because they are either: -

- broad-spectrum antimicrobials that should be reserved for the treatment of more complicated infections that are not responding to the Trusts first line antimicrobials or
- antimicrobials that are more commonly associated with the development of *C. difficile* infection

The "target antimicrobials" within the Trust include:

- piperacillin/tazobactam (Tazocin®)
- meropenem
- cephalosporins
- co-amoxiclav
- linezolid
- clindamycin
- quinolones

Patients prescribed "target antimicrobials" are identified from a prescribing report taken directly from the Electronic Prescribing Medicine Administration (EPMA) system. The ward rounds are a way of gaining assurance that the "target antimicrobials" are being prescribed appropriately across the Trust.

Ward Pharmacists are also able to refer patients for review on the antimicrobial ward round. Common reasons for Ward Pharmacist referral are: -

- Concerns that patient is deteriorating from an infection point of view and the clinical team have requested a review
- Patient is prescribed antimicrobials that are non-compliant with the antimicrobial formulary
- Culture and sensitivity results are available to allow rationalisation of antimicrobials but not actioned by clinical team

- Patient is clinically well and suitable for oral step down or cessation of antimicrobial therapy but the team with clinical responsibility for the patient are not undertaking this or are requesting Consultant Medical Microbiologists advice

Due to high Tazocin usage within the Trust, a third ward round was implemented part way through the year. Tazocin ward rounds, are carried out each Tuesday in addition to the two other ward rounds.

Summary of Antimicrobials Reviewed

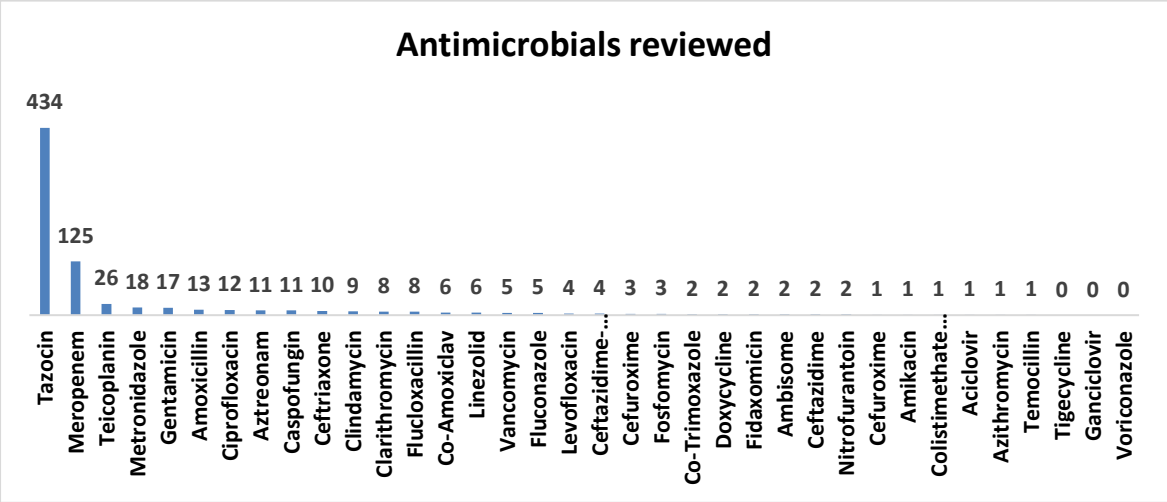
A total of 659 patients and 760 antimicrobials were reviewed on the ward rounds between 1st April 2022 and 31st March 2023. This is a significant increase on 2021/2022 where a total of 414 patients and 497 antimicrobials were reviewed on the ward rounds.

The 2 antibiotics most frequently reviewed were Piperacillin/Tazobactam (Tazocin®) and Meropenem. These antibiotics are targeted on the ward round because they are broad-spectrum antibiotics that should be prescribed only as per formulary, or inpatients who are known to have previously grown a multi-drug resistant (MDR) organism. The antibiotic ward round provides an opportunity for the Consultant Microbiologist and Antimicrobial Pharmacist to review patients prescribed these antibiotics to ensure they have received appropriate investigations and microbiological sampling so that an appropriate antibiotic de-escalation plan can be provided upon clinical improvement.

Table 8 Total Number of Antimicrobials Reviewed

Time period	Number of patients reviewed	Number of antimicrobials reviewed
April 2013 – March 2014	592	770
April 2014 – March 2015	420	579
April 2015 – March 2016	395	545
April 2016 - March 2017	713	829
April 2017 - March 2018	654	905
April 2018 – March 2019	667	828
April 2019 – March 2020	739	919
April 2020 – March 2021	550	676
April 2021 – March 2022	414	497
April 2022 – March 2023	659	760

Figure 33 Summary of the Different Antimicrobials reviewed on the Ward Rounds



Summary of Ward Round Interventions

Of the **760** antimicrobial prescriptions reviewed, we were able to add a stop date/course length to **273** (35.9%) prescriptions. A further **240** prescriptions were de-escalated, **69** prescriptions were escalated and **57** antibiotic prescriptions were stopped.

De-escalation is defined as: -

- a change in IV antimicrobial regimen to a narrower spectrum agent
- IV to oral step down.

Escalation is defined as:

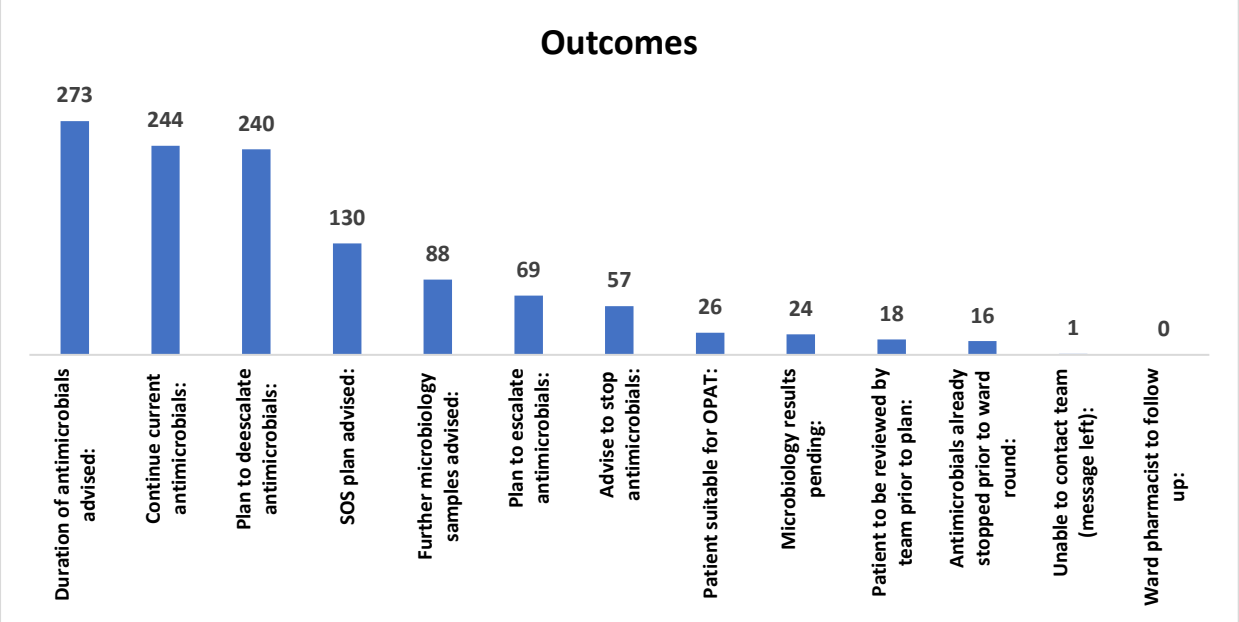
- additional antimicrobial cover added.
- oral to IV switch.

Changes to antimicrobial therapy were only made if the team with clinical responsibility for the patient could be contacted and the proposed changes were discussed and agreed.

Further advice and an "SOS" plan were provided for **130** patients. The "SOS" plan provides the clinical teams with advice in case of clinical deterioration. In addition to the antibiotic escalation plan it will include details of further investigations or microbiological sampling to be undertaken if clinical deterioration occurs.

(Please note: total exceeds 760 prescriptions, often multiple actions for one prescription i.e., de-escalation and addition of stop date).

Figure 34 Outcome of Antimicrobial Reviews



Tazocin Specific Ward Rounds

Outcomes are not documented in the same way as the bi-weekly ward rounds mentioned above as discussions are only recorded via Molis, not on Lorenzo. From the available documentation, 240 patients have been reviewed on these ward rounds.

(Please note: this is not a complete picture, as documentation of outcomes has not always been recorded for the duration of the year)

Benefits of the Ward Rounds

Patient Safety

During or prior to each ward round the Consultant Microbiologist accesses MOLIS (lab information system) and a review is undertaken of each patient's recent microbiology samples to see if any organisms have been isolated during this admission that will influence antibiotic prescribing decisions. Additional factors that are also considered include history of multi-drug resistant organisms or *C. difficile* infection.

The ward rounds are not just about reviewing the antibiotics prescribed but also ensuring the patient has had the appropriate microbiological samples sent or undergone appropriate clinical investigations to ensure antimicrobials can be stopped, escalated, or de-escalated as appropriate. These interventions ensure that patients are exposed to fewer days of broad-spectrum antimicrobial treatment or antibiotics are changed to more appropriate antimicrobial treatment in a timelier manner. Consequently, this improves patient safety because if patients are exposed to fewer days of unnecessary broad spectrum antimicrobial therapy then the risk of the patient going on to develop a HCAI such as *C. difficile* infection is reduced. Likewise, if it is identified that the patient has grown an MDR organism in the past then this may be relevant and antimicrobial therapy will be tailored to cover this organism and ensure safe and appropriate antimicrobial treatment.

The ward rounds allow the Consultant Microbiologist and Antimicrobial Pharmacist to review patients with complex histories/infections who benefit from more specialist input i.e., patients with infective endocarditis and patients who are prescribed antimicrobials with a narrow therapeutic window, providing specific advice on dosage adjustment and duration of treatment.

Junior Doctors & Antimicrobial Stewardship (AMS)

The Consultant Microbiologists and Pharmacist use the ward rounds as an opportunity to build up relationships with ward teams and provide education to junior doctors. Appropriate prescribing is just one part of good antimicrobial stewardship, timely and appropriate microbiological sampling, and regular clinical review of both the patient and the diagnosis are also vital parts of the Start Smart, Then Focus (SSTF) antimicrobial prescribing algorithm. The ward rounds seek to engage all doctors (but mostly junior doctors) and promote these vital steps and help them develop a wider understanding of AMS.

The antimicrobial formulary is actively promoted on each ward round and the junior doctors are reminded of the importance of AMS and their vital role in slowing down antimicrobial resistance (AMR). Junior doctors are encouraged to participate in the ward rounds, and they are informed of the reasons for any suggested changes to antimicrobial therapy which develops their knowledge of microbiology. It is hoped that the education provided during the ward rounds will influence their prescribing practice as they progress in their career and develop their confidence around diagnosis and management of different infections.

Financial benefits

Cost savings are made through the ward rounds by reducing unnecessary consumption of antimicrobials by timely cessation of antimicrobial treatment or de-escalation in treatment where appropriate. Nursing time is saved by the appropriate cessation of antimicrobials, particularly intravenous antimicrobials.

Identification of patients who may be suitable for early supported discharge for completion of long-term IV antibiotic therapy in the community setting via the OPAT team has financial savings for the Trust by reducing bed days.

Compliance with NICE Guidance

NICE guideline NG15 recommends that all care settings should establish an antimicrobial stewardship programme. This ward round is part of the Trusts AMS programme and ensures compliance with NICE guidance. It provides an opportunity to feedback to individual prescribers, monitor prescribing habits and provides education and training (see above).

Other benefits

The ward rounds help the Trust to manage antimicrobial shortages.

Participation in the antimicrobial ward rounds is a good development opportunity for Junior Pharmacists and improves their knowledge and confidence in AMR and AMS. Trainee Advanced Care Practitioners, medical students and various practitioners undertaking non-medical prescribing qualifications have also joined the ward rounds this year as an educational experience.

Educational sessions

This year has also seen an addition of two further two-hour education sessions to the FY1 and FY2 cohort of doctors. These additional sessions provide an interactive seminar presented by a Consultant Microbiologist and specialist Pharmacist to discuss in more depth antimicrobial stewardship and its practical application. It also provides an opportunity to promote key current concerns specific to the Trust regarding AMS.

This builds on the existing and well-established session provided by a Consultant Microbiologist early in FY1s career in the Trust.

Future developments

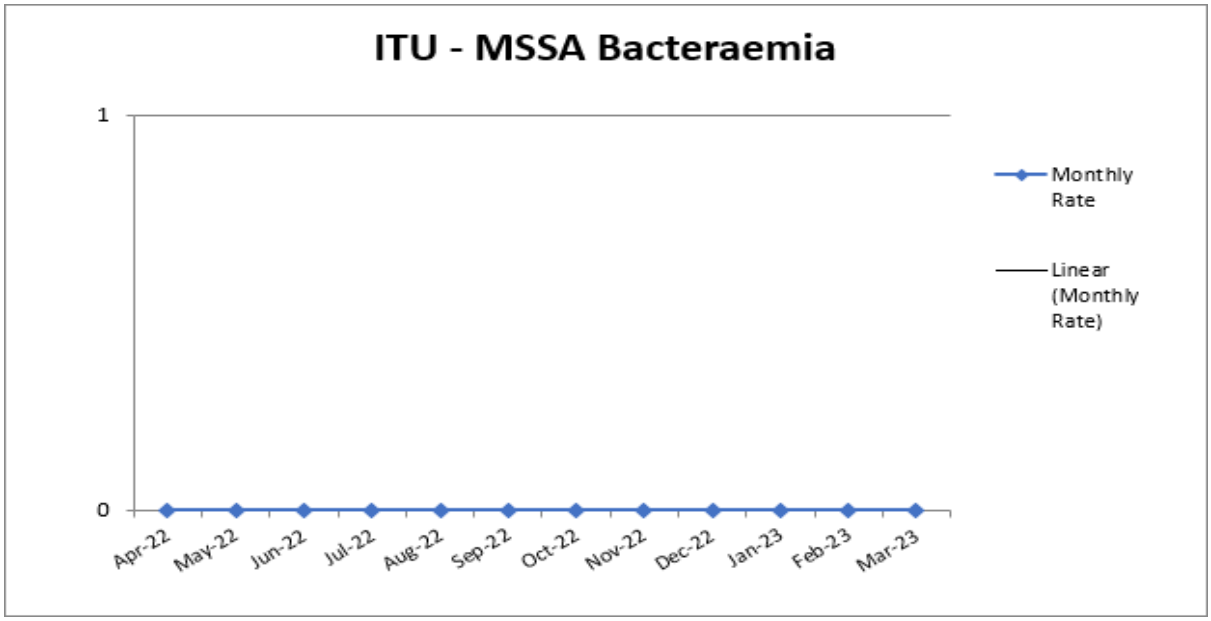
- Recruitment to the Band 7 Pharmacist position.
- The antimicrobial ward rounds could be expanded or further ward-based MDTs added so that more patients on antimicrobials are reviewed. However, this is limited by Consultant Microbiologist and Antimicrobial Pharmacist availability.
- Ensure outcomes associated with the Tazocin-specific ward round are recorded in the same way as the other ward rounds.
- Within pharmacy there is a plan to train and rotate junior Pharmacists through the antimicrobial ward round to expand their knowledge of antimicrobials and AMS.
- Promotion and focus on prompt switching of IV to Oral antimicrobials (IVOS) in line with new National CQUIN.

Critical Care Surveillance

The Critical Care Unit conducts enhanced surveillance of bloodstream infections and ventilator associated pneumonia cases.

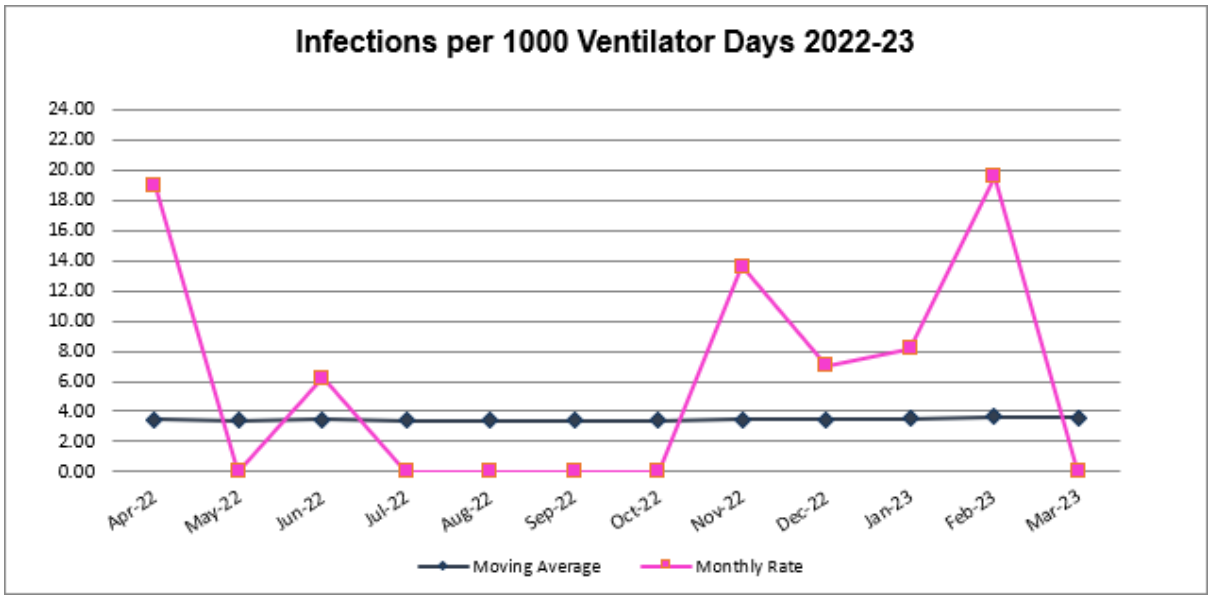
MSSA bacteraemia cases were monitored, and no intravascular line associated case was observed.

Figure 35 Critical Care MSSA Bacteraemia Surveillance



The Critical Care Unit also collates data on ventilator associated pneumonia casess (VAP). This facilitates identification of trends of bacterial pneumonia in ICU patients who are mechanically ventilated with data shown in figure 36.

Figure 36 Ventilator Associated Pneumonia Surveillance



Targets and Outcomes

Activities

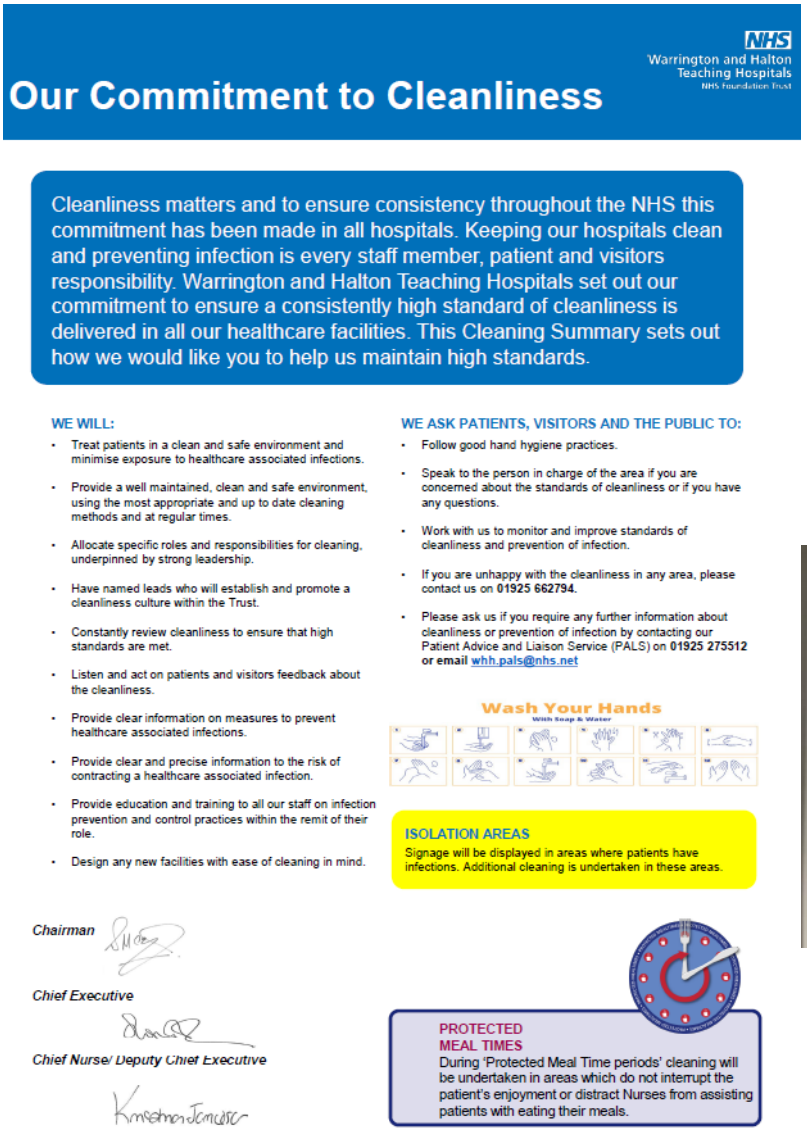
The Infection Prevention and Control Team has been involved in several initiatives within the Trust to promote the importance of infection prevention and control. These included: -

- Hand hygiene awareness raising events
- Unannounced spot checks
- Global hand hygiene day
- Matron/Facilities Walkabouts
- World Antibiotic Awareness Week
- Response to complaints
- Response to FOI requests

Awareness raising events

The team had a proactive approach to awareness raising events using Trust wide safety brief, good morning WHH and desktop messages.

Cleanliness



NHS
Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Our Commitment to Cleanliness

Cleanliness matters and to ensure consistency throughout the NHS this commitment has been made in all hospitals. Keeping our hospitals clean and preventing infection is every staff member, patient and visitors responsibility. Warrington and Halton Teaching Hospitals set out our commitment to ensure a consistently high standard of cleanliness is delivered in all our healthcare facilities. This Cleaning Summary sets out how we would like you to help us maintain high standards.

WE WILL:

- Treat patients in a clean and safe environment and minimise exposure to healthcare associated infections.
- Provide a well maintained, clean and safe environment, using the most appropriate and up to date cleaning methods and at regular times.
- Allocate specific roles and responsibilities for cleaning, underpinned by strong leadership.
- Have named leads who will establish and promote a cleanliness culture within the Trust.
- Constantly review cleanliness to ensure that high standards are met.
- Listen and act on patients and visitors feedback about the cleanliness.
- Provide clear information on measures to prevent healthcare associated infections.
- Provide clear and precise information to the risk of contracting a healthcare associated infection.
- Provide education and training to all our staff on infection prevention and control practices within the remit of their role.
- Design any new facilities with ease of cleaning in mind.

WE ASK PATIENTS, VISITORS AND THE PUBLIC TO:

- Follow good hand hygiene practices.
- Speak to the person in charge of the area if you are concerned about the standards of cleanliness or if you have any questions.
- Work with us to monitor and improve standards of cleanliness and prevention of infection.
- If you are unhappy with the cleanliness in any area, please contact us on **01925 662794.**
- Please ask us if you require any further information about cleanliness or prevention of infection by contacting our Patient Advice and Liaison Service (PALS) on **01925 275512 or email** whh.pals@nhs.net

Wash Your Hands
With Soap & Water

ISOLATION AREAS
Signage will be displayed in areas where patients have infections. Additional cleaning is undertaken in these areas.

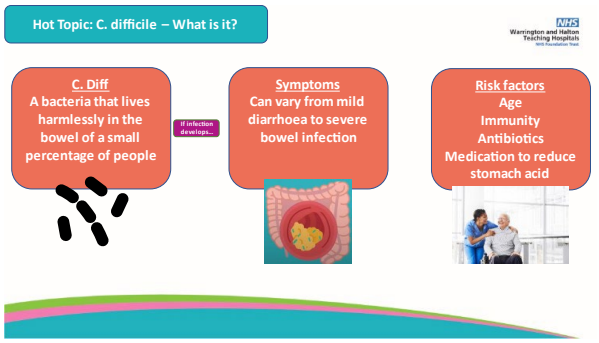
Chairman

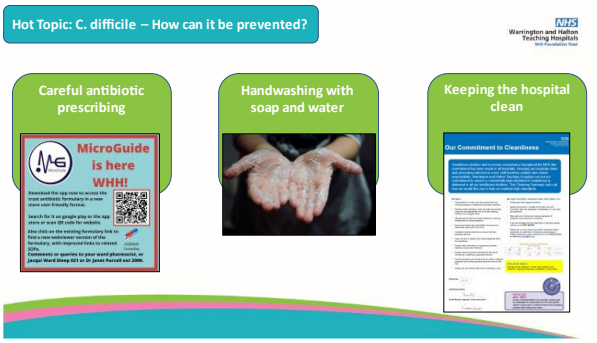
Chief Executive

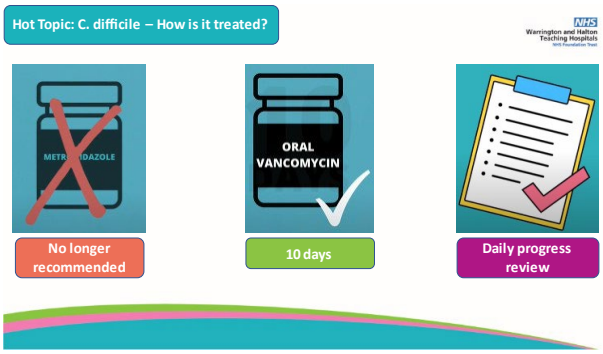
Chief Nurse/ Deputy Chief Executive

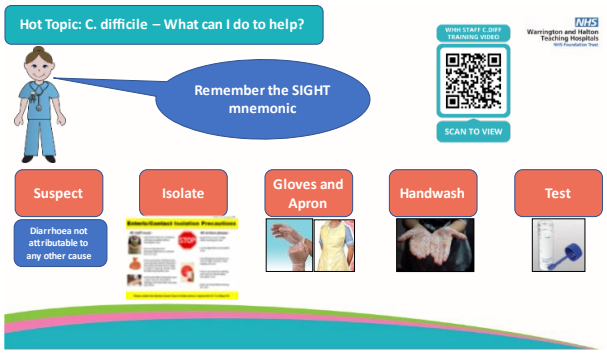
PROTECTED MEAL TIMES
During 'Protected Meal Time periods' cleaning will be undertaken in areas which do not interrupt the patient's enjoyment or distract Nurses from assisting patients with eating their meals.

C. difficile


Hot Topic: C. difficile – What is it?
C. Diff
A bacteria that lives harmlessly in the bowel of a small percentage of people
If infection develops...
Symptoms
Can vary from mild diarrhoea to severe bowel infection
Risk factors
Age
Immunity
Antibiotics
Medication to reduce stomach acid


Hot Topic: C. difficile – How can it be prevented?
Careful antibiotic prescribing
MicroGuide is here WHH!
Handwashing with soap and water
Keeping the hospital clean


Hot Topic: C. difficile – How is it treated?
METRONIDAZOLE
No longer recommended
ORAL VANCOMYCIN
10 days
Daily progress review


Hot Topic: C. difficile – What can I do to help?
Remember the SIGHT mnemonic
WHH STAFF C.DIFF TRAINING VIDEO
SCAN TO VIEW
Suspect
Diarrhoea not attributable to any other cause
Isolate
Gloves and Apron
Handwash
Test

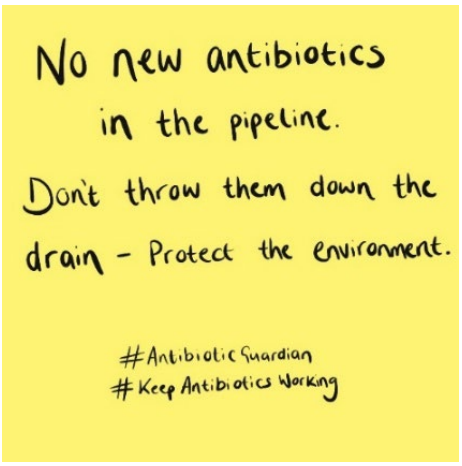

Infection Prevention Strategy
Infection Prevention Strategy
2022 - 2025
SPACE-R
We need your help
Our Infection Prevention Mission is...
To work together to deliver outstanding healthcare by engaging, educating, and empowering healthcare staff, patients, and their carers to prevent healthcare associated infections.
Our Infection Prevention Vision is...
A world in which healthcare associated infections have been reduced to the lowest possible level.
Contact the Infection Prevention & Control Nurses on Ext. 2117 or Bleep 018 for further information


WHH STAFF C.DIFF TRAINING VIDEO
SCAN TO VIEW

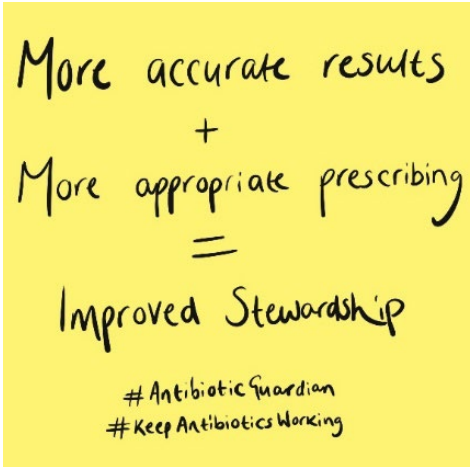

It's in your hands!
Protect antibiotics with hand hygiene
#AntibioticGuardian
#KeepAntibioticsWorking

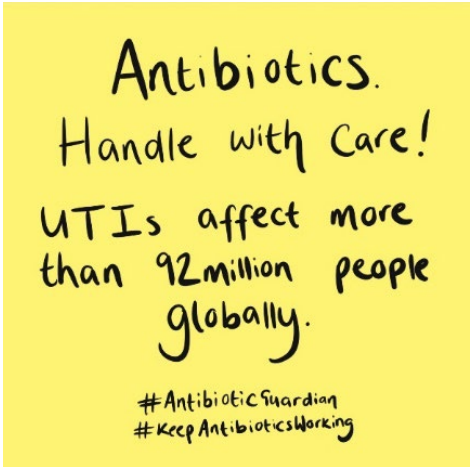

HANDLE
ANTIMICROBIALS
WITH CARE


NHS
Warrington and Halton Teaching Hospitals
NHS Foundation Trust
Working together to "reduce" antimicrobial resistance
Play Your Part
Keep hands clean
Stay up to date on recommended vaccines
Prepare food safely
Improve antibiotic use


No new antibiotics in the pipeline.
Don't throw them down the drain - Protect the environment.
#AntibioticGuardian
#KeepAntibioticsWorking


Reduce inappropriate prescriptions.
Reduce transmission.
Reduce resistance.
#AntibioticGuardian
#KeepAntibioticsWorking


More accurate results
+
More appropriate prescribing
=
Improved Stewardship
#AntibioticGuardian
#KeepAntibioticsWorking


Antibiotics.
Handle with Care!
UTIs affect more than 92million people globally.
#AntibioticGuardian
#KeepAntibioticsWorking

Improving Hydration

Updated policies and guidelines

Policies and guidelines relating to Covid-19 were developed as per the Covid-19 section of this report.

The following documents were revised and approved by the Infection Control Sub-Committee: -

- Mobile Air Conditioning Units SOP
- Viral Gastroenteritis Guidelines
- Monkeypox SOP
- MSSA Screening of Elective and Ambulatory Trauma Orthopaedic Cases SOP
- C. difficile Cohort Facility Operational Policy
- Blood and Body Fluid Spillage Guidelines
- Decontamination Policy
- Deceased Patient Infection Control Guidelines
- Ward/Department Closure Guidelines
- Healthcare Associated Infections – Local Surveillance Guidelines
- Mattress Inspection And Cleaning SOP
- Assessing Infection Risks When Admitting, Transferring, or Discharging Patients' Guidelines
- Specimen Collection Guidelines
- Blood Culture Policy
- Multi-Drug Resistant Organism Guidelines
- Group A Streptococcus Policy
- Group A Streptococcus Rapid Testing In Paediatrics
- Food Safety Policy

- ICSC Terms of Reference 2023/24
- IPC Annual Work Plan 2023/24
- IPC Assurance Framework (Reporting lines and infrastructure) 2023/24
- Cleanliness charter
- Ventilation Group Terms of reference
- Standard Precautions Personal Protective Equipment Audit Tool
- Risk assessment for cohorting patients in a bay on B11(Paediatrics)
- Decontamination Group Terms of Reference

Revised and updated infection control policies, procedures and information leaflets are available from the Trust's intranet for staff to access.

Contribution to other initiatives

Capital Projects

All areas that have undergone upgrade work have been reviewed and signed off by the IPCT prior to re-occupation by patients.

External groups

The Infection Prevention and Control Team participated in the following external groups: -

- Northwest Boroughs Partnership Mental Health Trust Infection Control Committee
- Place-based System Collaborative for Infection Prevention

Training Activities

The Infection Prevention and Control Team continue to provide a structured annual programme of education. This includes an Infection Control eLearning package for all staff. Training attendance figures were monitored monthly with details shown in table 9.

Table 9 Infection Control Training compliance

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

The Infection Prevention and Control Nurses (IPCNs) provided 2 virtual training sessions per week via Live MS Teams events to drive up compliance. CBUs with compliance below 85% have been directed to set improvement trajectories. Additional training sessions have been offered by the IPCNs to support the CBUs.

The following sessions are included in the infection control training plan:

- Trust corporate induction: all new starters
- Mandatory training: all staff

- Patient facing staff – annual
- Non-patient facing staff – 3 yearly

Other training was provided to:

- Trainee Nursing Associates
- Trainee Assistant Practitioners
- F1/F2 Doctors
  - Induction and updates
  - Blood culture specimens (indications; aseptic technique and performance management)
  - Prudent use of antibiotics

Medical Students

- Infection Prevention and Control
- Various infection/microbiology topics

Ad hoc clinical based teaching

Single point lessons are provided in response to incidents for: -

- C. difficile management
- CPE screening
- Isolation priorities
- Linen Management
- MRSA screening and suppression therapy
- Outbreak Management
- Personal protective equipment
- Sharps Safety

Conclusion

The IPCT have worked at an exemplar level throughout the year to provide education and guidance in response to the Covid-19 pandemic and deliver the annual work plan. This year has been more challenging due to high staff turnover in the small team and ongoing additional demands associated with the Covid-19 pandemic.

The team members worked hard to provide a high output of education, guidance, and positive outcomes for the Trust. It is to their great credit that team members stepped up to meet the additional requirements for education, production of policy documents and meeting attendance alongside a proactive agenda to address C. difficile cases and bloodstream infections from MRSA/MSSA and GNBSI.

Assurance on the prevention and control of infections is provided by a matrix approach of updating policies to incorporate best practice/legislation; robust and regular auditing of policies and practice; spot checks and self-assessment. Although some policies are overdue review, there was a vast amount of proactive and responsive activity for Covid-19.

High level briefing papers and reports submitted to the Patient Safety and Clinical Effectiveness Committee and quarterly reports submitted to the Quality Assurance Committee and Board of Director reports, provide assurance on infection control activities and outcomes.

Gratitude is extended to the Infection Prevention and Control Team for maintaining their proactive leadership of a challenging and extremely busy agenda.

3. ACTIONS REQUIRED/RESPONSIBLE OFFICER

The Quality Committee is asked to receive the Infection Prevention and Control DIPC Annual Report and note the progress made.

4. IMPACT ON QPS?

Q = Improvements to quality by reducing cases of healthcare associated infection

P = Training of staff to care for patients with suspected/diagnosed infections

S = Work with procurement to support the carbon net zero 2040 ambition

5. MEASUREMENTS/EVALUATIONS

Monitor: -
Progress against the Infection Control Sub-Committee work plan

- Healthcare associated infection surveillance data
    - C. difficile
    - MSSA bacteraemia
    - MRSA bacteraemia
    - E. coli bacteraemia
    - Pseudomonas aeruginosa bacteraemia
    - Klebsiella spp. bacteraemia
    - Covid-19 – Hospital onset probable and Hospital onset definite cases
    - Covid-19 Outbreaks

- Progress against HCAI prevention plans
    - Gram negative bloodstream infection reduction
    - *Staphylococcus aureus* bacteraemia reduction (MRSA/MSSA)
    - C. difficile infection reduction

- Delivery of the Infection Prevention and Control Strategy
- Education and training compliance figures
- Audit of policy/guideline compliance and action plan for non-compliance
- Progress with policy revisions

Progress against the IPC Strategy and Annual Action Plan will be monitored at the Infection Control Sub-Committee.

Compliance assessment against the Health and Social Care Act (2008), Code of practice on preventing infections and related guidance (2022) biannually.

6. TRAJECTORIES/ OBJECTIVES AGREED

- C. difficile ≤ 37 cases
- MRSA bacteraemia cases - Zero tolerance to avoidable cases

- MSSA bacteraemia cases – no threshold
- Gram negative bloodstream infections
    - E. coli bacteraemia ≤ 57 cases
    - P. aeruginosa bacteraemia ≤ 6 cases
    - Klebsiella spp. bacteraemia ≤ 19 cases
- IPC Strategy Delivery

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 to the Quality Assurance Committee and Trust Board quarterly.

Verbal updates are provided to Trust Board monthly as part of the IPR (in full) report.

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

8. TIMELINES

Financial year 2022/23

9. ASSURANCE COMMITTEE

Infection Control Sub-Committee

10. RECOMMENDATIONS

The Quality Assurance Committee is asked to receive and note the report and progress made.

Kimberley Salmon-Jamieson
Chief Nurse /Deputy Chief Executive Officer
Director of Infection Prevention and Control (DIPC)
June 2023

Appendix 1 Annual Work Programme 2023/24

Progress against this action plan will be monitored at the ICSC monthly. Updates will be made where additional activities are identified.

Governance													
	Target date	**Leads**	**A**	**M**	**J**	**J**	**A**	**S**	**O**	**N**	**D**	**J**	**F**	**M**
Review of ICSC Terms of Reference	Annual	Deputy DIPC												✓
Review of ICSC Cycle of Business	Annual	ADIPC												✓
Review of Annual Work Plan	Annual	ADIPC												✓
Review of IPCT infrastructure and reporting lines	Annual	ADIPC												✓
DIPC annual report	Annual	ADIPC			✓									
Quarterly DIPC reports to ICSC	Quarterly	ADIPC	✓			✓			✓		✓			
Quarterly DIPC reports to Quality Assurance Committee (QAC)	Quarterly	ADIPC		✓			✓			✓			✓	
Quarterly DIPC reports to Trust Board	Quarterly	ADIPC			✓			✓			✓			✓
Risk register review	Monthly	ADIPC	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
ICSC HLBP submission to PSCE; and H & S committees and CBU Governance Meeting	Monthly	ADIPC	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
RCAs/PIR of HCAI incidents: MRSA; CDT; COVID	Per case	LNs	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Submission of C. difficile RCA findings to the PLACE team for review	Quarterly	LNs / ADIPC		✓			✓			✓			✓	
Review of revised HCAI (GNBSI/C. difficile Objective for 2022/23)	Annual	ADIPC	✓											
IPCT team building session	Apr	ADIPC			✓									
Review of progress against this work plan	Quarterly	ADIPC	✓			✓			✓			✓		
Review of progress against the IC strategy	Biannual			✓						✓				
Provision of commentary for Trust Quality Account	Annual	ADIPC	✓											
Code of Practice for prevention of HCAIs – compliance assessment	Biannual	ADIPC					✓						✓	
Review of HCAI prevention action plans C. difficile;	3 / annum	ADIPC		✓				✓				✓		
Review of HCAI prevention action plans GNBSI;	3 / annum	ADIPC	✓				✓				✓			
Review of HCAI prevention action plans Staphylococcus aureus	3 / annum	ADIPC			✓				✓				✓	
Review of learning from Covid-19 Nosocomial Action Plan	3 / annum	ADIPC					✓					✓		
Revise investigation toolkit for GNBSI	Mar	ADIPC												✓
Review toolkit for investigation of MSSA bloodstream infections	Mar	ADIPC												✓
Review toolkit for investigation of C. difficile cases	Mar	ADIPC												✓
Review toolkit for Nosocomial Covid-19 cases (8-14 days and 15+ days)	Mar	ADIPC												✓
Committee/Group meeting attendance														
Antimicrobial Stewardship Group Meetings	Quarterly	AMSG Lead CMM	✓			✓			✓			✓		
Bed meetings	Daily	IPCNs	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

	Target date	Leads	A	M	J	J	A	S	O	N	D	J	F	M
CCG CDT review panel meetings	Quarterly	ADIPC		✓			✓			✓			✓	
CDT MDT	Weekly	IPCNs	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Decontamination Group	Quarterly	ICD / ADIPC	✓			✓			✓			✓		
Patient Flow Meetings/Event Planning Group	Monthly	ADIPC	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
SCIP Group – external	Bimonthly	TBC	✓			✓				✓		✓		✓
HCAI Network UKHSA	TBC	TBC												
Health and Safety Sub-committee	TBC	ADIPC												
Health Protection Forum WBC	TBC	ADIPC												
ICSC	Monthly	IPCT	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
HCAI data submission to Communications team	Monthly	ADIPC	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
HCAI Prevention Plan for next financial year	Annual	ADIPC												✓
ICU/IPCT meetings	TBC	Deputy DIPC	✓			✓			✓			✓		
NNU/IPC Meetings														
OHWB/IPC Meetings														
Incident meetings	As required	IPCT												
Infective Endocarditis MDT	Weekly	CMM	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
IPCT meetings	Biweekly	IPCT	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
IPS meetings	Biannual	IPCNs												
Medical Devices group	Quarterly	IPCNs	✓			✓			✓			✓		
Nursing & Midwifery Forum	Monthly	ADIPC/IPC Matron	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Nutritional steering group	Monthly	TBC												
NWB ICC	TBC	Deputy DIPC												
Patient Safety and Clinical Effectiveness Committee	Monthly	ADIPC	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Patient Experience Sub-Committee	Monthly	IPC Matron	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Quality Assurance Committee	Monthly	ADIPC	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Safer sharps group meeting	Monthly	IPCN	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Ventilation Assurance Group	Quarterly	ICD / ADIPC												
Ward B19 CDT MDT	Weekly	CMM	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Water safety group	Quarterly	ICD / ADIPC												
Surveillance														
Compliance with mandatory reporting of MRSA; MSSA; C. difficile; GNBSIs (E. coli, Klebsiella and Pseudomonas)	Monthly	IPCNs/ ADIPC	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Mandatory reporting data validation and timely sign off	Monthly	ADIPC	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Covid-19 outbreak reporting	Per incident	IPCNs	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
MSK compliance with Mandatory orthopaedic surveillance	Quarterly	LN MSK	✓			✓			✓			✓		
Zero tolerance to MRSA bacteraemia cases	Monthly	ALL												
SSSI	Quarterly	LN DD	✓			✓			✓			✓		

	Target date	Lead	A	M	J	J	A	S	O	N	D	J	F	M
HCAI surveillance reports – weekly to Chief Nurse, Associate Chief Nurses, Lead Nurses and Matrons	Weekly	IPC Admin	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Surveillance of HAI alert organisms (MRSA, VRE, CDT etc.)	Daily	IPCNs	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
HCAI reporting for Trust dashboards with commentary	Monthly	ADIPC	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
HCAI reporting to ICSC dashboards	Monthly	ADIPC	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Pseudomonas surveillance in Augmented care area (ICU: NNU : K25)	Fortnightly	IPCNs	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
VRE surveillance	Fortnightly	IPCNs	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Complete Quarterly Mandatory Laboratory returns and submit to UKHSA	Quarterly	Deputy DIPC	✓			✓			✓			✓		
Antibiotic ward rounds daily on ICU	Daily	CMMs	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Antibiotic ward rounds	Weekly	CMMs	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Environmental cleanliness monitoring														
Environmental cleanliness monitoring	Monthly	Facilities Manager	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Matron and IPC Walkabouts	Monthly	Matrons /IPCNs	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
First Impressions – SEE Walkabouts	TBC	IPC Matron												
Mock CQC inspections	TBC	Matrons	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Estates PAM assessment	Annual	ADE												✓
Legionella Assessments and compass flushing reports	TBC	ADE	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
NHS Cleaning standards and Cleanliness Charter Efficacy Audits	Monthly	HoF	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Audit														
Audit Programme (IPC led) against standard precautions with reporting to ICSC	Annual	IPCNs	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Hand hygiene audits	Weekly	LNs	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
MRSA pre-operative screening audit	Quarterly	LN DD	✓			✓			✓			✓		
MRSA screening compliance audits	Monthly	IPCNS	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Support areas requiring improvements identified on the Quality Metrics programme	Monthly	IPCNs	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Policy /guideline/SOP/Leaflet Reviews														
CJD Nursing Management	Apr	IPCNs	✓											
CJD Instrument Handling	Apr	IPCNs	✓											
Tuberculosis	Apr	IPCNs	✓											
Scabies	May	IPCNs		✓										
Chickenpox	May	IPCNs		✓										
Meningitis and Meningococcal Disease	May	IPCNs		✓										
Viral haemorrhagic fevers	Jun	IPCNs			✓									
Safe handling and disposal of waste	Jun	IPCNs			✓									
Isolation of immunosuppressed patients	Jun	IPCNs			✓									
Working with dogs in healthcare	Jul	IPCNs				✓								
Awareness raising events														
Global Hand washing Day	May	IPCNS		✓										

	Target date	Lead	A	M	J	J	A	S	O	N	D	J	F	M
Uniform and workwear promotion	TBC	All												
October IC week – Topic Boards	Oct	IPCNs							✓					
Trust wide Safety Brief – IPC promotion	Oct	ADIPC							✓					
November World Antibiotic Awareness Week	Nov	CMM								✓				
Seasonal flu campaign with OHWB	Dec	OHWB							✓	✓	✓	✓		
Covid PPE refresher training	TBC	TBC												
World TB Day	Mar	IPCNs												✓
Education														
Provide Mandatory training for IPC supporting areas with low compliance figures	Monthly	IPCNS	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Mandatory training sessions as per timetable	Monthly	IPCNs	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Induction training sessions as per timetable	Monthly	IPCNs	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Single Point Lessons as requirement identifies	Monthly	IPCNs	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

D = deferred
✓= Planned
✓= Completed

Quality Assurance Committee

AGENDA REFERENCE:	QAC/23/07/154
SUBJECT:	Health and Safety Annual Report 2022/23
DATE OF MEETING:	28th June 2023
AUTHOR(S):	Layla Alani, Director of Integrated Governance and Quality
EXECUTIVE DIRECTOR SPONSOR:	Kimberley Salmon-Jamieson, Chief Nurse and+ Deputy Chief Executive
LINK TO STRATEGIC OBJECTIVE:	SO1: We will... Always put our patients first through high quality, safe care and an excellent patient experience.
EXECUTIVE SUMMARY	The Health and Safety Annual Report describes the structures and responsibilities of the Trust in ensuring a health and safe environment for staff, patients and the public. The information provided within this report relates to the financial year 2022/23. The report provides assurance of the monitoring of incidents to ensure that efforts for improvement are focused. In 2022/23 Health and Safety incident reporting reduced by 2.85%. In the previous year 1715 incidents were reported in comparison to 1666 (2022/23). The top 5 themes of incidents for 2022/23 were: • Antisocial, Abusive and Violent behaviour, e.g. violence and aggression and verbal abuse. • Equipment / Medical Devices e.g. unavailability, failure of equipment, or training. • Infrastructure / Environment and Resource, e.g. car parking, environment cleanliness, workplace temperatures, estates. • Needlestick Injury, e.g. sharps inoculation, fluid splashes. • Lost Property incidents Incidents relating to challenging behaviour are largely due to system pressures and an increase in the number of vulnerable patients attending the Emergency Department, A1 (AMU), B12 and B14. This has improved during the reporting period following the introduction in the Emergency Department of bodycams. A reduction of

57% of these incidents has been reported since they were introduced in 2022.

There were 25 RIDDOR reportable incidents reported within the Trust in 2022/23 compared to 24 in the previous financial year.

During 2022/23 the Health and Safety Team carried out the Annual Health & Safety Audit in line with the agreed Audit plan. All CBUs were audited:

- 38 wards/departments achieved 100% compliance.
- 27 areas achieved over 90%.
- 7 areas were below 90%.

Areas that were not fully compliant with the Health and Safety compliance audit, have an agreed action plan in place. There is an audit schedule in place which is monitored by the Health and Safety Sub-committee.

Health and Safety related mandatory training compliance is as follows:

Course/Compliance	**April-23**
Conflict resolution	89.35%
Corporate induction	97.77%
Falls Awareness	97.15%
Health Safety and Welfare	91.68%
Local induction	91.79%
Moving and handling Level 1	91.72%
De-escalation (commenced March 2022)	32.93%

The management of sharps has shown good compliance overall and is detailed within this report. Where improvement is required, this has been identified with action plans in place and is supported by a planned quarterly audit programme for 2023/24.

Assurance statement:

There is an established pro-active safety management system within the Trust with clear processes and procedures to ensure compliance with all relevant Health and Safety regulations.

PURPOSE: (please select as appropriate)	Information	Approval **X**	To note	Decision
RECOMMENDATIONS:	This report provides assurance to the Quality Assurance Committee that responsibilities for Health and Safety			

	are understood and monitored to fulfil the Trust's statutory duties. The Trust must see statutory compliance as a minimum standard to be achieved and must continue to build a strong Health and Safety culture throughout the organisation. The Quality Assurance Committee is asked to note and accept the contents of this Annual Report for 2023/24.	
PREVIOUSLY CONSIDERED BY:	**Committee**	
	Agenda Ref.	
	Date of meeting	
	Summary of Outcome	
NEXT STEPS: **State whether this report needs to be referred to at another meeting or requires additional monitoring**	**Submit to QAC**	
FREEDOM OF INFORMATION STATUS (FOIA):	**Release in Full**	
FOIA EXEMPTIONS APPLIED: **(if relevant)**	**NA**	

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Health and Safety Annual Report

June 2023

1. Executive Summary

All Health Care Organisations are regulated by the Health and Safety Executive (HSE). The Trust Board accepts the statutory obligations under the Health and Safety at Work Act 1974 which, along with subordinate and other legislative requirements are recognised as the minimum standards to be achieved.

Warrington and Halton Teaching Hospitals NHS (WHH) is committed to continually providing best practice standards in the delivery of a positive Health and Safety culture and considers this a fundamental component in providing a safe and healthy environment for staff, patients and the public.

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

2. Introduction

This report provides the Health and Safety Sub Committee and Quality Assurance Committee with a summary of Health and Safety activity during the financial year 2022/23. This includes analysis of standards that relate directly to the management of Health and Safety.

The Health and Safety at Work Ect Act (1974) provides a legislative framework to promote and encourage excellent Health and Safety standards at work with delegated responsibility from the Chief Executive Officer to the Chief Nurse. The standards as noted below are supported by policies, Standard Operating Procedures and risk assessments to ensure that all WHH staff are aware of how to optimise safety at work for themselves, our patients and the public.

The Health and Safety at Work Etc Act (1974) requires that the Trust provides and maintains:

- A Health and Safety Policy.
- Safe systems of work to control risks in connection with the use, handling, storage and transportation of articles and substances.
- A safe and secure working environment, including provision and maintenance of access and egress to premises.
- Safe and suitable plant and work equipment.
- Information, instruction, training and supervision as necessary.

There are Health and Safety mechanisms in place to provide assurance of compliance with proactive monitoring and triangulation through existing governance mechanisms.

3. WHH Health and Safety Management Structure

The law places an 'absolute duty' on employers to carry out risk assessments, which must include:

- Identified hazards arising from or in connection with the work.
- Who will be affected by the hazards.
- The control measures in place or proposed control measures.
- Evaluation of the risk.
- Review date.

WHH adopts a structured approach to the completion of risk assessments to ensure consistency across the organisation. Risk assessments are completed on the Trust's risk assessment form and are reviewed as follows:

- Whenever there is a significant change e.g. staff, environment or equipment.
- After an accident or 'near miss".
- After noncompliance identified through audits and inspection programmes.
- At least annually.

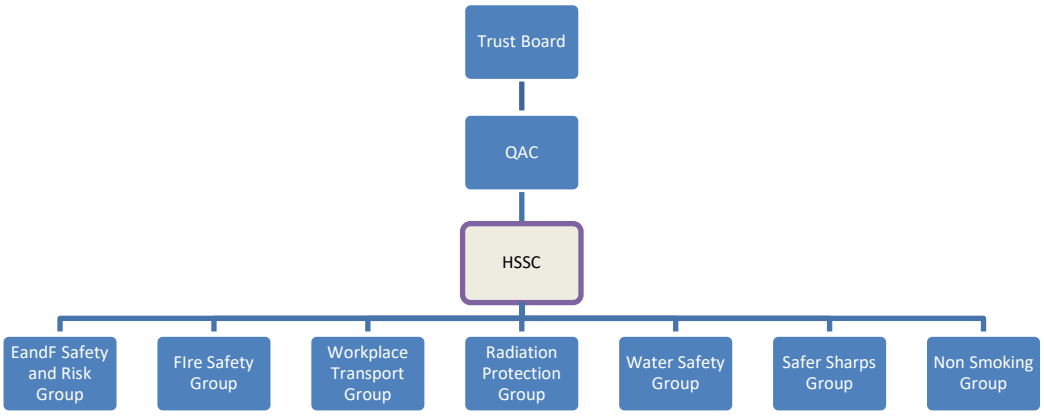
All Wards and Departments have in place risk assessments as part of the Risk Management Framework, with escalation to the appropriate risk register if required. Specific items are escalated to the Health and Safety Sub Committee (as required) for additional scrutiny, oversight and assurance.

4. Health and Safety Committee Structure

The Health and Safety Sub-committee is responsible for monitoring the development, implementation, audit and delivery of Health and Safety organisational management throughout the Trust. The Health and Safety Sub-committee receives reports and has responsibility for the ratification of policies approved at sub-group level. It is in this way that compliance with external organisational requirements such as the Health and Safety Executive, Care Quality Commission and NHS Resolution are managed.

The Director of Integrated Governance and Quality is the Chair of the Health and Safety Sub-committee which is accountable to the Quality Assurance Committee (QAC), which in turn reports to Trust Board.

The Health and Safety supporting committees are structured as follows:



5. Health and Safety Policy

WHH follow the approved Health and Safety Executive guidance for the management of Health and Safety known as HSG 65.

This document provides clarification and direction in relation to:

- Effective Health and Safety policies.
- Organisation of Health and Safety.
- Planning and implementation of requirements.
- Measuring and auditing performance.

The diagram above describes the essential requirements of successful Health and Safety management (HSG 65). By using this model, the Trust ensure that the requirements noted below are met with evidence collated:

- Legal and statutory obligations under the Health and Safety at Work Ect Act (1974) and subsequent regulations are met.
- Health and Safety management is understood and effectively managed.
- Health and Safety compliance is evidenced providing assurance to the Trust Board.
- Health and Safety is an integral part of WHH culture and its daily operating systems.
- To protect staff, patients, public, services, reputation and finances, through the process of early identification of risks relating to Health and Safety. Where risks are identified sufficient assessments, controls and mitigation are in place.
- Safe systems of work are in place and adhered to.
- Provide a safe working environment without risks to health.
- Adequate provision of welfare facilities.
- Provision of sufficient training, instruction and information to enable all employees to contribute positively to their own safety and health at work.
- There are safe arrangements for the use, handling and storage and transport of articles, materials and substances.
- There is safe access and egress.
- Staff understand the need to comply with Health and Safety policies and procedures.
- There is a top-down commitment to Health and Safety.
- Workplace risks are assessed, and safe systems of work are in place.
- A supportive culture to learning from incidents is evidenced.

6. Underpinning Legislation

The following regulations underpin the Trust's approach to safety management enabling a safe and secure environment to be maintained *(the list is not exhaustive).* These are referenced within and supported by the Health and Safety at Work Etc Act (1974) which has four main objectives:

1. Provide training and information on how to carry out work processes safely.
2. Provide a safe place to work and working environment.
3. Develop a Health and Safety policy.
4. Undertake risk assessments.

Health and Safety at Work Act (1974, forms the basis of specific areas of focus detailed within table)	
Workplace (Health, Safety and Welfare) Regulations 1992	Construction, Design and Management Regulations 2015
Control of Substances Hazardous to Health 2002	Management at Work Regulations 1999
Electricity at Work Regulations (sub section 1974)	Noise at Work Regulations 2021
Consultation with Employees Regulations (subsection 1974)	Personal Protective Equipment Regulations 2022
Display Screen Equipment Regulations 1992	Work Equipment Regulations 1998
Confined Spaces Regulations (sub section, 1974)	RIDDOR Regulations (sub section, 1974)

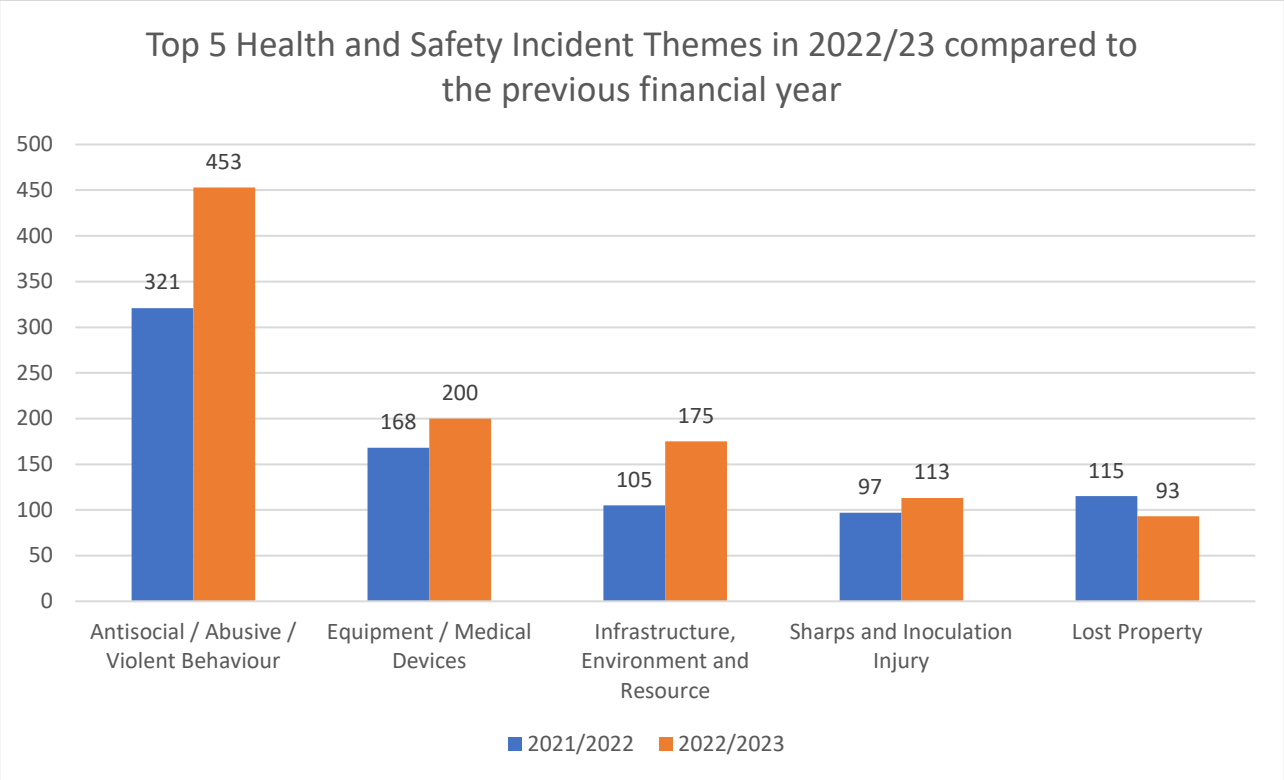
Control of Asbestos Regulations 2012	Manual Handling Regulations 1992
Lifting Operations and Lifting Equipment Regulations 1998	Work at Height Regulations 2005

7. Incident Reporting 2022/23

NB: On 1st August 2022, the categories and subcategories on the Local Risk Management System were changed to support extraction and analysis of data. All historic data from the previous categories were updated and added to the new categories. This means that each new category contains both new and archived data.

In 2022/23 Health and Safety incident reporting reduced slightly by 2.85%. In the previous year 1715 incidents were reported in comparison to 1666 (2022/23). Graph 1 below details the top 5 themes of incidents for 2022/23 with comparison to the previous financial year.

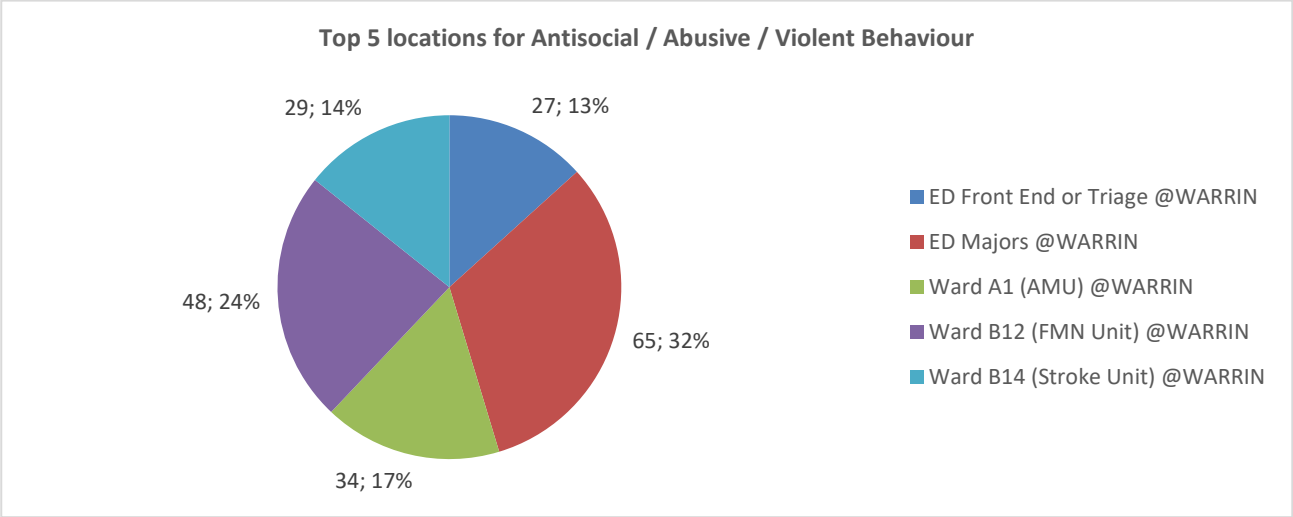
Graph 1



7.1 Antisocial, Abusive and Violent Behaviour incidents

There has been an increase of 41.12% (453 compared with 321) in the number of incidents associated with challenging behaviour compared with 2021/22.

This is a likely consequence of operational pressures, increased wait times and an increased number of vulnerable patients attending the Trust, particularly within the Emergency Department (n=92). This is also referenced through clinical governance mechanisms. The Top 5 reporting areas are displayed in the chart below.



NB All Antisocial, Abusive and Violent Behaviour incidents are reviewed and monitored by the Health and Safety Sub-Committee. Staff are supported through de-escalation and conflict resolution training and the role of the Local Security Management Specialist (LSMS) who is notified of all incidents of this nature.

Body Worn Camera's (BWC)

A trial of BWC commenced in ED during December 2022 – February 2023. During the trial there was a 57% reduction in incidents involving violence and aggression. It is predicted that this element of incident reporting will evidence an improved position in 2023/2024. The LSMS and Security Team continue to provide support to the ED team. Focused training dates for conflict resolution have been arranged for ED staff including reception staff.

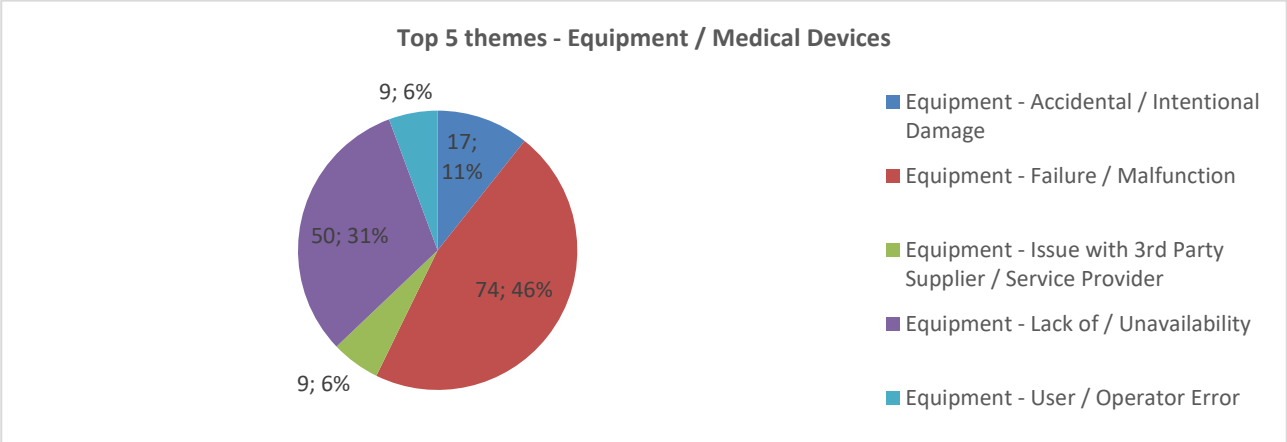
De-escalation training

Conflict resolution training compliance is reported at 89.35%. De-escalation training commenced in March 2022, which has risen to 32.93%. All areas have trajectories in place. There is currently a vacant de-escalation training post. The LSMS is now providing this training in the interim until the vacant post is filled. The LSMS has adapted the training programme to increase the number of staff that can be trained to 15 candidates per course with additional dates scheduled.

Course/Compliance	April-23
Conflict resolution	89.35%
Corporate induction	97.77%
Falls Awareness	97.15%
Health Safety and Welfare	91.68%
Local induction	91.79%
Moving and handling Level 1	91.72%
De-escalation (commenced March 2022)	32.93%

7.2 Equipment, medical device incidents

There has been an increase of 19% (200 compared with 168) in the number of incidents associated with Equipment, Medical Devices (n=32) compared with 2021/22.



(N=74) incidents related to equipment – Failure /malfunction, e.g. nurse calls / patient buzzers not operative and ward fridge temperatures out of range are some examples. No overall themes were identified.

(N=50) incidents related to equipment – Lack of / unavailability. A theme was identified in relation to (n=17) provision of the correct patient transfer equipment for the deceased. The correct deceased patient transfer equipment has now been purchased and all relevant staff have been trained in its use.

A number of incidents related to failure or non-availability of Stryker Power Tool and battery issues in Theatres. A deep dive has been undertaken and reported to the Health and Safety Sub Committee.

The Health & Safety Sub Committee noted that the issue had been raised to the Executives. A risk was recorded on DATIX with a score of 16, due to the majority of theatre cases being supported by power tools. Theatre staff meet daily to communicate, document and provide feedback on all such incidents.

(N=17) *Equipment – Accidental / intentional Damage* - related to general damage to medical devices / equipment, no themes were identified.

(N=9) incidents related to *Equipment – User / operator error*, no themes were identified.

(N=9) incidents related to *Equipment – 3rd Party Supplier*, no themes were identified.

All incidents and themes are reviewed and monitored at the Trust Medical Device Group.

7.3 Infrastructure, Environment and Resource

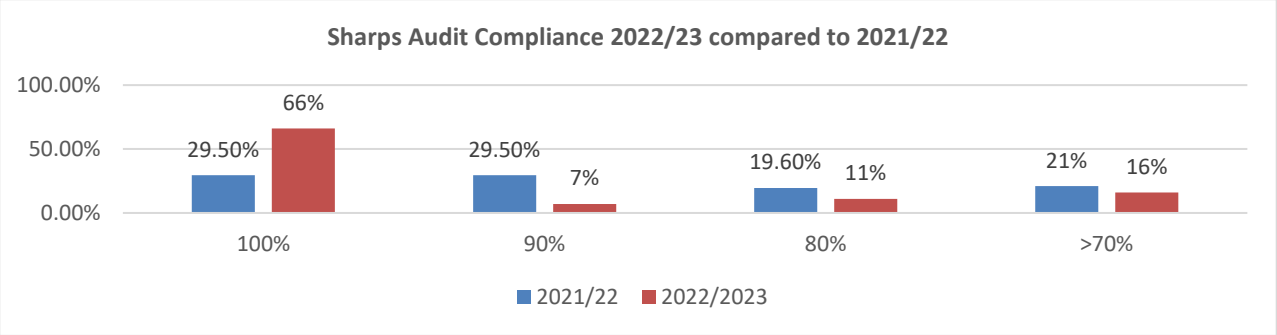
The Category of infrastructure / environment and resource contains the following sub-categories e.g. car parking, catering issues, environmental cleanliness, workplace temperatures, estates issues leaks, fixture and fitting issues (this is not exhaustive).

Graph 1 (above) displays that in 2022/23 there was an increase of 66.6% (175 compared with 105) relating to infrastructure, environment and resource incidents when compared to 2021/22. The main reason for the increase was due to the increase of incidents reported (n=55) in ambient temperature in the workplace. There were also 12 incidents reported related to ingress of water e.g. leaks from roof/heating pipes. Incidents are reported to the estates help desk and all jobs are monitored through the Estates and Facilities Risk and Safety Group.

7.4 Needlestick injury incidents

Graph 1 (above) displays that in 2022/23 there was an increase in needlestick injury incidents (n=16) when compared with 2021/22 (97 compared with 113). Focused areas of improvement have been identified receiving direct support from the Head of Health, Safety and Risk, as detailed below.

The graph below shows the compliance levels from the Trust wide Sharps audit:



Action plans are in place as required supported by a bi-monthly Sharps Management audit Programme and focused weekly walk rounds undertaken by the Head of Health and Safety. There is a full programme of sharps training available to clinical staff:

- Nursing and Midwifery: safer sharps training (day 3 of induction)
- HCAs: taught safer sharps techniques
- Junior Doctors: during their extended induction have a skills refresh based on demonstration e.g. cannulation.
- Students or trainees: Clinical Education will follow up any sharps incidents via the Practice Educator Facilitation team.
- Clinical staff groups complete the Infection Control ESR module (annually), which includes updates on Sharps training.

7.5 Lost Property incidents

Graph 1 (above) displays that in 2022/23 there was a decrease of 19% (115 compared with 93) in lost property incidents (n=22) when compared with 2021/22. The majority of lost property incidents reported in this category related to loss of SMART Cards. The Information Security Manager undertakes regular ward/departmental audits, to review management of SMART cards and to highlight the implications leaving of smartcards in situ. The results of these audits are then disseminated to the Ward Manager's meeting to build awareness.

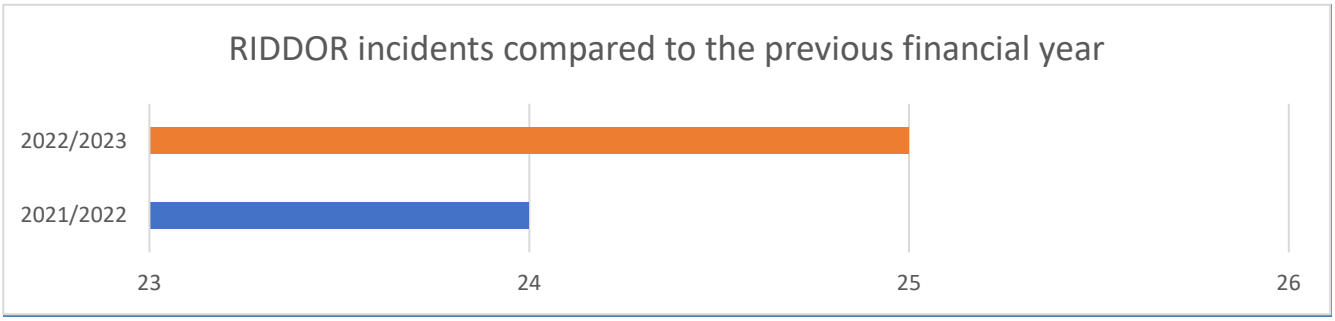
8. RIDDOR Reporting

Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (2013), states that certain workplace accidents, incidents, ill health and certain near miss events must be recorded.

Depending on the severity and nature of the injury, and indeed the party affected, the Trust has a legal duty to report this data to the Health and Safety Executive (HSE). This reporting process is undertaken by the Health and Safety Advisors and overseen by the Senior Safety and Risk Manager and Head of Health, Safety and Risk.

Graph 2 below shows there were 25 RIDDOR reportable incidents reported within the Trust in 2022/23 compared to 24 in the previous financial year (n=1). This evidences a static position.

Graph 2

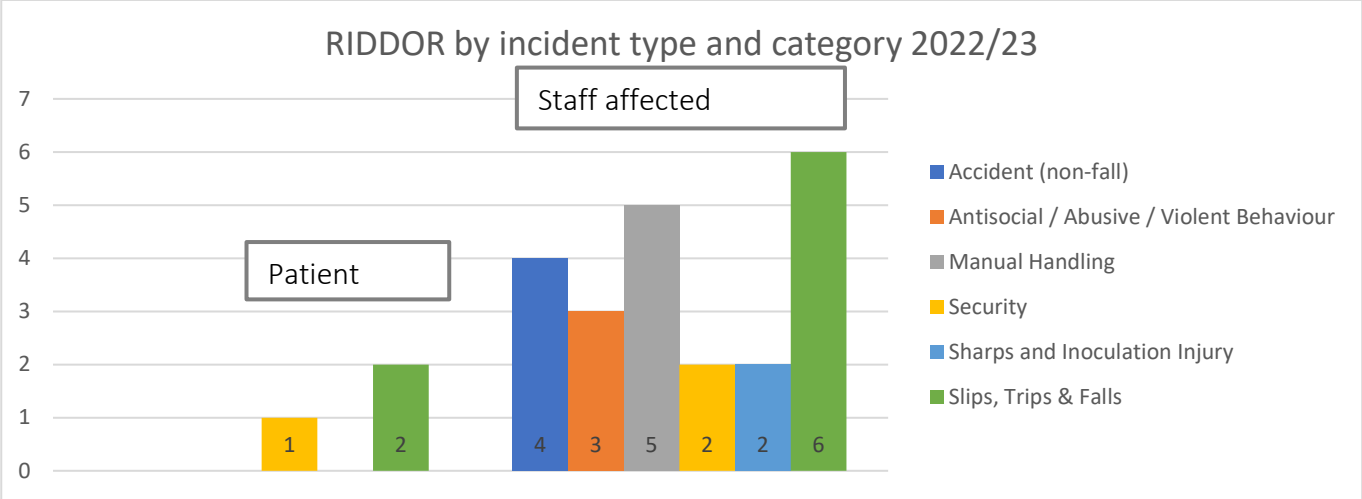


The RIDDOR incidents were as follows (further detail is provided in Appendix 1):

22 incidents affected staff (increase of 1 when compared to 2021/22)
3 incidents affected a patient (increase of 3 when compared to 2021/22). These are detailed in Graph 3.

Graph 3 below provides detail on the reporting of RIDDOR by sub-category. The highest number (n=8) relates to slips, trips and falls alongside moving and handling (n=5) e.g. poor technique, unexpected considerable force, weight distribution etc. Accident (non-fall) was (n=4), e.g. ankle injury due to passenger lift dropping and trapped fingers etc.

Graph 3 RIDDOR by type and category



9. Employers Liability (EL) and Public Liability (PL) Claims 2022/23

In 2022/2023 the Trust received 50% less PL claims.
EL claims related to Violence and aggression, equipment (Tug vehicle collide) and hospital infrastructure – Mesothelioma.

Claim type and status	2022/2023	2021/2022
EL received	10	9
PL Received	5	10

10. Health and Safety Audit

The Trust has developed a Health and Safety audit tool, to measure compliance against key regulatory standards (see table below).

By regularly reviewing compliance against these standards, the Trust can:

- Provide assurance that there is an effective system of internal control to monitor identified Health and Safety related risks.
- Monitor control measures stemming from local risk assessments.
- Monitor safety performance using agreed criteria to enable continual improvement.
- Provide a safe and healthy environment (including welfare arrangements) for staff and patients.

Risk Assessments	Night Work
Workplace Transport	Management of Sharps
Control of Substances Hazardous to Health	Slips, Trips and Falls (Non Patient)
New and Expectant Mothers	Display Screen Equipment
First Aid	Incident Reporting
Work at Height	Legionella
Work Equipment	Radiation
Welfare Provisions	Stress at Work
Health and Safety Local Induction	Personal Protective Equipment
Manual Handling	Management of Ligatures

There are policies and guidance documents in place to assist managers in following processes and procedures which will enable them to reach full compliance.

During 2022/23 the Health and Safety Team carried out the Annual Health & Safety Audit in line with the agreed Audit plan. The audit reviews e.g. risk assessments, slip, trip and fall and management arrangements for staff & visitors etc. All CBUs were audited of which there are 72 individual ward & departments. The results of the audits are as follows:

- 38 wards/departments achieved 100% compliance.
- 27 areas achieved over 90%.
- 7 areas were below 90%.

Areas not achieving 100% were provided with an action plan listing the area for improvement to gain full compliance.

11. Control of Substances Hazardous to Health (COSHH)

To ensure compliance with the Control of Substances Hazardous to Health Regulations, the Trust records the following information on a system called “SYPOL”:

- COSHH Risk Assessments
- COSH Control Sheets
- COSHH Safety Data Sheets

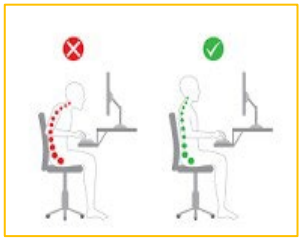
To-date, there are 1,279 completed COSHH assessments available with new assessments being added accordingly. There are 1,138 different materials used within the Trust.

11.1 Assurance:

- The majority of products and their activities fall within the category of low risk.
- All new COSHH risk assessments are created, approved and returned to the appropriate departments to be shared with staff.
- Bi-monthly reports are produced and circulated throughout the Trust to ensure Wards and Departments are notified of any updated risk assessments.

- Any substance rated as 'high' is managed with a robust Standard Operating Procedure, following advice from the safety data sheet and/or manufacturer.

12. Display Screen Equipment (DSE) Assessments



Health and Safety Advisors provide formal individual DSE workstation assessments for members of staff following a referral process undertaken by their manager or recommendation from Workplace Health and Wellbeing. The assessments generally take place when a member of staff is suffering pain and discomfort at their workstation, or they have a pre-existing medical condition.

During the period April 2022 to March 2023, the department carried out 63 workstation assessments for staff.

The main reason for other referral was existing health issues such as disc degeneration, sciatica, shoulder impingement, pain and discomfort during and after pregnancy, arthritis/osteoarthritis, carpal tunnel syndrome, migraines, previous hip replacement and general aches and pains in the lumbar region.

12.1 Assurance.

The assessments are to support staff within the workplace to prevent harm or any exacerbation of existing conditions. This is carried out by making reasonable adjustments to workstations.

Due to the increase in home working/agile working, additional information and advice has also been provided during the assessment regarding the setting up of workstations within the home to prevent poor posture.

13. Health and Safety Training.

The following Health and Safety training is in place. A large number of the training sessions available are mandatory and this is recorded on the Trust central system – ESR. Monthly compliance reports are sent out via the Organisational Development Team.

Topic	Training Requirements
Health and Safety Training for Senior Managers	Booklet to be read and signed 3 yearly
Health and Safety Training	E-learning to be completed 3 yearly
Non-Clinical Manual Handling	Classroom or e-learning to be completed 3 yearly
Clinical Manual Handling	Classroom training to be repeated every 2 years
Working at Height	Departmental based annually

The programme consists of:

- Health and Safety Awareness Training for all Staff – This is a general awareness of Health and Safety law and how it is managed throughout the Trust. The training can be accessed via eLearning or a Health and Safety Awareness Booklet.

- Health and Safety Awareness for Senior Managers and Doctors – This is a training booklet which provides up to date information on current legislation and corporate manslaughter.

14. Trust Mandatory Training Compliance relating to Health and Safety

The table below shows the most recent compliance with Health and Safety related training:

Course/Compliance	April-23
Conflict resolution	89.35%
Corporate induction	97.77%
Falls Awareness	97.15%
Health Safety and Welfare	91.68%
Local induction	91.79%
Moving and handling Level 1	91.72%
De-escalation training	32.93%

15. Estates and Facilities Health, Safety and Risk Safety Group

15.1 Specific requirements:

- Promote and monitor the effective management of Health and Safety risks within the Estates, Facilities and Medical Engineering Departments.
- Continually review new and existing Health and Safety legislation, to ensure that the Estates, Facilities and Medical Engineering Department are compliant.
- To ensure that there are effective systems in place for the identification, control, monitoring and reviewing of risk, ensuring that they are evaluated using the Trust Framework for Grading Risk, and that the appropriate level of management action is decided and implemented accordingly.
- Ensure that effective arrangements are in place for planning, organizing, controlling, monitoring and reviewing preventative and protective measures.
- Ensure that all department staff are provided with comprehensive information on the risks within their areas and the mitigations in place to reduce those risks
- Review of all incidents and investigation of incidents involving Estates, Facilities and Medical Engineering Department or contracting staff, identifying trends and ensure that appropriate action is taken
- Ensure that the Department of Health Estates and Facilities procedure for reporting defects and failures relating to non-medical equipment, engineering plant, installed services and building fabric is complied with (latest guidance DH (2008) 01).

15.2 Asbestos

The Trust continue to make consistent progress on asbestos management including the appointment of an Authorising Engineer for asbestos safety. The Trust carries out annual re-inspections in accordance with its new Ratified asbestos policy and asbestos management plan to meet its statutory requirements as set out within the Control of Asbestos Regulations 2012 (CAR 2012). A responsible Person dedicated to asbestos management has been formally appointed as well as named Authorised Persons who are responsible for ensuring the requirements of CAR 2012 are complied with for all projects and works were asbestos may be liable to be disturbed. The asbestos group has also implemented a training regime for all staff from basic asbestos awareness training up to detailed training on Regulation 4 CAR 2012 the Duty to Manage Asbestos.

Assurance: The Trust is confident that it fully complies with the duties placed upon it by the Control of Asbestos Regulations 2012.

15.3 Fire Safety Group

The Fire Safety Group meets monthly and is responsible for the review of all fire safety matters within the Trust. There are no noted incidents in relation to fire incidents in 2022/23.

Remedial Fire Works and Upgrades:

- Work to improve the landings and replace the fire doors for the wards has been completed.
- Ongoing in-house preventative maintenance continues, and a tender process is underway for an external certified and third party approved contractor to manage all fire door maintenance.
- The Fire Alarm system in Wards and Departments have been completed with the new systems commissioned. The new fire panels have been installed in all buildings and are interconnected with the communication centre main panel.
- An innovative project has been undertaken this reporting period to support a solution to a compartmentation issue above our emergency department canopy. The project has been recognised as a huge success to a complex problem with multiple design considerations and is being showcased by the National Association of Healthcare Fire officers at both regional and national conferences.

16. Recommendations

The Health and Safety Subcommittee are asked to note the contents of the Health and Safety Annual Report.

Appendix 1: RIDDOR

Incident affecting patient:

- A patient slipped on the corridor on Appleton Wing.
- A patient tripped on a raised mat by the main entrance doors as she left the hospital.
- A patient was injured standing on broken glass, following an episode of clinically challenging behaviour.
- Incidents affecting staff:
- Eight incidents were due to slip, trip or fall.
- Five incidents were in relation to injuries from moving and handling.
- Three incidents were in relation to injuries sustained whilst managing patients with clinically challenging behaviours.
- One incident was in relation to an injured ankle.
- One incident was in relation to a shoulder injury.
- One incident was in relation to a needlestick injury from a known Hep B patient.
- One incident was in relation to a urine splash from a known Hep B patient.
- One incident was due to fingers being trapped in a door.
- One incident was due to a road traffic collision in the community.

NHS
Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Health and Safety Annual Report

Layla Alani
Director of Integrated Governance and Quality
June 2023

Health and Safety Annual Report 22/23

Warrington and Halton Teaching Hospitals NHS Foundation Trust

- **The Health and Safety Annual Report describes**
  - Structures and responsibilities of the Trust in ensuring a health and safe environment for staff, patients and the public.
- **Health and Safety incident reporting reduced by 2.85%**
- **Sharps Management –** Action plans for focused support
- **The top 5 themes of incidents for 2022/23 were:**
  - Antisocial, Abusive and Violent behaviour
  - Equipment / Medical Devices
  - Infrastructure / Environment
  - Needlestick Injury
  - Lost Property incidents
- **Introduction of ED Bodycams = 57% reduction**
- **25 RIDDOR reportable incidents – static**
- **Annual Health and Safety Audit in line with the agreed Audit plan:**
  - 38 wards/departments achieved 100% compliance
  - 27 areas achieved over 90%
  - 7 areas were below 90%
- **Health and Safety related mandatory training overall compliant – De-escalation training improving**

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Quality Assurance Committee

AGENDA REFERENCE:	**QAC/23/07/156**
SUBJECT:	**Risk Management Strategy Annual Report 2022/23**
DATE OF MEETING:	11th July 2023
AUTHOR(S):	Layla Alani, Director of Governance, Deputy Chief Nurse, Nicola Edmundson, Associate Director of Governance, Tommy Fitzpatrick, Senior Health, Safety & Risk Manager
EXECUTIVE DIRECTOR SPONSOR:	Kimberley Salmon-Jamieson, Chief Nurse & Deputy Chief Executive
LINK TO STRATEGIC OBJECTIVE:	SO1: We will... Always put our patients first through high quality, safe care and an excellent patient experience.
EXECUTIVE SUMMARY	**Assurance statement.** Warrington and Halton Teaching Hospitals NHS Foundation Trust (WHH) has a fully implemented risk management system in place at both a corporate and strategic level. This report details the risk management arrangements in place throughout 2022/23. • The risk management process is successfully embedded across the Trust which was identified in the last CQC inspection report as "Good". • Various levels of risk registers are in place and are actively managed and reviewed by identified leads and Clinical Business Units. • External training was commissioned and attended during 2022 for senior leads including Clinical Business Unit Managers, Clinical Directors and Lead Nurses. • A review of all risk registers took place in 2022/23. • A monthly Risk Review Group meeting takes place and is chaired by the Chief Nurse/Deputy Chief Executive. All specialities present their risk registers on a rolling programme which will be reviewed at least 4 times a year, however, if required they will be reviewed more often. • An assessment and review of Risk Management Maturity Arrangements and Practice was commissioned in September 2022. An action plan has been developed to address the 9 recommendations identified. • MIAA undertook a review of Risk Management Core Controls in 2022/23. The Overall assurance opinion found that there is a strong system of internal control which has been effectively designed to meet the system objectives, and that controls are consistently applied in all areas reviewed. (Substantial Assurance). • The Trust Board approved a new Trust Risk Appetite Statement following an externally led Board Assurance Framework and Risk Appetite development session.

	• The management of risks formed part of the Trust's external Well-Led review which concluded that there is a comprehensive Board Assurance Framework which drives the work of the Board and its Committees. • A full review of the Risk Management Strategy will take place in 2023/24.			
PURPOSE: (please select as appropriate)	Information	Approval	To note **X**	Decision
RECOMMENDATIONS:	The Quality Assurance Committee is asked to receive and note the report.			
PREVIOUSLY CONSIDERED BY:	Committee			
	Agenda Ref.	•		
	Date of meeting	•		
	Summary of Outcome	•		
NEXT STEPS: **State whether this report needs to be referred to at another meeting or requires additional monitoring**	Quality Assurance Committee			
FREEDOM OF INFORMATION STATUS (FOIA):	Release in Full			
FOIA EXEMPTIONS APPLIED: **(if relevant)**	Section 22 - Information intended for future publication			

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Risk Management Strategy
Annual Report

June 2023

Contents

1. Executive Summary

Warrington and Halton Teaching Hospitals NHS Foundation Trust (WHH) has a fully implemented risk management system in place at both corporate and strategic level.

This report details the risk management arrangements that were in place throughout 2022/23.

2. Introduction

The management of risk is achieved by ensuring an effective Governance Framework is in place and embedded fully across the organisation.

WHH acknowledges, a robust risk management system will have a positive impact on service delivery and therefore ensure the safety of all patients, visitors and staff.

The Trust has made improvements to strengthen this process over the past 12 months by:

- Commissioning of external training throughout May 2022 to July 2022 for all senior key leads including Clinical Business Unit Managers, Clinical Directors, Care Group Leads and Lead Nurses.
- A full review of the risk appetite statement by the Trust Board.
- A full review of risk descriptors (including implementation of a new descriptor model) to ensure that risks are consistent, clear and concise.
- A full review of the DATIX risk module.
- A data cleanse exercise of the DATIX risk module.
- Commissioning of a full external review of risk management across the organisation with recommendations identified.

3. Risk Management Strategy

The purpose of the Risk Management Strategy is to encourage a culture where risk management is seen as an essential process of the Trust's activities to ensure structures and processes are in place to support the assessment and management of risks throughout the Trust.

The strategy outlines the processes in place to manage risk at all levels across the Trust to ensure the delivery of organisational objectives.

Having a robust risk management system means having a planned and systematic approach to the identification, evaluation and control of the risks facing Warrington and Halton Teaching Hospitals NHS Foundation Trust (WHH) and is a means of preventing harm to patients and staff, minimising costs and disruption to the Trust, caused by undesired events.

The aim of this strategy is to ensure that the Trust has an effective process to support better decision making through the understanding of risks and their likely impact.

4. Risk Management Process

There is a clear risk management process embedded across the Trust as reflected in the Good Governance Institute report received November 2022.

'The trust has a well-established process for managing risk which is defined in the Risk Management Strategy. This process is consistent with recommended practice in the NHS although the strategy is approaching its review date and requires some updating to account for organisational changes over the past two years'.

The Risk Management Strategy is being reviewed to reflect the above recommendation.

The process described in the table below involves identifying possible risks before they occur, ensuring proactive management in minimising and mitigating risk and potential impact.

<table>
<tr><th colspan="4">Identification</th></tr>
<tr><td colspan="2"><u>Identification:</u>
Using incidents, complaints, claims, patient feedback, safety inspections, external review, objectives or ad hoc assessments.</td><td colspan="2"><u>Board assesses risks to objectives:</u>
Risk identification to be aligned to annual/business planning process.</td></tr>
<tr><th colspan="4">Quantification</th></tr>
<tr><td colspan="4"><u>Risks Scored:</u>
Using a matrix of 1 to 5 in likelihood & severity giving a maximum score of 25; this affects how the risk is escalated. Support for risk assessment can be given by the Governance Department.</td></tr>
<tr><th colspan="4">Risk Registers</th></tr>
<tr><td colspan="4"><u>Strategic Risk Register (Board Assurance Framework):</u>
• Those risks linked to the delivery of strategic objectives.
• Those operational risks either 15 and below deemed to be strategic.
• Those operational risks deemed to be strategic following cross-sectional analysis of impact and likelihood.</td></tr>
<tr><td colspan="4"><u>Corporate Risk Register:</u>
• Those risks mapped against delivery of corporate objectives.
• Those risks that are deemed to deserve corporate visibility following cross-sectional analysis of impact and likelihood.
These risks typically comprise of risks scoring 9 and above (NB: risk scores below 9 can also be entered).</td></tr>
<tr><td colspan="4"><u>Operational Risk Registers:</u>
• Risks 8 and below – Local Risk Registers managed at Ward/Departmental Level.
• Risk 9 and above – CBU Risk Register managed by the CBU.
All risks 15 or above will be escalated & considered for inclusion on the Strategic Risk Register at the Risk Review Group.</td></tr>
<tr><td colspan="4"><u>Board:</u>
• Establishes principal strategic and corporate objectives and for ensuring the organisation achieve these.
• Ensuring that there are effective systems in place to identify and manage the risks associated with the achievement of these objectives through the Board Assurance Framework and through the Corporate Risk Register.</td></tr>
<tr><td><u>Audit Committee:</u>
• Annual Governance statement – reviewing systems of internal control.
• Internal audits of issues linked to strategic risks & monitoring of these action plans.</td><td><u>Quality Assurance Committee:</u>
• Oversees risks relating to patient care and patient experience.
• Monthly review of strategic risk register.</td><td><u>Finance & Sustainability Committee:</u>
• Oversees financial risk on behalf of the Trust and report on any additional risk, controls, assurances which will be recorded on the appropriate risk register.</td><td><u>Strategic People Committee:</u>
• Oversees all workforce risks on behalf of the Trust and report on any additional risk/ controls/ assurances which will be recorded on the appropriate risk register.</td></tr>
</table>

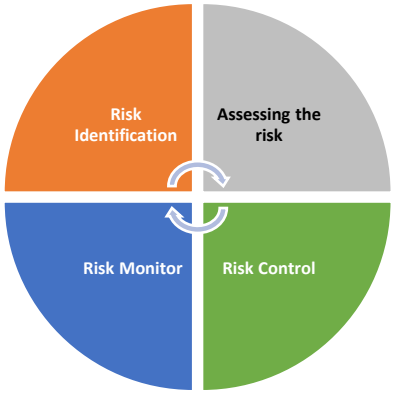
Risk Review Group	CBU Meetings
• Monthly report to Quality Committee highlighting exceptions, recommendations for new strategic risks, review of existing strategic risks and an assurance review of a CBU risk register. • Rolling review of CBU Risk Register at the Risk Review Group – at least six-monthly review for each CBU. • Updates also provided to the Patient Safety and Clinical effectiveness Sub Committee.	• Review and discuss all risks at a score of 9 or above. • Review and discuss all their services risks from Wards, Departments on a monthly basis. • Any changes must be recorded on the risk register and communicated to all relevant staff.

Ward and Departmental Meetings

- Discuss all the Department's active risks.
- Risks scored less than 8 managed locally.
- Any changes agreed must be recorded on the risk register and communicated to all staff.

4.1 Assurance:

- The risk management process is successfully embedded across the Trust and was acknowledged as "Good" in the review undertaken by the Good Governance Institute (2022). This was also reflected in the external review.
- System of internal control, risk management and governance gained a rating of 'Substantial" Assurance from the Head of Mersey Internal Audit. This was presented within the Annual Report at Audit Committee in April 2023.
- Risk registers are in place at service level with scrutiny provided by Clinical Business Units and Care Groups ahead of the monthly Risk Review Group (cyclical basis). This is chaired by the Chief Nurse/Deputy Chief Executive.



- External training was commissioned within 2022 for senior leads including Clinical Business Unit Managers, Care Group Leads, Clinical Directors and Lead Nurses in attendance.
- A review of all risk registers took place in 2022/23 by the Head of Risk & Safety.

5. Risk Management Training Needs Analysis

The requirement for risk management training within the Trust is outlined below. The table covers the training needs for all levels of staff throughout the organisation.

Topic	Training Requirements
Risk Management for Senior Managers	One off training programme
Risk Management for Managers	One off training programme
Risk Assessment Training	For all staff who are required to complete risk assessments as part of their role

5.1 Assurance:

- The Risk leads are trained by the Head of Risk and Safety. External training was commissioned within 2022 for senior leads including Clinical Business Unit Managers, Care Group Leads, Clinical Directors and Lead Nurses in attendance.

6. Risk Registers.

Strategic Risk Register / Board Assurance Framework (BAF)
The Board Assurance Framework (BAF) is fully embedded within the Trust. This assurance framework records the principal risks that could impact on the Trust achieving its strategic objectives. The key information reported to the Board includes: • Identifying controls in place to manage strategic objectives. • Provide assurance about the effectiveness of the controls in place. • Identify those objectives at risk because there are gaps in the assurance.
Corporate Risk Register
The Corporate Register is fully embedded within the Trust. The risk register comprises of all risks which may potentially prevent the Trust from carrying out daily operations. The Corporate Risk Register effectively links with the BAF. Risks from the Corporate Risk Register are escalated/de-escalated to and from the BAF as appropriate.
Clinical Business Unit (CBU) and Corporate Services Risk Registers
All CBU''s and Corporate Services have risk registers in place. There is a consistent and standardised approach to the reporting and managing of risk registers.
Local Risk Registers
Local risk registers are in place and are managed at Ward/ departmental level. There is an escalation process in place should the risks need to be added to the CBU risk register for further review.
Additional Risk Registers
Throughout the global pandemic, the Trust developed a COVID19 Risk Register to ensure that all risks related to the virus were recorded. This risk register was sighted at all appropriate Sub-Committees and the Quality Assurance Committee. In December 2022, a full review of the COVID 19 Risk Register took place by the Head of Health, Safety and Risk. This included details of when the risk was opened, the assurances in place, if the risks were escalated or de-escalated from the Corporate Risk Register or the BAF and the grading of the risks. A report was presented to the Risk Review Group in January 2023, and it was agreed to close the COVID 19 Risk Register. The group were satisfied that the risks had been managed robustly with appropriate mitigations in place. Any open risks were transferred to the relevant risk registers.

6.1 Assurance:

- Risks are managed and reviewed to assure both operational and strategic objectives are being met.
- The Trust can be assured that risks are being mitigated and/or escalated when required with oversight of this taking place at the Risk Review Group.
- The Trust has sight of all levels of risk which are monitored and reviewed through the structures in place noted within this report.
- There is an escalation process in place to ensure that risks are placed on the most appropriate risk register. Any risks escalated or de-escalated from the BAF or Corporate Risk Register is done so via the recommendation of the appropriate Committee meeting.

7. Risk Review Group.

The Risk Review Group takes place monthly to oversee the recording and monitoring of risk registers within the Trust.

Monthly meetings take place to review the effectiveness of the controls in place, following actions being taken. All Clinical Business Units (CBU's) attend the meeting on a 12-month rolling programme with each of them expected to attend at least 4 times each year. Corporate Services will attend at least each quarter. Risks scoring 9 and above are scrutinised by the Risk Review Group to ensure that there is assurance that each risk is being effectively managed.

Both the Strategic Risk Register and Corporate Risk Register reports are presented at each meeting and the group will make recommendations to the relevant Board Committee to the amendment of risks on both the Strategic and Corporate Risk Registers.

8. Risk Register Annual Position Statement.

The table below represents the **total** number of risks on **all** risk registers in DATIX.

Risk Register	Total no of Risks
CBU/Dept Risk Register	332
Corporate Risk Register	22
Strategic Risk Register / BAF	12
Total:	366

The table below represents the number of risks grouped by risk score by CBU.

CBU Risk Register	1 to 3 Low Risk	4 to 6 Moderate Risk	8 to 12 High Risk	15 to 25 Extreme Risk	Total
Clinical Support Services	0	8	25	2	35
Corporate Services	5	27	88	14	134
Digestive Diseases	0	7	12	8	27
Integrated Medicine and Community	0	5	9	3	17
Medical Care	1	10	17	5	33
Surgical Specialties	4	8	15	9	36
Trust wide (relates to staffing)	0	0	1	0	1
Urgent and Emergency Care	0	2	17	15	34
Women's and Children's	0	1	12	2	15
Total:	10	68	196	58	332

The table below provides a breakdown of Corporate Service by Specialty by risk score.

Corporate Services by Specialty	1 to 3 Low Risk	4 to 6 Moderate Risk	8 to 12 High Risk	15 to 25 Extreme Risk	Total
Communications, Marketing and Engagement	0	0	5	0	5
Corporate Nursing	0	3	6	1	10
Digital Services (IM&T)	0	1	6	0	7
Education & Organisational Development	0	1	2	0	3
Elective Care and Performance	0	0	2	1	3
Estates & Facilities	0	7	41	8	56
Finance, Procurement and Commercial Development	2	2	4	2	10
Human Resources	3	6	5	1	15
Integrated Governance & Quality	0	1	8	0	9
Strategy	0	6	7	1	14
Medical Records	0	0	1	0	1

z. [Archive] Emergency Planning	0	0	1	0	1
Total:	5	27	88	14	134

9. Corporate Risk Register.

The Corporate Risk Register comprises of all risks that could prevent the Trust from carrying out its daily operations. This links into the Strategic Risk Register which is managed by the Company Secretary & Associate Director of Corporate Governance.

Risks on the Corporate Risk Register may be escalated or de-escalated to or from the Strategic Risk Register as appropriate. Currently there are 22 risks on the Corporate Risk Register, the table below shows risks grouped by score.

	1 to 3 Low Risk	4 to 6 Moderate Risk	8 to 12 High Risk	15 to 25 Extreme Risk	Total
Corporate Risk Register	0	0	15	7	22

The table below shows risks grouped by CBU.

	Clinical Support Services	Corporate Services	Surgical Specialties	Trust wide	Urgent & Emergency Care	Women & Children	Total
Corporate Risk Register	3	14	1	1	1	2	22

A Corporate Risk Register Report is presented to the Risk Review Group on a monthly basis. This report contains proposals to amend or close any risks held on the Corporate Risk Register.

The report also includes proposals to change risk ratings, amendment of risk title, escalate to the Strategic Risk Register or closing of any risks etc.

Overview of changes to the Corporate Risk Register from April 2022 to March 2023.

Risk activity	Number of Risks
Risks added to the Corporate Risk Register	22
Risks closed from the Corporate Risk Register	5
Risk escalated from the Corporate Risk Register to the Strategic Risk Register	0
Risks de-escalated from the Strategic Risk Register to the Corporate Risk Register	0
Changes to Risk Descriptions	2
Changes to Risk Ratings	**2**

10. External Reviews.

10.1 Risk Management Maturity Arrangements and Practice.

An assessment and review of Risk Management Maturity Arrangements and Practice was commissioned in September 2022 by the Chief Nurse/Deputy Chief Executive of Warrington and Halton Teaching Hospitals NHS Foundation Trust (WHH).

The overall objective of this review was to evaluate and determine the adequacy and maturity of the current risk system and controls in place, and plan for further improvement. This was undertaken using an assessment tool based on HM Treasury's Risk Management Assessment Framework (2009), derived from the European Foundation for Quality Management (EFQM) excellence model. The exercise included interviews with relevant senior managers and a review of relevant Trust documentation.

10.1.1 Overall Assurance.

The detailed assessment and review of risk maturity, based around the Trusts Risk Management Strategy has been translated into an overall view of a risk maturity score of Level 3 cumulatively. Level 3 is determined as 'Good'.

The Trust's position in November 2022 utilising the risk management maturity assessment tool is summarised in the table below.

Risk Management Maturity Assessment		
Level	Score	Description of Overall Assessment Level
1	<20% (1-30)	The organisation has an awareness and understanding of risk management.
2	>20-40% (31-60)	Approaches for addressing risks are being developed and action plans for implementation are being developed.
3	>40-60% (61-80)	Risk management applied consistently and thoroughly across the organisation.
4	>60-80% (81-95)	The organisation is proactive in driving and maintaining the embedding of risk management and integration in all areas of the organisation.
5	>80-100% (95-110)	The organisation sustains risk capacity, organisational & business resilience, and commitment to excellence in risk management, leaders regarded as exemplars.

10.1.1 Recommendations by priority.

Priority rating		**Number of recommendations**	**Total**
High priority		3	9
Medium priority		6	
Low priority		0	

See section 11 (below) for a full breakdown of recommendations.

10.2 Merseyside Internal Audit Agency (MIAA).

MIAA undertook the following review of Risk Management Core Controls in 2022/23:

- **Audit Objective:** to provide assurance that core risk management controls have been adequately designed.
- **Scope Limitations:** the review focussed on core risk management controls only with an emphasis on control design.
- **Overall assurance opinion:** There is a strong system of internal control which has been effectively designed to meet the system objectives, and that controls are consistently applied in all areas reviewed. (Substantial Assurance).
- **Key Findings:**
  - Medium rating was awarded as at the time of the review as the risk appetite was in the process of being developed and formally approved. This has now been completed.

NB: The above key finding will be incorporated into Risk Management Maturity Arrangements and Practice Recommendation 2. Define the organisation's risk appetite. (See Section below).

11. Recommendations.

The maturity assessment provided the following 9 recommendations and a plan for further risk management development.

No.	**Recommendation**
1.	Strengthen the organisation's Risk Management Strategy.
2.	Define the organisation's risk appetite.
3.	Ensure effective arrangements for managing risk with stakeholders and partners across the Integrated Care System.
4.	Ensure a comprehensive risk management process. E.g. Consideration to be given to undertake horizon scanning through a systematic examination of information to identify potential threats,

	risks, emerging themes, and opportunities allowing for better preparedness and to support decision making
5.	Increase the coverage and utilisation of appropriate risk assessments throughout the Trust. E.g.: ▪ Strengthen the Clinical Business Unit meetings and use the underpinning structure to monitor gaps in risk assessment, using monthly risk register reports and the ward and department assurance reports. ▪ Undertake a mapping exercise to cleanse and streamline the data of the 400 risks on the Datix database. ▪ Develop performance indicators/metrics.
6.	Increase the use of Trust wide data to inform the risk management process.
7.	Enhance the knowledge and skills base of staff in risk management across the Trust, thereby also further encouraging an open and transparent reporting culture.
8.	Strengthen the system of assurance regarding risk through to Board level. E.g. the Trust would benefit from strengthening the BAF / Strategic Risk Register report due to a number of risk scores remaining static
9.	Serial Annual Maturity Assessment.

12. Action Plan & Objectives.

The above recommendations have now been translated into a SMART Action Plan, which is led by the Head of Health, Safety and Risk.

A full review of the Risk Management Strategy will take place in 2023/24, to encompass the 9 recommendations and form the Trust risk objectives for the next two years.

The revised Risk Management Strategy will also provide an understanding of risk appetite and tolerances, outline training arrangements and set out the aims to continuously improve the risk management arrangements throughout the Trust.

13. RECOMMENDATIONS

The Quality Assurance Committee are asked to note the contents of this Risk Management Strategy Annual Report.

NHS
Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Risk Management Annual Report

Layla Alani
Director of Integrated Governance and Quality
June 2023

Overview of the Risk Management Annual Report for 2022/23

Warrington and Halton Teaching Hospitals NHS Foundation Trust

IF

THEN

RESULTING IN

Risk Process

- Robust structure
- Risk registers regularly reviewed

Risk Review

- Risk Review Group meets monthly and is led by the Chief Nurse/Deputy CEO
- Additional scrutiny of risks rated as 9 and above
- All specialities present their risk registers at least 4 times a year

Training / Development

- (Insert No) CBU Managers, Clinical Directors, Care Group Leads and Lead Nurses attended Amberwing Risk Training
- Trust Board attended externally led BAF and risk appetite development session

Internal Review (MIAA)

- MIAA - review of Risk Management Core Controls in 2022/23
- Overall assurance opinion: Substantial Assurance (with one moderate finding) - at the time of the review, the risk appetite was in the process of being developed and formally approved.

External Review

- Risk Management Maturity Arrangements and Practice (RMMAP)review - September 2022
- GGI Well-Led review: A comprehensive Board Assurance Framework which drives the work of the Board and its Committees

Action plan

- Implement the recommendations from the (RMMAP) and MIAA,
- Undertake a full review of the Risk Management Strategy in 2023/24

FINANCE AND SUSTAINABILITY COMMITTEE

AGENDA REFERENCE:	**FSC/23/06/59**
SUBJECT:	**Digital Strategy Group (DSG) update**
DATE OF MEETING:	28th June 2023
AUTHOR(S):	Tom Poulter, Chief Information Officer
EXECUTIVE DIRECTOR SPONSOR:	Paul Fitzsimmons, Executive Medical Director
LINK TO STRATEGIC OBJECTIVES:	SO1: We will ... Always put our patients first delivering safe and effective care and an excellent patient experiencece.
EXECUTIVE SUMMARY:	The Digital Strategy Group (DSG) met on 12th June 2023. This report provides a summary of the updates received from the DSG feeder groups, providing the following assurance status for key delivery areas: ○ **Digital Transformation Highlight Report** Moderate Assurance ○ **Digital Service Delivery Highlight Report** Moderate Assurance ○ **Digital Care Highlight Report** Moderate Assurance ○ **Digital Analytics Highlight Report** Moderate Assurance **Items for escalation to Finance and Sustainability Committee** (for information only): ○ Confirmed £675k central funding allocation for Patient Engagement Platform (PEP), but internal approvals required via Exec, FSC and board approval before confirmation ○ Urgent work is being undertaken to migrate Fraxinus applications and the data warehouse to new server hardware, to ensure cyber security compliance ○ WHH Digital Week took place in May 2023 and a series of engagement activities are taking place as part of the Digital Strategy refresh ○ Progress is being made to prepare for going fully digital with lab test results, pending outcome of clinical policy review related to results acknowledgment

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

PREVIOUSLY CONSIDERED BY:		
	Committee	Not Applicable
	Agenda Ref.	
	Date of meeting	
	Summary of Outcome	

NEXT STEPS: ***State whether this report needs to be referred to at another meeting or requires additional monitoring***	Choose an item.
FREEDOM OF INFORMATION STATUS (FOIA):	Partial FOIA Exempt
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	Section 43 – prejudice to commercial interests

SUBJECT	Digital Strategy Group update	AGENDA REF	FSC/23/06/59

1. BACKGROUND/CONTEXT

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

2. KEY ELEMENTS

Channel 3 Consultancy Update

The Digital Strategy will be aligned to the Digital Clinical Safety Strategy, ICS Strategy, and Quality Strategy. The Priorities should align with the QPS Framework and Sub-strategies and will be positioned to be clear and robust. Streamlining will take place in order to determine what needs to be an improvement plan/enablement plan as opposed to a sub-strategy.

The strategy has been developed through a process of engagement, which includes 1:1 interviews, a core clinical/operational group and a digital finance group. Channel 3 have held two workshops with a larger group and then had interviews with Execs to fully understand the operational and clinical challenges and priorities, the digital solutions that enable them and then a communication of that moving forward. There have been 26 1:1s with people engaged across clinical, ops and management.

Emerging Priorities include:

- Shared Care Records
- Patient Engagement/Empowerment Portal (PEP)
- Data Analytics Enablement (inc. CIPHA population health)
- Technical Infrastructure, Network and Device Refresh

Cyber Security and Clinical Digital Safety are also recognised as cross-cutting priority areas for the duration of the strategy and on an ongoing basis.

The remaining priorities will be positioned as "EPR readiness" workstreams, particularly 'paperless and the drive to digitise existing processes in preparation for Lorenzo replacement.

Patient Engagement Portal (PEP)

Regional opportunity for patient empowerment platform the regional team have done an audit for acute organisations across northwest and this links with mobile platform that enables patients to take more empowerment and optimise communication. Regional team developed a road map all driven by NHS app. Key the suppliers are integrated with NHS app/login. There is a revenue opportunity to be available this year to our trust which will fund a 3-year license from the audit we were classified as red for having no portal, but it gives us the opportunity to bid for £675,000. We've submitted our bidding request and it was confirmed that WHH have been awarded the full amount.

Digital Transformation Delivery Highlight Report (Moderate Assurance)

- Commissioned consultancy support from Channel 3 to help develop the sub strategies to set out further detail on how we will deliver the vision and objectives e.g. technology sub-strategy, patient engagement sub-strategy, EPR sub-strategy.
- Digital Services are supporting Junior Doctor Strikes, drop ins this week and floorwalkers.
- Digital week centre of attention around digital enhancement to enable greater quality of care in or wards/clinical areas. During this we recruited over 20 digital champions from across the organisation with reference to how people can support and be engaged digitally.
- The statuses of our all of our projects been ratified and assured that any paths are green, mitigations where applicable will be picked up.
- Smartsheet's is a new live format of reporting now being used for the meetings highlight reports each month. This is how we'll be conducting our digital transformation group going forward, with the live dashboards and at any point we can click into any of these programmes and understand more information.
- Patient experiences are moving along via emeals and further hospedia replacement paper coming back shortly.

Digital Service Delivery Highlight Report (Moderate Assurance)

- Dedalus has been graded amber due to an unplanned outage that we had at the end of April and there was a 15-minute outage which has been subject to a root cause analysis and that's being managed through the group.
- To note we also have Clinisys graded amber we are continuing to campaign the ICB digital team to develop strategic supplier management plans for vendors, like Clinisys who were installed across multiple trusts, so we are liaising to strengthen the processes in that area.
- Cyber security incident at the trust didn't have a significant impact but did disrupt some of our lab processes.
- 12-hour planned outage for CRIS – Raised concerns but no negotiation due to take place 22/04/23. Darren Owens main point of contact.
- Vendor Management routine meetings are taking place for Service reviews and outstanding issues.

Digital Care Delivery Highlight Report (Moderate Assurance)

- Clinical Transformation/Optimisation Go lives:
  - Halton Clinical Diagnostic Centre Clinics: Phase 1 – built clinics for Phlebotomy, Spirometry, Sleep Studies; additional location config to ensure the data flows correctly, enabling Information and Finance to easily identify the activity as CDC activity and charge the correct tariff.
  - Dynamed DTI Link in Lorenzo– in line with Dynamed launch at Grand Round, we have developed a click through from Lorenzo to the research website Dynamed.
- Pharmacy team heart and chest currently submitting for HIMSS level 7 accreditation.
- Therapies Optimisation – Orthotics paper light, Cardiac Rehab/Heart Failure mostly paper light, Dietetics laptops delivered in April and in use, Prosthetics 5 x CDCs developed.
- ECPMS Journey – data cleansing. What can be removed or identified in our current systems as not needed in the new system for EPCMS readiness.

- The group discussed rejecting hand-written requests into pathology – ALL orders should be made on ICE – we would like to set up Task and Finish Group around ICE Results Acknowledgment.

Digital Analytics Highlight Report (Moderate Assurance)

- 17 deliverables have been achieved in May 2023. There are currently 11 deliverables for June 2023. In addition there is 1 delayed deliverable (Datix Ward Dashboard) with a plan to deliver the dashboard in June.
- A plan has been developed with the Supplier, Digital Analytics and Digital Services colleagues with agreed timescales of 12-16 weeks. A meeting to sign off the statement of works and finalise the cost, with the CIO and the Supplier, is scheduled for early June to scope out the Data Warehouse Transfer.
- Regular meetings take place between Digital Analytics and Digital Services to ensure alignment of workstreams.

3. ACTIONS REQUIRED/RESPONSIBLE OFFICER

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

- Received Funding for PEP but notify that will need FSC and board approval before drawing in.
- Escalation of server migration issues with regards to Fraxinus and data warehouse.
- Summarise Digital Week activities and strategy engagement.
- Set up Task and Finish Group around ICE Results Acknowledgment.

4. RECOMMENDATIONS

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

We are WHH & We are PROUD to make a difference

NHS
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FINANCE AND SUSTAINABILITY COMMITTEE

AGENDA REFERENCE:	**FSC/23/07/72**			
SUBJECT:	**Emergency preparedness, resilience and response (EPRR) annual report for 2022-23**			
DATE OF MEETING:	26th July 2023			
AUTHOR(S):	Rachel Clint, EPRR Manager			
EXECUTIVE DIRECTOR SPONSOR:	Daniel Moore, Chief Operating Officer			
LINK TO STRATEGIC OBJECTIVES:	SO1: We will ... Always put our patients first delivering safe and effective care and an excellent patient experiencece.			
EXECUTIVE SUMMARY:	This report will:- • Provide an overview of the emergency preparedness arrangements within Warrington and Halton Hospitals NHS Foundation Trust. • Outline the work that has been undertaken in the area during the past 12 months. • Describe the trust response to incidents which have occurred during 2022-23. • Describe the response to COVID-19 and highlight the associated work to be prioritised in 2023-24. • Summarise the planned work streams and priorities for the year ahead.			
PURPOSE: (please select as appropriate)	Information	Approval	To note √	Decision
RECOMMENDATION:	The Finance and Sustainability Committee are asked to note the EPRR Annual Report			
PREVIOUSLY CONSIDERED BY:	**Committee**	Not Applicable		
	Agenda Ref.			
	Date of meeting			
	Summary of Outcome			
NEXT STEPS: ***State whether this report needs to be referred to at another meeting or requires additional monitoring***	**Submit to Trust Board**			
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None			

FINANCE AND SUSTAINABILITY COMMITTEE

SUBJECT	Emergency Preparedness, Resilience and Response (EPRR) annual report for 2022-2023	AGENDA REF	FSC/23/07/72

1. BACKGROUND/CONTEXT

All NHS organisations are required to deliver their legal duties and responsibilities for Emergency Preparedness, Resilience and Response (EPRR) set out in The Civil Contingencies Act 2004. As a Category 1 responder under the Act, the trust has a duty to develop robust plans to prepare and respond effectively to emergencies, to assess risks and develop plans to maintain the continuity of our services in the event of a disruption.

Like most NHS organisations WHH has had our resilience tested on several occasions over the last year, most notably in the form of the operational pressures associated with winter, but also through the occurrences of industrial action. The NHS has remained in a Level 3 incident since March 2022, meaning Cheshire and Merseyside Integrated Care Board oversee the responses to significant events such as industrial action and winter pressures.

The trust plans and procedures, along with the commitment of WHH staff, have enabled WHH to manage incidents in a professional manner which has helped to minimise disruption to patient care.

2. KEY ELEMENTS

Purpose

The purpose of the annual report is to: -

- Provide an overview of the emergency preparedness arrangements within Warrington and Halton Teaching Hospitals
- Outline the work that has been undertaken in emergency planning during the past 12 months.
- Describe the trust response to incidents which have occurred during 2022-23.
- Summarise the planned work streams and priorities for the year ahead.

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3. ACTIONS REQUIRED/RESPONSIBLE OFFICER

Emergency Preparedness Structure

The Trust has a Major Incident Plan in place which is built on the principles of risk assessment, multi-agency co-operation, emergency planning, sharing information and communicating with public. This plan is underpinned by several associated business continuity plans which outline how our critical services will continue to be provided in the event of a disruptive incident.

Lead Officers

- Dan Moore, Chief Operating Officer is the designated Lead Executive Director with responsibility for Emergency Planning within the Trust.
- John Summers is the Non-Executive Director with responsibility for Emergency Planning.
- The Lead Director is currently supported by Alan Moore, Interim EPRR Manager, who is covering for maternity leave of Rachel Clint, Head of Emergency Preparedness (EPRR Manager)
- Trust Board are updated on significant matters associated with EPRR.

Committee Structure

To discharge our responsibilities effectively under the Civil Contingencies Act (2004), emergency preparedness arrangements have been embedded into the Trust's Committee structure.

The Event Planning Group (EPG), chaired by the Chief Operating Officer, is charged with the responsibility of overseeing the development of emergency preparedness arrangements within the Trust. The group meets monthly, and its membership includes senior managers from Planned Care, Unplanned Care and Clinical Support Services and there is clinical and corporate services representation.

In addition to Emergency Preparedness matters the role of the EPG is to anticipate and plan for forthcoming events which are likely to prevent a challenge to our services and resources and to develop co-ordinated plans. Minutes of the Group's meetings are produced, and high-level briefing reports are provided to the Finance and Sustainability Committee and to the Strategic Executive Oversight Group as appropriate.

EPRR External Structure:

The NHS England Area Team has lead responsibility for co-ordinating a local health response to an emergency. A Cheshire, Halton and Warrington Local Health Resilience Partnership (LHRP) exist to deliver National EPRR strategy in the context of local risks. The LHRP brings together the health sector organisations involved in emergency preparedness and strengthen cross-agency working. The quarterly Strategic LHRP meetings are attended by The Chief Operating Officer or Deputy. The Trust Resilience Manager attends the Practitioner and task group meetings. This structure is currently under review following the establishment of the Integrated Care Board in July 2022.

4. MEASUREMENTS/EVALUATIONS

Training

The Trust has an ongoing programme of exercises and training events to test and validate emergency plans. In 2022-23 there have been more opportunities to engage teams in training exercises and this programme will continue with some routine training along with standalone tabletop exercises.

Senior Manager on-call training has been enhanced through the delivery of bi-annual events to on-call managers, with thematic focus areas based on the needs of trainees.

National Occupational Standards were introduced by NHSE in 2022 for Strategic and Tactical Managers. All Executive's and SMOCs have been invited to attend the rolling training programme and are required to maintain evidence of their training standards. The EPRR Lead has also attended train the trainer sessions.

Assurance Process

The Trust is required to undertake an annual self-assessment against the NHS England Core Standards for EPRR. The full assurance exercise was last undertaken in September 2022. The annual self-assessment provided by NHSE was refreshed for 2022 with some revised and more specific areas of consideration. The Trust self-assessment was submitted as 'substantial compliance'. There was a deep dive assessing the evacuation and shelter capabilities of acute settings.

The self-assessment indicated WHH met full compliance in 89-99% of the relevant NHS EPRR Core Standards (60 out of 64 at full compliance). Four areas were assessed as being 'partially compliant' and are detailed below:

1. Decision Logging

• To ensure decisions are recorded during business continuity, critical and major incidents, the organisation must ensure:

i. Key response staff are aware of the need for creating their own personal records and decision logs to the required standards and storing them in accordance with the organisations' records management policy.

ii. Has 24-hour access to a trained loggist(s) to ensure support to the decision maker.

2. Business Impact Analysis/Assessment (BIA)

The organisation annually assesses and documents the impact of disruption to its services through Business Impact Analysis(es).

The organisation has identified prioritised activities by undertaking a strategic Business Impact Analysis/Assessments. Business Impact Analysis/Assessment is the key first stage in the development of a BCMS and is therefore critical to a business continuity programme.

Documented process on how BIA will be conducted, including:

• the method to be used

• the frequency of review

• how the information will be used to inform planning

• how RA is used to support.

The organisation should undertake a review of its critical function using a Business Impact Analysis/assessment. Without a Business Impact Analysis organisations are not able to assess/assure compliance without it. The following points should be considered when undertaking a BIA:

• Determining impacts over time should demonstrate to top management how quickly the organisation needs to respond to a disruption.

• A consistent approach to performing the BIA should be used throughout the organisation.

• BIA method used should be robust enough to ensure the information is collected consistently and impartially.

3. Data Protection and Security Toolkit

Organisation's Information Technology department certify that they are compliant with the Data Protection and Security Toolkit on an annual basis.

Evidence

• Statement of compliance

• Action plan to obtain compliance if not achieved

4. BC audit

The organisation has a process for internal audit, and outcomes are included in the report to the board.

The organisation has conducted audits at planned intervals to confirm they are conforming with its own business continuity programme.

• process documented in EPRR policy/Business continuity policy or BCMS aligned to the audit programme for the organisation

• Board papers

• Audit reports

• Remedial action plan that is agreed by top management.

• An independent business continuity management audit report.

• Internal audits should be undertaken as agreed by the organisation's audit planning schedule on a rolling cycle.

• External audits should be undertaken in alignment with the organisations audit programme.

Internal plans are in place to support the achievement of full compliance during this year's assurance process.

Incidents & Exercises

During 2022-23 the following significant incidents and exercises occurred:

NHS National Incident Level 3 (March 2022- present)

In 2022-2023, the previous pressures associated with COVID-19 experienced in the two years prior have reduced. Urgent and Emergency care has experienced an increased demand and acute capacity has been constrained by demands on the social care sector.

Pressures on patient flow have dominated the trust emergency planning workstream in the last year and robust winter planning enabled a successful approach to winter pressures. Learning from 2020-22 was embedded to support the response to the winter, with Care Groups structures and ward configurations embedded into practice. Learning from winter 2022-23 will be embedded into the planning for the year ahead.

Level 4 Heat Health Alert / Heatwave (17th -19th July) and associated Bleep Outage (18th – 21st July)

A Level 4 Heat Health Alert was issued by the Met Office on Friday 15th July, signifying 'there is a 100 % probability of Heat-Health Alert criteria being met between 0000 on Monday and 0000 on Wednesday in parts of England.'

A Tactical response to the Heat Health Warning was stepped up by the Chief Operating Officer from Friday 15th July. Several actions were put in place to support the management of the extreme heat. The actions and lessons identified have been captured in the Heatwave Plan to enable further successful planning for future events.

On the evening of Monday 18th July 2022, the SMOC was alerted to issues with the Bleep system affecting some areas across the Trust. Two-way radios were used as mitigation. On Tuesday 19th July 2022 the intermittent issues with the Bleep System continued.

It was identified that the issues were caused by the intense heat in the lift motor room where the pager transmitters are located. The temperature inside the lift motor room caused the transmitters to burn out, culminating in the transmitters losing voltage, hence disrupting the outgoing messages. The transmitters are designed to withstand heat up to 50 degrees Celsius, but the continuous heat build-up resulted in transmission intermittence and poor performance of the paging system.

The issue was resolved on the morning of Thursday 21st July 2022, with no harm caused to patients and learning captured for more resilient planning. A SOP for unplanned Bleep outages has been developed post learning from this event.

Creamfields (25th- 29th August 2022)

The Creamfields Music Festival occurred in Daresbury in August 2022.

The August Bank Holiday weekend has historically been a busy period for the Trust. Fluctuations in demand associated with bank holiday periods exist, but the August Bank holiday weekend also coincides

with the staging of the Creamfields Music Festival (CF) in Daresbury, of which Warrington Hospital is the primary receiving hospital for the event.

Creamfields 2022 was held between Thursday 25 August and Monday 29th August. A series of planning meetings with external organisations and partners took place, along with internal Bank Holiday weekend planning meetings.

Events Medical Service (EMS) was once again appointed as the main provider of healthcare on site and worked in partnership with NWAS. As far as possible, it was planned that patients would be treated on site or referred direct to admitting specialities.

Predictions for attendances, admissions, discharges, and occupancy were shared based upon the past 6-week trends, alongside previous Bank Holiday and Creamfields Festival weekend activity. Historically most activity associated with the festival occurs on the Saturday and the Sunday when the festival reaches a peak of circa 70000 attendees.

As the local receiving Trust to the festival, it was imperative for robust plans to be in place in advance of the event to ensure the capacity for safe, patient-focused care across the Bank Holiday period and in the days that followed.

Representatives from clinical, nursing, and operational teams met with the event organisers and medical team twice in advance of the festival weekend. There were monthly preparation updates through the Event Planning Group and the Creamfields operational order and medical plans shared with senior operational and clinical colleagues. A bank holiday handover meeting took place on Friday 28th August. The Creamfields Event Team invited the Trust to attend two daily Silver Command meetings at 10.00am and 19.00pm across the 4-day festival. The aim of these meeting was to coordinate any items to escalate or plans for mutual aid if required.

A Trust debrief was carried out along with a full event debrief. A medical debrief with NHS colleagues and Creamfields organisers took place on 23 February 2023 where there was recognition of the Trust's points raised in the full debrief, and a commitment to improve the planning in these areas.

What went well?

- Internal planning
- Communication – internal escalation processes in place
- NWAS Operational plan and communication of the plan
- Access to NWAS contact on site.
- Internal plans from Care Groups including enhanced staffing models across the weekend.
- Security was helpful with difficult patients in the ED.
- Enhanced SMOC over the CF festival weekend
- Use of X-ray limited the number of attends at the Urgent Care Centre at Halton and minor injury patient attends at Warrington A&E were reduced compared to previous years.
- Compassionate care for patients and their relatives, especially those who arrived Friday and stayed beyond the festival weekend.

Learning

- Communication – before and during the event. The CF22 team were less accessible than the previous year and good practice was not maintained.
- Communication of standby patients between the CF site and WHH ED- lack of medical interaction
- Capacity pressures across C&M added challenge to the weekend
- Improve communications channels open with event team / wider partners.
- Continued command and control structure to pick up and escalate key national / regional communications.
- Cascading of significant information was limited.
- Daily command and control meetings at 10am and 7pm – poorly attended and no medical representation from EMS.
- No communication about the substances of concern – the Trust relied on the information accessed via the Creamfields stories on Instagram – at least two communications had not been shared and no information directly reached WHH over the weekend. This information is significant for the ED, Critical Care and Pharmacy Teams
- The patients who were sent to WHH had high acuity – more education about the impacts the substances were having on individuals could have been shared between the site and the hospital and potentially the festivalgoers.
- Communications about the relative impact of the drug use between the Creamfields team and WHH was lacking. For example, by Saturday one quarter of WHH Critical Care capacity was occupied by attendees of the Creamfields festival and 4/5 had admitted due to substance use
- The handover notes for patients arriving at the hospital were brief.
- One patient had severe DKA, and blood sugars were not checked for 16 hours until arrival at WHH – patient claimed they had told medical team re diabetes but was assumed to have misused drugs
- Patients arriving at hospital reported poor mobile signal and the inability to contact friends who remained at the site.
- When festivalgoers ejected from the festival some arrived/ were brough to the hospital by police – should these have been held in the welfare/medical tent at Creamfields?
- Relatives of patients admitted – a handful of hospital attendees were seriously ill, and their loved ones attended to be with them, travelling from Wales, Scotland, and other peripheral areas. The families were unable to book local accommodation with it being a busy bank holiday weekend. WHH were able to use a small space allocated for resident doctors, but this would not always be the case. WHH also provided relatives with welfare packs.
- Health system - Ambulance diverts – WHH was asked for diverts from St Helens and Knowsley (STHK) on two occasions over the holiday weekend – useful if this was not an option unless major incident in future years. When WHH requested to divert on Monday this was not supported as STHK had earlier request to Leighton accepted
- Internal – counselling opportunities for ED and Critical Care staff – have an offer available over the weekend.

Impact on WHH

- Patients arriving from the festival were particularly unwell this year and the festival created more challenge than previous events (coupled with site pressures the weekend was particularly challenging)
- The Creamfields festival created a significant an impact on Critical Care with five very unwell young adults being admitted and one unfortunate loss of life.
- 48 festival related attends, 11 admitted, 5 ICU.

Recommendations

- Terms of Reference / participant lists/ clarity of expectations from the Creamfields team to ensure full representation at the Silver Command meetings.
- Communications between onsite medical team and WHH medical teams
- Official line of communication regarding substances of concern / intelligence to appropriately prepare the local receiving hospital.
- A prearranged programme of counsellor support to WHH teams affected by the impacts
- Sustained use of onsite X-ray to deter arrivals to Urgent Care / ED
- Direct line of contact between the medical lead on the Creamfields site and the clinical lead in Critical care / ED
- Learning from the unfortunate death of the young lady. Time it took to get to the patient on site. Learning from the high acuity of patients received at WHH this year and use of communications in future festivals.
- Internal recommendations have been captured through internal debrief that took place Tuesday 30th August, the day after the event.
- A separate medical debrief would be beneficial to support additional planning for the 2023 festival.

Unplanned Lorenzo downtime (16th September 2022)

The IT Helpdesk and Silver Command manager were alerted to a Lorenzo unplanned outage at 07.45am. Lorenzo is the main electronic patient record system used for clinical notes across services at WHH. Lorenzo stopped feeding information into the data warehouse at 07.37am. The event was managed as an internal business continuity incident using recommendations from previous experiences and the SOP for unplanned downtime.

Losing the main electronic medical records system during the Lorenzo downtime, created risks associated with prescribing and/or administration of medicines documented on paper, resulting in missed doses or administration of additional doses if staff are unaware of this. Also, there would subsequently be a reliance on E Outcome and wider systems where staff were less familiar with using.

The unplanned downtime occurred on the Friday leading in to a three-day bank holiday weekend. This inevitably impacted upon discharges ahead of the bank holiday. Resilient plans and effective communication were in place to support the trust response to this event.

Public Health Commander Training (June 2022 – onwards)

The NHS needs to be able to plan for and respond to a wide range of incidents and emergencies that could affect health or patient care. These could be anything from extreme weather conditions to an infectious disease outbreak or a major transport accident or a terrorist act. This is underpinned by legislation contained in the Civil Contingencies Act 2004 (CCA), the Civil Contingencies Act 2004 (Contingency Planning Regulations) 2005, the NHS Act 2006 and the Health and Care Act 2022.

This work is referred to in the health service as 'emergency preparedness, resilience and response' (EPRR). The day-to-day management of people and patients in the NHS is subject to legal frameworks, duty of care, candour and moral obligation. This does not change when responding to an incident; however, these events can lead to greater public and legal scrutiny. If staff are planning for or responding to an incident, they need to have the tools and skills to do so in line with their assigned NHS command and/or incident response role.

The minimum national occupational standards that health commanders, managers and staff responding to incidents as part of an incident management team and other staff involved in EPRR must achieve to be competent and effectively undertake their roles. All staff with a command role in incident management must maintain continual professional development (CPD), maintaining personal development portfolios (PDPs) in accordance with NHS Core Standards for EPRR.

As part of the revised EPRR Framework in June 2022, the minimal occupational standards were introduced, and all 1st and 2nd on-call managers are expected to attend these every two years. Participation.

Industrial Action (November 2022 – ongoing)

The EPRR Manager has been working collaboratively with the Associate Chief People Officer to coordinate the management of periods of industrial action directly and indirectly affecting WHH. An Industrial Action Task and Finish Group was stepped up in October 2022 and runs weekly to update key stakeholders about the ballot status for the various Unions and planning for the specific strike events directly and indirectly impacting upon WHH and partner providers. Preparation has included the development of clinical mitigation plans for Ambulance Service and Junior Doctors industrial action dates and Tactical response plans for the dates of industrial action. The EPRR Manager continues to engage with the ICB and participate in exercises and debriefs to support further planning.

Senior Manager on-call (SMOC) Training (November 2022, July 2023)

Bi-annual SMOC training has been delivered ensuring both experienced and newer members of the senior operational management team are confident with trust plans and out of hour arrangements. An accompanying SMOC handbook is frequently updated and acts as a guide to support the role and gives an overview of several significant documents that may require access at pace. The trust On-Call Guidelines have also been updated.

Planned IT and Telephony Downtime (ongoing)

There have been several instances of IT and Telephony downtimes. A robust operational management plan has been developed to ensure all wards and departments are aware of the details of each period of downtime, the mitigation, actions, service impact and recovery from the downtime. A series of preparatory meetings have enabled thorough planning ahead of scheduled downtime and in the last year there have been no service impacts because of the installation of appropriate updates to systems. SOPs were developed in Summer 2022 to support preparation for planned IT infrastructure downtimes.

Wider events / disruptions

Several events with potential implications on the Trust have been monitored. These include:

- Monkeypox outbreak
- Cybersecurity issues in community settings
- Potential winter energy disruption and winter planning
- OPEL 4 – Due to operational pressures over winter, WHH declared OPEL 4 on the following dates: 30th December 2022, 19th December 2022, 12th December 2022 and 11th October 2022.

Work undertaken in 2022/23

The following policies were reviewed and updated to reflect local and national developments during 2022-2023:

- Trust Escalation Plan
- Full Capacity Plan
- Severe Weather Plans (including Cold Weather Plans and Heatwave Plans)
- On-call Guidelines
- SMOC Handbook
- Winter Escalation Plans
- Internal Winter Plan
- System Winter Plan
- Bank Holiday Plans
- Unplanned downtime SOP
- Planned downtime SOP.
- Operational Planning for Industrial Action SOP
- Major Incident Plan

Engagement has continued with the following external groups:

- Cheshire Health Resilience Partnership
- System Partners (Cheshire and Merseyside ICB, Warrington Borough Council, Halton Borough Council, Bridgewater)
- Close liaison has been maintained with partner agencies in planning for local mass gathering events i.e., Creamfields festival. Member of Creamfields Safety Advisory Group and liaison with NWAS

Single Point of Contact

The EPRR Manager has continued to act as the trusts Single Point of Contact (SPOC). This includes the store, monitoring, and cascading of national and local guidelines. In a Level 3 incident the SPOC maintains vigilance for any key communication both within working hours and between the hours on

08.00am and 18.00pm Monday to Friday and between 09.00am and 18.00pm on weekends and bank holidays.

5. TRAJECTORIES/OBJECTIVES AGREED

Work programme for 2023/24

In 2022-23 the core focus has returned to emergency planning beyond the day-to-day responses to the COVID-19 pandemic and associated operational pressures experienced in recent years. It is understood that the Single Point of Contact remains in place for the year ahead and will continue to be managed by the EPRR Manager, who will continue to adapt to new ways of working within the ICB structure.

For 2023-24, the focus will include reviewing all EPRR Plans in line with the Core Assurance Framework and testing a number of these plans. EPRR in an ongoing cycle of planning, training, testing, and improving. Although debrief activities have been carried out, it is prudent to continue to capture the learning through response and recovery to enable effective winter preparation for 2023/24. This will include collaboration with key stakeholders involved in the responses, raising staff awareness, testing plans, and identifying any areas for improvement.

In support of and in addition to the above, the following work plans will be undertaken:

- Continue to deliver training to key staff in Emergency Preparedness and Incident Management through SMOC training, Site Manager training and ad-hoc events.
- Continue to encourage and support opportunities for 1st and 2nd on-call managers to attend the Public Health Commander training to ensure minimal occupational standards are met.
- Test the Trust Major Incident plan ensuring wider stakeholder input.
- Continue to develop Trust wide CBRN plans to complement the plans in UEC.
- Embed learning from 2022/23 to support planning for winter pressures.
- Continue as a full and active member of the Local Health Resilience Planning Group
- Update plans and procedures in line with any new National guidance
- EPRR education within care groups and the workforce to enhance resilience.
- Review the Corporate Business Continuity Plan and request all areas revisit their plans.
- Monitor the lessons learned from other local, regional and national incidents.
- Review the Fuel Plan taking in to account planning for winter energy resilience.
- Continue to support the trust response to the Public Inquiry into COVID-19 as appropriate.

6. MONITORING/REPORTING ROUTES

The NHS England led LHRP meets bi- monthly externally and is attended by the Trust Emergency Planning Lead; the outcomes are fed into the Trusts Event Planning Group meeting. The Single Point of Contact will continue to cascade appropriate updates to Care Groups, clinical leads, and corporate colleagues.

7. TIMELINES

This report is presented annually to the Finance and Sustainability Committee and the to the Board.

8. ASSURANCE COMMITTEE (IF RELEVANT)

The EPRR Manager escalates issues to the Event Planning Group. This subgroup continues to escalate changes through to Performance Review Group, the Executive Team meeting and Finance and Suitability Committee.

9. RECOMMENDATIONS

The Board is asked to note the significant work and achievements undertaken during 2022-23 and the planned work programme for 2023-24 in support of the Trust's objectives.

QUALITY ASSURANCE COMMITTE

AGENDA REFERENCE:	**QAC/23/07/149**
SUBJECT:	Learning from Deaths Report Q4 2023
DATE OF MEETING:	11th July 2023
AUTHOR(S):	Dr. Lalitha Chinnappan, Trust-wide Lead for Mortality Dr. Judith Raper, Deputy lead for Mortality Emily Barnett, Clinical Effectiveness Manager
EXECUTIVE DIRECTOR SPONSOR:	Paul Fitzsimmons, Executive Medical Director
LINK TO STRATEGIC OBJECTIVE:	SO1: We will... Always put our patients first delivery safe and effective care and an excellent patient experience.
EXECUTIVE SUMMARY	This paper summarises 'Learning from Deaths' for Q4 2022 / 2023, for noting and scrutiny, in compliance with National Guidance requirements on Learning from Deaths. **Key points to note are:** • During Q4 2022/2023, 344 deaths occurred within the Trust. • Of these, 91 met the criteria to be subject to a Structured Judgement Review (SJR). • 133 SJRs have been completed in Q4. • In Q4, no serious incident investigations have been reported where the patient has died. • The latest HSMR (Hospital Standardised Mortality Ratio) based on 12 months data up to January 2023 is 93.53. This result is a low value outlier. • The latest HES SHMI (Summary Hospital-level Mortality Indicator based on Hospital Episode Statistics) for the 12-month period up to January 2023 is 99.52. This result is not an outlier. • Attached as an appendix is the MRG theme of the month following May 2023 MRG **(Appendix 1)**

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

RECOMMENDATIONS:	Quality Assurance Committee is asked to note the contents of the paper.	
PREVIOUSLY CONSIDERED BY:	**Committee**	Not Applicable
	Agenda Ref.	
	Date of meeting	
	Summary of Outcome	
NEXT STEPS: ***State whether this report needs to be referred to at another meeting or requires additional monitoring***	**Submit to Trust Board**	

FREEDOM OF INFORMATION STATUS (FOIA):	Release in Full

QUALITY ASSURANCE COMMITTE

SUBJECT	Learning from Deaths report Q4 2022/2023	AGENDA REF:	QAC/

1. BACKGROUND/CONTEXT

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

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

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

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

2. KEY ELEMENTS

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

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

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

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

3. MEASUREMENTS/EVALUATIONS

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

- All deaths of patients subject to care interventions with elective procedures.
- Patients undergoing an emergency laparotomy.
- SHMI/HSMR outliers identified using the HED system.
- Deaths where learning will inform existing or planned improvement work, for example if work is planned on improving sepsis care, relevant deaths should be reviewed, as determined by the Trust.
- Death of a patient with severe mental health needs.
- Death of a patient who had a 'standard' DOLs in place during their admission. A 10% random selection will be made for any death of a patient with an 'urgent' DOLs in place during their admission.
- Trauma deaths will be reviewed and presented at MRG on a quarterly basis.
- Patients who have died aged between 18 and 55 years.
- Patients who have died with no DNACPR in place.
- Once a quarter, a further sample of other deaths will be selected that do not fit the above identified categories, to ensure we take an overview of where learning and improvement is needed most overall.
- All Coroners' reports received post-inquest will be triangulated with the SJR to enhance the learning.
- Any concern that a member of staff may have in relation to a patient death will be reviewed through the mortality review process.
- At the request of the Medical Director or Chief Nurse.

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

MRG – Forward planning

1) Thematic review and related work-streams have been created to enable SJR's with common themes to be accumulated. The workstreams created are: DNACPR, Patient Transfers, Specialty Input, DoLS/ Capacity and Good practice. This will then enable work stream leads to address the issues identified with the aim to bring about clinical changes and positively impact both patient care and trust mortality.

2) Learning from MRG is taken quarterly to the Palliative and End of Life Care Steering Group and hence informs developments including review of P&EOLC Strategy to encourage timely referral to specialist palliative care, recognition of dying, and early Treatment Escalation Planning, and the CPR Decision Making and Discussions Workstream and associated education.

3) Any identified learning is shared through the specific Speciality Governance Meetings to ensure learning is widely disseminated and as a Trust we are making those improvements to better our patient safety, quality and experience.

4) A SOP has been agreed that a 10% random selection of urgent DoLs will be referred for SJR. This has taken effect from May 2023.

5) Good practice is now highlighted by MRG certificates being issued to members of staff who have been noted during review of a SJR to have excellent documentation within the patients records.

During Quarter 4 there were between 27 – 34 deaths per month that were flagged as requiring an SJR to be completed. Therefore, the average deaths requiring a SJR per month are 30. Currently we have 8 Mortality reviewers, with 7 of them being allocated 5 cases per month and 1 being allocated 6 per month, leaving a total monthly allocation of 36 SJRs – This will change from July onwards with only 35 being allocated per month due to a change in mortality reviewers.
Currently we are up to date in the allocation of SJR's. This is due to the new SOP process of only 10% random selection of urgent DOLs cases being flagged for SJR, which has reduced the number of SJRs required each month. This reduction in allocated SJRs will allow for more focused learning to be shared with the relevant teams to better improve our Quality of Care.

3.1 Mortality Review Data Q4 2022/2023

- During Quarter 4, 91 deaths met the criteria to be subject to a Structured Judgement Review (SJR).
- During Quarter 4, 124 deaths were allocated to a review for a Structured Judgement review.
- 133 SJRs have been completed in Q4, an increase of 32 from Q3.
- Of the 133 SJRs completed, 29 were allocated in Q3 and 104 were allocated in previous quarters.

Fig. 1 – Key Mortality Data

Total deaths in Q4	Total LD Deaths Q4	SI investigations commenced in Q4 relating to patient deaths	Those meeting SJR criteria Q4	Number of SJR reviews completed in Q4	Number of SJR Reviews that were allocated in Q4 and completed compared to Q3	
344	1	0	91	133	Q3 Total SJR completed – 101 SJRs were completed on 41 out of the 81 assigned in Q3 65%	Q4 Total SJR Completed – 133 SJRs were completed on 86 out of the 124 assigned in Q4 69% ↑

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

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

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

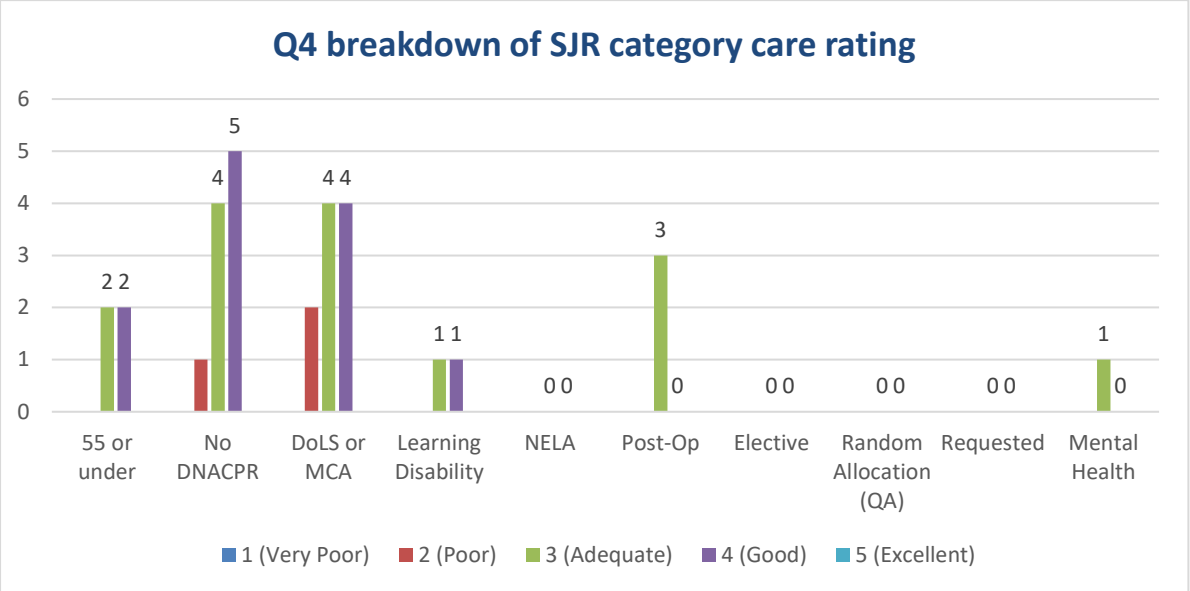
Fig. 2 – Shows the overall and phase of care ratings of the 133 SJRs completed in Quarter 4.

Phase of Care *	N/A	Very Poor	Poor	Adequate	Good	Excellent
First 24 hours/admission	6	0	1	31	90	5
Ongoing care	21	0	4	45	63	0
Care during procedure	113	0	0	4	16	0

End of life care	64	0	0	20	47	2
Patient records/documentation	7	0	2	40	81	3
Overall care	**7**	**0**	**3**	**44**	**79**	**0**

- In SJRs completed within Quarter 4, there has been no very poor care at any stage of admission.
- 3 overall were noted as 'poor' care.
  - 12209: This case is to be discussed during June 2023 MRG meeting.
  - 12946: This case is to be discussed during June 2023 MRG meeting.
  - 10058: This case was reviewed by the MRG in March 2023. It was noted that although the outcome would not have changed for this patient, palliative input could have been sought earlier. This learning has been taken to the ENT Speciality Governance meeting to highlight any training needs and provide learning where needed. This case was logged as an incident and reviewed by the incident team with no further actions required.
- All phases of care and documentation records including overall care had a majority of 'good' ratings.

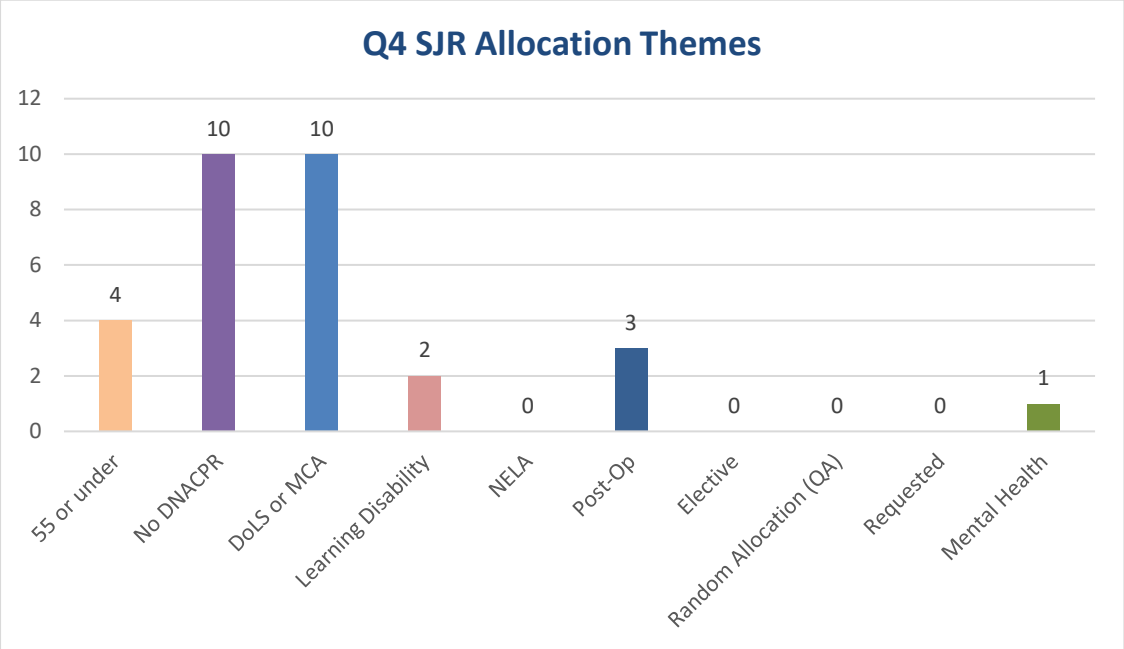
Fig 3 - Shows the breakdown of care ratings in each SJR category in Quarter 4



- All categories except for one allocation for 'No DNACPR' and one allocation of 'DoLs' are predominantly receiving good care.
- Random Allocation patient shown 'good' care. Random allocations are used by the Clinical Effectiveness Coordinator when screening deaths where they feel there could be an issue in care, but the patient does not fall into an SJR category.
- 1 death for Learning Disability shown 'excellent' care.

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

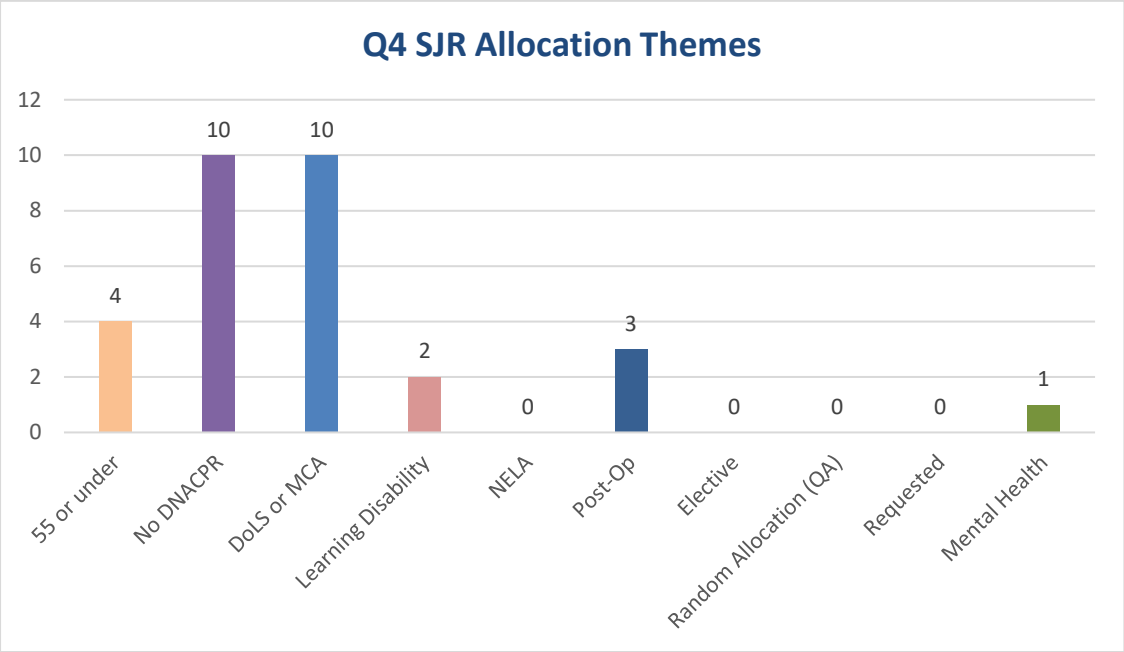
Fig 4 - Shows the frequency of each SJR category allocated to reviewers in Quarter 4



- DOLS were the most frequently allocated category to reviewers in Q4.

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

Fig 5 - Shows the frequency of each SJR category presented at MRG in Quarter 4



- The category with the highest number of SJR's requiring further discussion at MRG in Q4 is patients with 'DoLS' and 'No DNACPR'. This corresponds to the number that are allocated. There is input and representation at MRG from the Safeguarding Team and Palliative Care which facilitates learning and development of improvement plans.
- There is DNACPR workstream within MRG to collate this learning for the Trust's DNACPR lead.

3.2 Learning from deaths

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

Learning	**Action**
Patient received CPR but had a DNACPR in place in the community, but this was not brought into hospital with patient.	• Deputy MRG Lead to share this in the GP Forum. • To be added to the DNACPR Workstream.
No screenings of care placed prior to going to theatre and no advanced directive discussion with patient or family but there was a good geriatric review.	• SJR to be shared in Anaesthetic Speciality Governance meeting. • To be added to the DNACPR Workstream. • Deputy MRG Lead to liaise with the Orthopaedic Team for a wider discussion.

A lack of communication with Microbiology and Ophthalmology was highlighted in this case. The question of, what safeguarding is in place when prolonged antibiotics are administered for patients without a clear indication of cause, was raised.	• A discussion with pharmacy, Dr Zaman and microbiology will take place. • This case will be added to the speciality workstream to highlight the lack of Microbiology input
Themes **Appendix 1** – Explains Clinical Coding local policy – Diagnosis Terms. Newsletters are included on CBU and Specialty Governance agendas each month.	

3.3 Learning from Serious Incident investigations:

No SI's were reported during the quarter 4 period relating to a patient's death.

4.0 Mortality Indicators

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

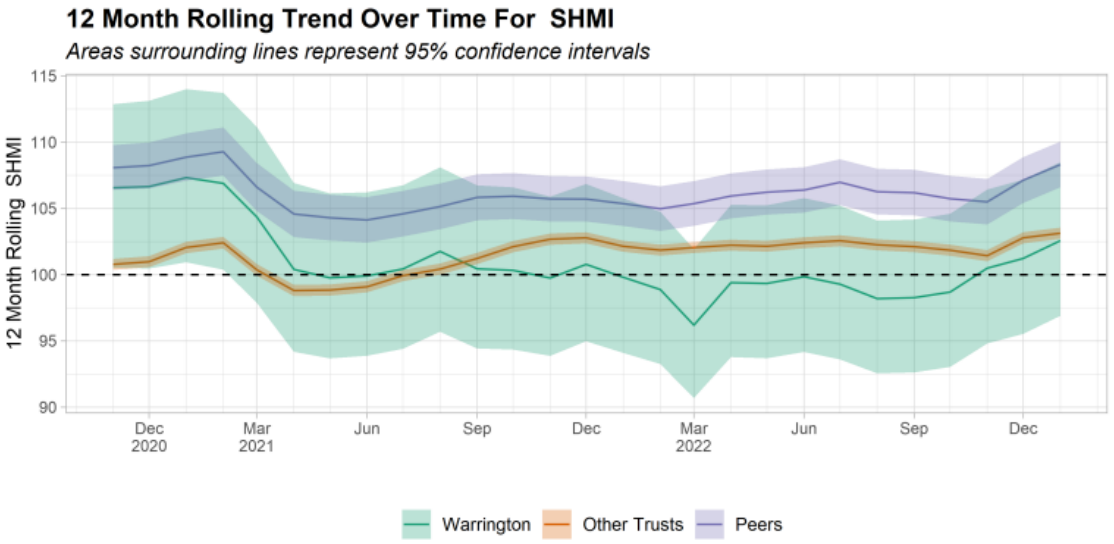
To have a red flag means the HSMR is above 100 and the lower confidence interval is above 100 which signifies the variation is unlikely to be due to random or chance variation and other issues may be causing the variation.

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

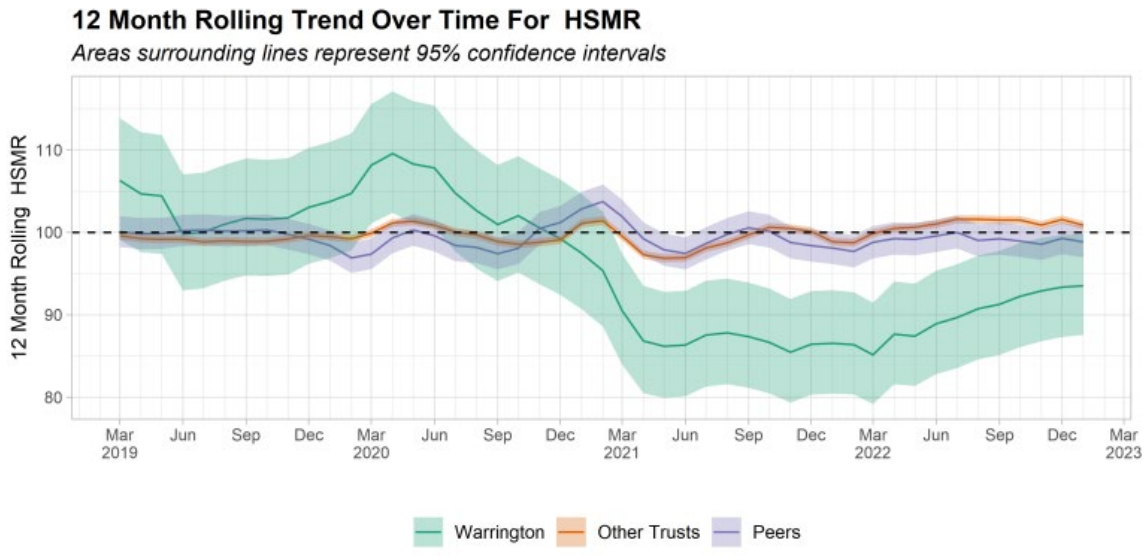
(SHMI banding=1), 'as expected' (SHMI banding=2) or 'lower than expected' (SHMI banding=3) when compared to the national baseline.
HSMR should be closely monitored alongside SHMI mortality indices with intelligence from HED and internal intelligence from risks, incidents, and complaints data.

4.1 HSMR and SHMI indicators

Month	HSMR	SHMI	Total Deaths
January 2023	93.2	96.72	141
February 2023	92.38	96.72	94
March 2023	93.53	97.41	110



HES SHMI (which is based on 12 months data up to and including December 2022) is 98.98 This result is not an outlier using an over-dispersed funnel plot and is not an outlier based on the stricter Poisson method.



Standard 56 CCS group HSMR (which is based on 12 months data up to and including January 2023) is 93.52 for Warrington. This result is a low value outlier based on the 95% Poisson method.

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

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

4. MONITORING/REPORTING ROUTES

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

5. TIMELINES

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

6. RECOMMENDATIONS

The Quality Assurance Committee are asked to note this report.

Appendix 1:

NHS
Warrington and Halton Teaching Hospitals
NHS Foundation Trust

MRG Theme of the month May 2023

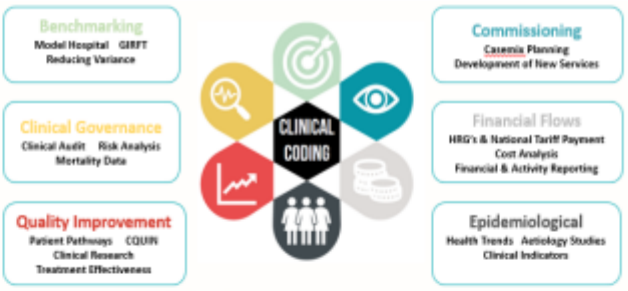
Clinical Coding Local Policy - Diagnosis Terms

Authored: Karen Ellson, Clinical Coding Quality Improvement Manager.
Paula Brereton, Head of Clinical Coding & Service Development.

Background

Issues pertaining to clinical documentation were discovered in relation to the use of diagnosis terminology that is not suitable for coding purposes, specifically the terms "impression" and "likely". The usage of these terms may impact the precision of the primary diagnosis as well as the coding of additional secondary diagnosis, which is crucial in reflecting the intricacy of patient care.

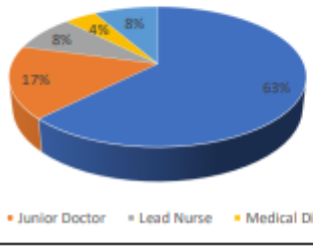
It is of utmost importance that clinically coded data is accurate, as it serves both clinical and statistical purposes. Any inaccuracies in the coded data may affect patient care and impede the ability to assess and address health trends on a larger scale.



Clinical Engagement

Following a presentation to the Medical Cabinet and Mortality Review Group, active clinical engagement, and a survey of a representative sample of clinicians, a consensus was reached to adopt the terminology of "impression" and "likely". This agreement was supported by the Mortality Review Group and Medical Director, signifying a broad consensus and approval of the decision.

Survey Responses.



NHS
Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Survey Results

1. When clinically documenting, what do you consider the term **'IMPRESSION'** to be synonymous with? (please select all that apply)

More Details

Diagnosis	5
Working Diagnosis	19
Treat As	12
Probably/Presumed	12
None of the above	1

2. When clinically documenting, what do you consider the term **'LIKELY'** to be synonymous with? (please select all that apply)

More Details

Diagnosis	3
Working Diagnosis	14
Treat As	8
Probably/Presumed	15
None of the above	1

Quality Improvement

The Executive Medical Director and Clinical Coding have approved and signed a new Clinical Coding Local Policy which will be effective for patients discharged from 1st April 2023.

The policy states that when the terms "impression" or "likely" are used within the clinical record, they should be interpreted as being equivalent to terms such as:

- Working Diagnosis
- Treat As
- Probable
- Presumed

Furthermore, the policy mandates that the Trust should use the terms "impression and "likely" as the diagnosis being treated or investigated when coding patient conditions.

The adoption of this policy is expected to improve the accuracy and quality of the clinically coded data for the Trust, with particular emphasis on Mortality data.

Impact Analysis

The clinically coded data will be monitored for its impact following the implementation of the local policy, and the result will be shared.

Contact

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QUALITY ASSURANCE COMMITTEE

AGENDA REFERENCE:	**QAC/23/06/132**
SUBJECT:	**The National Adult Inpatient Survey Results for 2021**
DATE OF MEETING:	13th June 2023
AUTHOR(S):	Ali Kennah, Deputy Chief Nurse Jen McCartney, Head of Patient Experience, and Inclusion
EXECUTIVE DIRECTOR SPONSOR:	Kimberley Salmon-Jamieson, Chief Nurse & Deputy Chief Executive
LINK TO STRATEGIC OBJECTIVE:	SO1: We will... Always put our patients first delivering safe and effective care and an excellent patient experience.
EXECUTIVE SUMMARY	The report details the Trust's overall scores achieved in the National Adult Inpatient Survey 2021. Results have been benchmarked against the 2020 survey to identify any improvements made and declines in performance to focus on. A further comparative analysis will be undertaken following receipt of survey results of the survey in 2022. The Trust National Inpatient Survey is managed externally by IQVIA who provide the Trust with a detailed management report of results complemented by the CQC national benchmarking report. The Trusts overall response rate for the National Adult Inpatient Survey in 2021 was 39% which matches the national response rate of 39%. The 2020 response rate was 41%. 461 completed questionnaires were returned from the sample of 1250, 65 patients were excluded from the total sample. This report details findings from both the IQVIA management report and the national CQC benchmarking report detailing. ▪ National Inpatient Survey 2021 results ▪ Data comparison against results received in the Trust National Inpatient Survey 2020 ▪ Regional and national benchmarking against other NHS Trusts in England The results demonstrate a stable performance as detailed below. - 4 questions demonstrating a decline in performance pertaining to support with personal care and information received by the patient at discharge regarding medication and equipment. - 30 questions demonstrating a similar rating.

	- 7 questions demonstrating an improvement in performance in relation to noise and light at night, information shared pre and post operatively and information on what to do and not to do following discharge. - 6 questions are new to the 2021 survey therefore unable to directly compare performance/			
PURPOSE: (please select as appropriate)	Information X	Approval	To note X	Decision
RECOMMENDATIONS:	The Quality Assurance Committee are asked to receive the contents of this paper and note the analysis of the National Adult Inpatient Survey 2021 results detailed in this report.			
PREVIOUSLY CONSIDERED BY:	**Committee**	Patient Experience Sub Committee		
	Agenda Ref.	WHH/PESC/22/174		
	Date of meeting	8th November 2022		
	Summary of Outcome	Information noted with actions to disseminate results to relevant teams.		
NEXT STEPS: ***State whether this report needs to be referred to at another meeting or requires additional monitoring***	Choose an item.			
FREEDOM OF INFORMATION STATUS (FOIA):	**Release in Full**			
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	Choose an item.			

QUALITY ASSURANCE COMMITTEE

SUBJECT:	**The National Adult Inpatient Survey Results for 2021**	**AGENDA REF:**	**QAC/23/06/132**

1. Background

The National Adult Inpatient Survey has been an annual requirement since 2002 by the Care Quality Commission (CQC) which looks at the experiences of adults that have been an inpatient at Warrington and Halton Teaching Hospitals (WHH) during November 2021. The aim is to obtain detailed patient feedback on the standards of service and care, this can then be used to help set priorities for delivering a better service for patients and the public. The results are also used by the CQC to measure and monitor performance at both regional and national levels. The results are also used by the CQC as intelligence to monitor, influence and add weight at inspection planning stages to identify possible areas or fields to look at on inspection.

At WHH the survey is undertaken by IQVIA on behalf of the Trust with sampling completed by the WHH Data Warehouse Team. They follow the national guidance issued on the NHS Patient Survey Programme by the CQC on behalf of NHS England and the Department of Health and Social Care.

This report details the results compiled by IQVIA supporting internal data comparison with Trust results received in 2021. Regional and national benchmarking is detailed following results received in the CQC National benchmarking report published in September 2021

The survey required a sample of 1250 consecutively discharged inpatients aged 16 and over, this sample is worked back from 30th November 2021. To be eligible to complete the survey patients had to have had a stay of at least one night in hospital and were not maternity or psychiatric patients. The final response sample for 2021 was 1186 due to 65 patients being excluded from the sample for the following reasons:

- Moved / not known at address – 16.
- Deceased – 49

The Trusts overall response rate for the National Adult Inpatient Survey in 2021 was 39% which matches the national response rate of 39%. The 2020 response rate was 41%.

The survey is made up of 10 sections, which are:

1. Admission to hospital
2. The hospital and ward
3. Doctors
4. Nurses
5. Your care and treatment
6. Operations and procedures
7. Leaving hospital
8. Feedback on the quality of your care
9. Respect and dignity
10. Overall Experience

The survey is complemented with questions relating to demographics. Results of this are not scored but provide intelligence on the population of patients who took part in the survey. Details of these questions can be found in section 3 of this paper.

The 2021 survey was conducted utilising both paper and digital methods. There were minor questionnaire changes including 3 new questions and changes to question wording. Therefore the 2021 survey results are directly comparable with data from the Adult Inpatient Survey 2020. In the instance where questions are different no comparable scoring can be made however themes have been collated and are recorded in section 2 of this paper.

2. Overview of Results

Internal data review in comparison to the National Adult Inpatient Survey 2020

The results of the National Inpatient Survey 2021 have been analysed in direct comparison to the results of the same survey undertaken in 2020 to ascertain where improvements have been made and to highlight areas of improvement. Results have been broken down into sections and rag rated according to performance. Table one below demonstrates where the results have improved, stayed the same or improved in the 2021 survey from the 2020 survey.

Table 1 – National Inpatient Survey Results 2021 compared to 2020.

	Questions - Declining performance trajectory	Questions - Static performance	Questions - Improving performance trajectory	Questions - New question so unable to compare	Total
Admission to Hospital	**0**	**2**	**0**	**0**	**2**
The Hospital and the ward	**1**	**5**	**3**	**4**	**13**
Doctors	**0**	**3**	**0**	**0**	**3**
Nurses	**0**	**4**	**0**	**0**	**4**
Care and Treatment	**0**	**7**	**0**	**1**	**8**
Operations and Procedures	**0**	**0**	**3**	**0**	**3**
Leaving Hospital	**3**	**6**	**1**	**1**	**11**
Feedback on care	**0**	**1**	**0**	**0**	**1**
Respect and Dignity	**0**	**1**	**0**	**0**	**1**
Overall Experience	**0**	**1**	**0**	**0**	**1**
Total	**4**	**30**	**7**	**6**	**47**

Overall results demonstrate a secure picture.

- 4 questions demonstrating a decline in performance.
- 30 questions demonstrating a static performance.
- 7 questions demonstrating an improvement in performance.
- 6 questions are new to the 2021 survey therefore unable to directly compare performance.

Analysis of the survey results in 2021 have demonstrated a slight decline in performance in relation to 4 questions detailed in table one. Each question is rated out of 10, declines in performance are minimal and range from 0.6 to 1.0 These areas are as follows:

- **Question 9:** Did patients get enough help from staff to wash or keep themselves clean. The survey results for 2021 indicate a reduction in performance from a score of 9.0 to 8.3, a reduction of 0.6.
- **Question 37:** Did hospital staff discuss additional equipment of changes to patients' homes after leaving hospital. The survey results for 2021 indicate a reduction in performance from a score of 9.3 to 8.3, a reduction of 1.0.
- **Question 41:** In relation to medication to take home were patients given an explanation in relation to
  - The purpose of the medicine
  - Side effects

  - How to take medication
  - Written information about the medicine.
  - Given the medication, but no information.

  The survey results for 2021 indicate an overall reduction in performance from a score of 5.0 to 4.3, a reduction of 0.7.
- **Question 43:** Did hospital staff tell you who to contact if they were worried about their condition after they left the hospital. The survey results for 2021 indicate a reduction in performance from a score of 8.1 to 7.4, a reduction of 0.6.

Analysis of the survey results in 2021 have demonstrated an improvement in relation to 7 questions detailed in table one. These areas are as follows:

- Patients being prevented from sleeping at night by noise form staff indicates an increase in performance by 0.5.
- Patients being prevented from sleeping at night by hospital lighting indicates an increase in performance by 0.3.
- Patients getting enough help from staff to eat their meals indicates an increase in performance by 0.8.
- Staff adequately answering questions posed by patients about the operations or procedures before they take place?
- Staff explaining to patients how they might feel after an operation or procedure indicates an increase in performance by 0.1.
- Staff explaining how well an operation or procedure may have gone indicates an increase in performance by 0.3.
- Staff giving information to patients about what they should or should not do after leaving hospital indicates an increase in performance by 0.6.

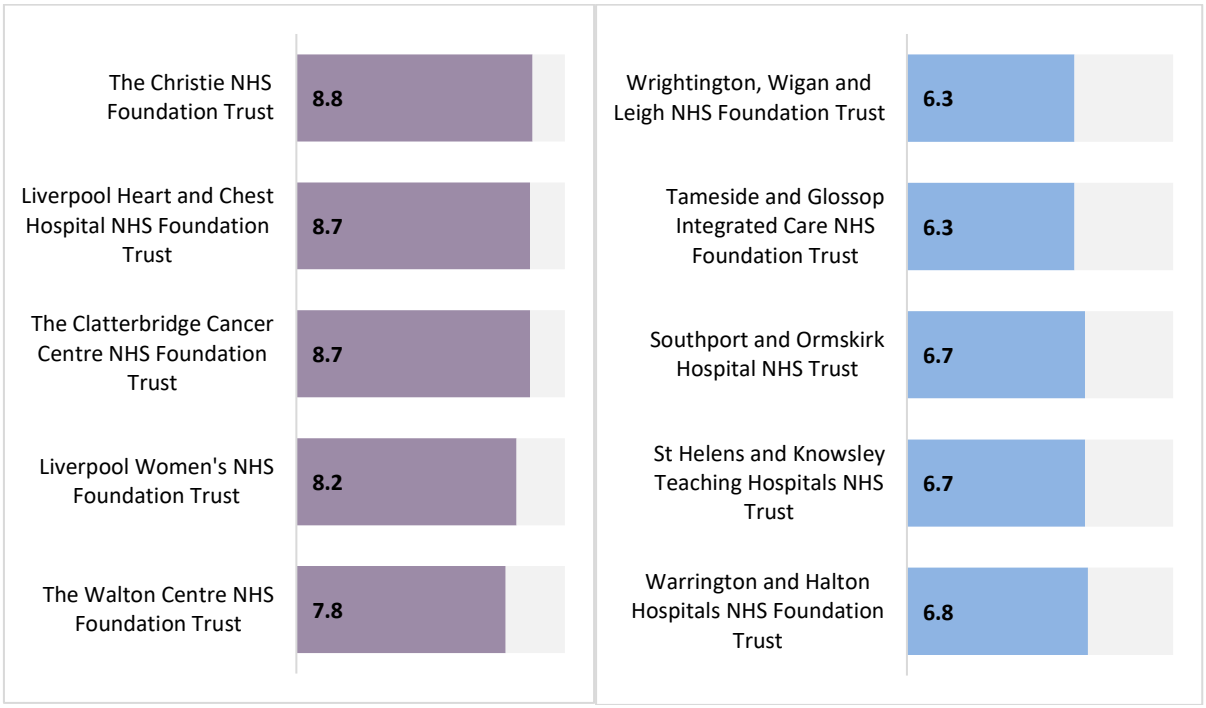
3. Regional Benchmarking

The CQC benchmarking report details of where the Trust is rated in relation to other Trusts within the Northwest region.

As noted in the CQC benchmarking report WHH were noted to be performing in the bottom 5 Trusts in the Northwest region for admission to hospital. This is reflected in the Trust super stranded position. It is pertinent to note however that the top performing Trusts in this category are all specialist hospitals as detailed in table two below. need to explain what 'admission to hospital' means in this instance

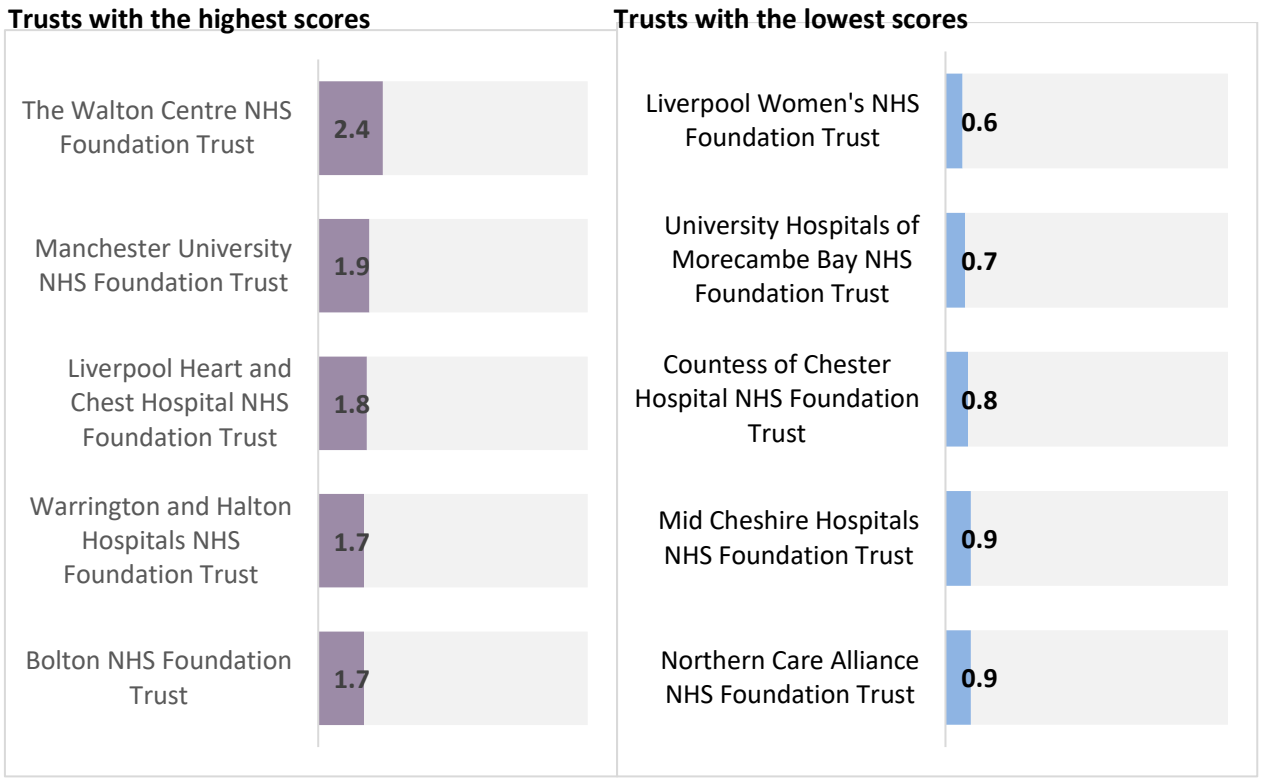
*Table 2: Regional Benchmark – **Admission to hospital***

Trusts with the highest scores	Trusts with the lowest scores



WHH is noted as the top performing Trust regionally in the section relating to feedback on the quality of care as detailed in table three below.

*Table 3: Regional Benchmark – **Quality of care feedback***



National Average Benchmarking

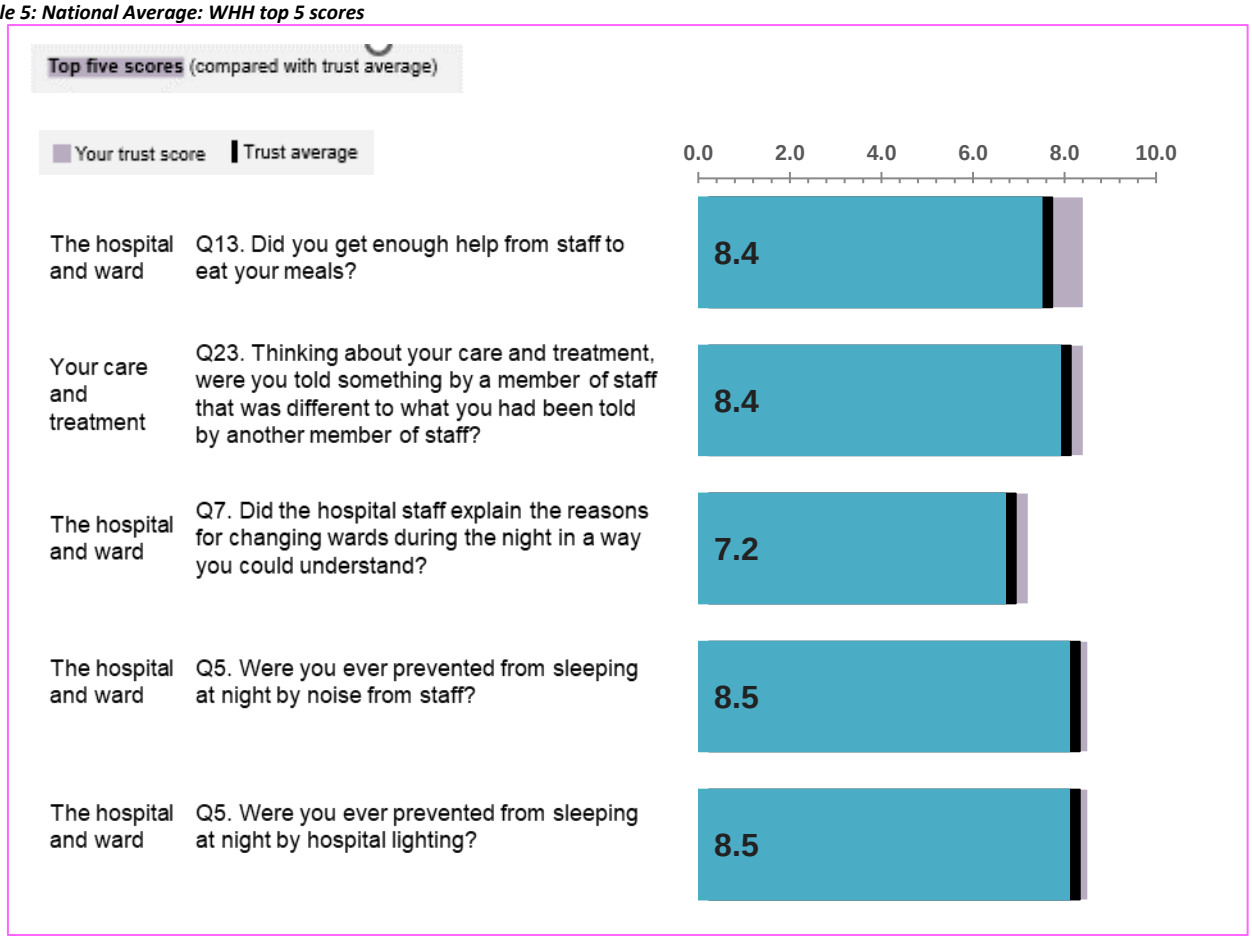
In addition to regional benchmarking, the CQC benchmarking report also details where the Trust is ranked in relation to other Trusts nationally. This benchmarking is carried out separately to regional benchmarking.

The questions in which WHH faired the lowest in comparison with the national average are detailed in table four below. These five questions are calculated by comparing the Trust's results to the National Trust average (the average trust score across England).

Table 4: National Average: WHH bottom 5 scores.

The questions in which WHH were rated the highest in comparison with the national average are detailed in table five below. These five questions are calculated by comparing the Trust's results to the National Trust average (The average trust score across England).

Table 5: National Average: WHH top 5 scores



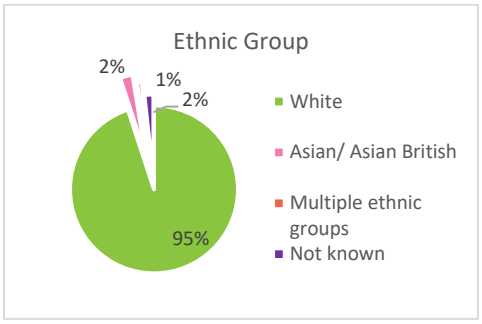
3. Respondent Demographic Characteristics and Accessibility

The respondent demographic characteristics recorded for the National Adult Inpatient Survey 2021 are:

1. **Ethnicity**
2. **Religion**
3. **Long term conditions** – *physical or mental health conditions, disabilities or illnesses that have lasted or are expected to last 12 months of more.*
4. **Sex** – *At birth you were registered as…"*
5. **Age**

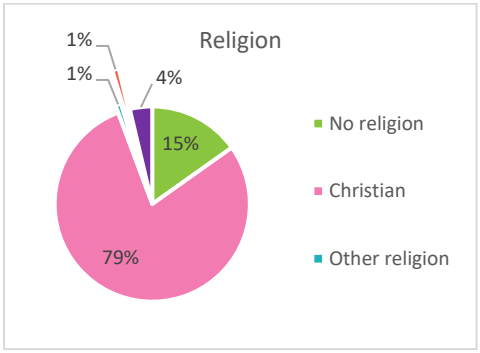
Ethnicity

Of those surveyed 94% stated their ethnicity was 'White' - this is made up of English/Welsh/Scottish/Northern Irish/British/Irish and any other White background.



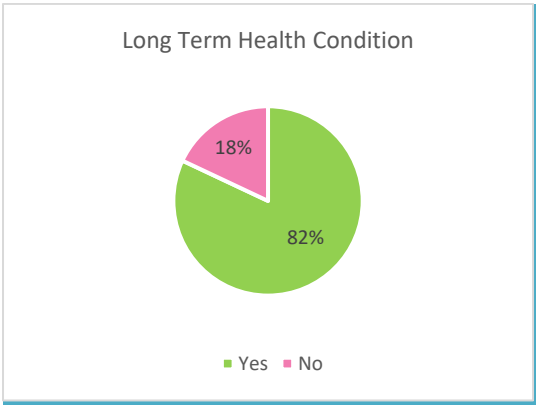
Religion

Of those surveyed 79% stated their religion as 'Christian' followed by 19% stating they did not identify with any religion.



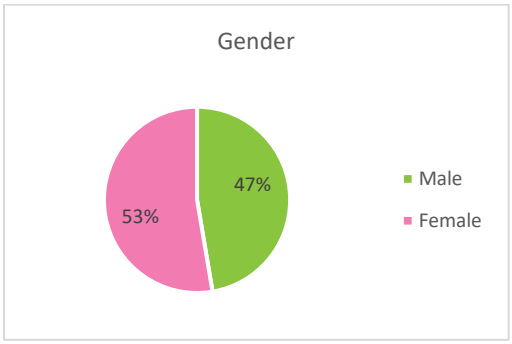
Long Term Conditions

Of those surveyed 82% of respondents said they have physical or mental health conditions, disabilities or illnesses that have lasted or are expected to last 12 months or more.



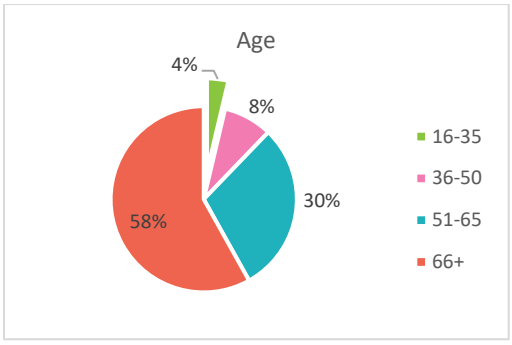
Sex and Gender

Of those surveyed 52% of participants identified as female with 47% identifying as male. There were no participants who stated their gender is different from the sex they were registered with at birth.



Age

Of those surveyed they 58% stated they were over 66 years of age followed by 30% stating they were aged between 51 and 65.



Accessibility Formats:

The 2021 online survey included the following accessible formats:

- Change font size.
- Change background colour.
- Screen-reader compatible
- Other language options
- British Sign Language (BSL)

By request, contractors were also able to supply:

- A helpline – utilising Language Line Solutions® for interpretation.
- Large-print questionnaires
- Easy Read format.
- Braille

Dissent posters were also displayed in common languages across the Trust.

4. Conclusion

The scores for Warrington and Halton Teaching Hospitals (WHH) indicate that the Trust is performing in the upper to mid-range when compared to other Trusts surveyed by IQVIA. Most scores (37) are in the mid-range with 10 in the upper-20% range, and only 1 in the lower-20% range.

In comparison to the National Inpatient Survey 2020 the Trust sustained a secure position with 7 metrics demonstrating an improvement, 4 in decline out of a possible 47 questions.

Intelligence within the survey results will be shared with existing workstreams within the Trust to strengthen improvement plans in these areas.

In addition to acting on the areas for improvement, actions will be taken to celebrate positive scores both internally and externally. Themes relate to communication between staff and patients which builds trust and ensures patients feel included in conversations about their care. It is also pleasing to note that improvements have been made in known areas such as 'noise and light at night' where this has been an area of concern in previous years.

In comparison to regional benchmarking within the Northwest, the Trust were ranked in the top five Trusts in relation to the feedback received for the quality of care in which we deliver. The Trust ranked low in relation to admission to hospital which is reflected in the Trust super stranded position.

When compared nationally the Trust performed well in relation to supporting patients with their meals, consistent information relating to patient care and not being prevented from sleeping as a result of staff noise and hospital lighting. The Trust ranked lower than the national average in relation to admission to hospital and being prevented from sleep by other patients.

To enable accurate monitoring, an action plan has been initiated as detailed in appendix 1 which is monitored via the Patient Experience Sub-Committee with escalation and assurance to Quality Assurance Committee bi-annually.

The Patient Experience and Inclusion Team have ensured plans are in place to increase the response rate of the National Adult Inpatient Survey in 2023. These include but are not limited to;

- Social media campaign.
- Survey details shared on wards via information posters.
- Continued reminders sent to patients supported by IQVIA.

All results of the National Adult Inpatient Survey will continue to be comparatively analysed with previous years to ensure insight into areas of success and improvements required.

5. Recommendation

The Quality Assurance Committee are asked to receive the contents of this paper and note the analysis of the National Adult Inpatient Survey 2021 results detailed in this report.

6. Appendix One – National Inpatient Survey 2021 Action Plan

National Adult Inpatient Survey 2021 Action Plan

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	Section	Actions	Lead	RAG	Target Date	Current Position (Assurance)	Completion Date
1.	Admission to Hospital – are we saying this action plan hands off this action?	Information to be shared with key stakeholders such as patient flow, where best next initiatives to support improvement	Head of Patient Experience and Inclusion		December 2022	Information shared via Patient Experience Sub Committee and Patient EDI Sub Committee. Information also shared with Associate Chief Nurse of Unplanned care to feed into existing workstreams for improvement in these areas.	November 2022
2.	The Hospital and Ward	Information to be shared with Ward Managers in relation to personal care support for patients.	Head of Patient Experience and Inclusion		December 2022	Information disseminated via Patient Information shared via Patient Experience Sub Committee and Patient EDI Sub Committee. Information also shared and discussed at ward managers meetings	November 2022
		Volunteers to be reintroduced and embedded on wards as appropriate	Head of Patient Experience and Inclusion / Volunteer and		September 2023	Volunteers reintroduced to the Trust and insourced in August 2022. Ongoing recruitment campaigns in place to support and Volunteer and Experience Manager working with ward managers to ensure suitable placements.	

			Experience Manager			**Update April 2023 –** Collaboration with Warrington Voluntary Action to extend access to volunteers. Volunteers added to Patient Experience Strategy 2023 – 2025 as an objective. Plans in place to celebrate National Volunteers week on 1 – 7th June 2023 which will include recruitment.	
7.	**Leaving Hospital**	Information to be shared with key stakeholders such as patient flow, where best next initiatives to support improvement	Head of Patient Experience and Inclusion		December 2022	Information shared via Patient Experience Sub Committee and Patient EDI Sub Committee. Information also shared with Associate Chief Nurse of Unplanned care to feed into existing workstreams of improvement in these areas	November 2022
		Information to be shared with key stakeholders such as ward managers, information incorporated into where best next and discharge initiatives to support improvement	Head of Patient Experience and Inclusion		December 2022	Information shared via Patient Experience Sub Committee and Patient EDI Sub Committee. Information also shared with Associate Chief Nurse of Unplanned care to feed into existing workstreams of improvement in these areas in particular discharge processes.	December 2022
8.	**Overall**	Celebrate and share good practice	Head of Patient Experience and Inclusion		December 2022	Information shared at Patient Experience Sub Committee and Patient EDI Sub Committee with actions set for wider sharing of results	November 2022

QUALITY ASSURANCE COMMITTE

AGENDA REFERENCE:	**QAC/23/04/76**
SUBJECT:	**Perinatal Mortality Annual Review 2022**
DATE OF MEETING:	11th April 2023
AUTHOR(S):	Ailsa Gaskill-Jones – Interim Director of Midwifery
EXECUTIVE DIRECTOR SPONSOR:	Kimberley Salmon-Jamieson, Chief Nurse & Deputy Chief Executive
LINK TO STRATEGIC OBJECTIVE:	SO1: We will... Always put our patients first delivering safe and effective care and an excellent patient experience.
EXECUTIVE SUMMARY	Since 2013 "Mothers and Babies Reducing Risk through Audits and Confidential Enquiries across the UK" (MBRRACE-UK) produces an annual "Perinatal Mortality Surveillance Report". This report provides rates for stillbirths and neonatal deaths for each provider as well as reporting the national picture. Warrington and Halton NHS Foundation Trust (WHH) participates in reporting data into the Perinatal Mortality Review Tool (PMRT) which allows the analysis to take place. The timelines for submissions of deaths and the analysis of these means that when the reports are published by MBRRACE that they are based on deaths that occurred two years previously. In January 2023 a paper was submitted to Quality Assurance Committee (QAC) to review WHH MBRRACE-UK Reports over 5 years (2016-2020). The paper proposed a number of recommendations including: • Provide an annual report to QAC in April each year which includes all relevant deaths in the previous year and the findings of the reviews, including trends and themes and improvement activities This report presents an overview of Warrington and Halton Teaching Hospitals (WHH) NHS Foundation deaths from 1/1/2022 – 31/12/2022 and an overview of the key findings, learning and good practice for these cases. This learning is identified utilising the Perinatal Review Tool which has been developed to standardise the reviews of stillbirths and neonatal deaths across England, Scotland and Wales.

	NHS Resolution have incorporated the use of the National Perinatal Mortality Review Tool (PMRT) into Safety Action One of the Maternity Incentive Scheme (Year 4). During 2022 WHH reported 16 babies to Mothers and Babies Reducing Risk through Confidential Enquires across the UK (MBRRACE-UK). This comprised of 8 stillbirths and 8 Neonatal Deaths. WHH stillbirth rate for 2022 was 2.86 per 1000 births. The MBRRACE-UK national rate is 3.51 per 1000 births. WHH Neonatal mortality rate for 2022 was 0.8 per 1000 live births. The North West Neonatal Operational Delivery Dashboard (NWODN) shows a mean neonatal mortality rate for 2022 across the ODN of 0.6 per 1000 live births. The NWODN will flag when trusts are identified as an outlier in relation to neonatal mortality. WHH has not been identified as an outlier. During 2022 WHH undertook 11 PMRT review panels reviewing 13 cases. Parental perspective of the care they received were sought in all cases. There were two cases where the review group identified care issues which they considered may have made a difference to the outcome, one in the period up to where the baby died and one in care following the death of the baby. There was one case where the review group identified care issues which they considered were likely to have made a difference to the outcome of the care following the death of the baby. In the majority of cases care was graded either grade A (the review group concluded that there were no issues with care identified) or grade B (the review group identified care issues which they considered would have made no difference to the outcome).

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

RECOMMENDATIONS:	Quality Assurance Committee is requested to: • To note the content of the report. • To share the findings of this report with the Trust Board for information and assurance.	
PREVIOUSLY CONSIDERED BY:	**Committee**	Not Applicable
	Agenda Ref.	
	Date of meeting	
	Summary of Outcome	
NEXT STEPS: ***State whether this report needs to be referred to at another meeting or requires additional monitoring***	Choose an item.	
FREEDOM OF INFORMATION STATUS (FOIA):	**Release in Full**	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	Choose an item.	

NAME OF COMMITTEE

SUBJECT	Perinatal Mortality Annual Review 2022	AGENDA REF:	QAC/23/04/76

1. BACKGROUND/CONTEXT

The NHS Long Term Plan is to achieve a 50% reduction in stillbirths and neonatal deaths by 2025. The Mothers and Babies Reducing Risk through Audits and Confidential Enquires (MBRRACE) -UK confidential enquiries, reported that 60-80% of term perinatal deaths might have been prevented and recommends Trusts should undertake robust reviews and develop lessons learned to reduce the rate of stillbirth.

NHS Resolution (NHSR) have incorporated the national Perinatal Mortality Review Tool (PMRT) into Safety Action One of the Maternity Incentive Scheme (MIS) Year 4 standards and recommended each maternity service audits all babies born stillborn and neonatal deaths to its Trust Boards using a PMRT reporting template. The audit and reports must be presented quarterly.

This annual report presents WHH PMRT audit data for 2022 and highlights good practice and lessons learned during the mortality reviews.

Definitions:

- **Perinatal mortality** refers to the number of stillbirths and early neonatal deaths in the first week of life.
- **Late Fetal Loss** is when a baby is born between 22+0 weeks and 23+6-weeks gestation showing no signs of life.
- **Stillbirth** is when a baby is born showing no signs of life after 24+0 weeks of pregnancy.
- **Early Neonatal death** occurs when a baby is born after 20+0 weeks gestation or weighs 400grams or more and lives but dies within 7 days of being born.
- **Neonatal Mortality Rate** refers to the number of babies which have died within the first 28 days of life.

Perinatal Mortality Review Tool (PMRT) is a national standardised approach to systematically review circumstances and care leading up to and surrounding each stillbirth and neonatal death. The review should incorporate a multidisciplinary approach which includes communication with parents on their experience of care provided and any questions they may have. Following the review, a grading of care is provided by the multidisciplinary review team.

2. KEY ELEMENTS

The Perinatal Review Tool has been developed to standardise the reviews of still births and neonatal deaths across England, Scotland and Wales. During 2022 reporting period 16 cases were reported to MBRRACE-UK comprised of 8 stillbirths and 8 neonatal deaths. Of the eight stillbirths, one was a late fetal loss born at 23+2 weeks. Of the eight neonatal deaths, five were babies born before 24 weeks gestation. MBBRACE data does not include neonatal deaths before 24 weeks gestation. Where criteria for review using the PMRT tool was not met the deaths were notified and surveillance completed.

2.1 WHH Stillbirth Rate

- WHH stillbirth rate for 2022 is 2.86 per 1000 births.
- The MBRRACE-UK national stillbirth rate for 2022 is 3.51 per 1000 births
- WHH had 7 stillbirths >24 weeks
- WHH had 0 intrapartum stillbirths
- WHH had two term stillbirths (babies born from 37 weeks gestation)

Table 1: WHH stillbirth data over 12-month Period:

Metric	Q4 21/22	Q1 22/23	Q2 22/23	Q3 22/23	12-month total
Number of live births	644	573	577	641	2435
Total number of stillbirths >24 weeks	1	3	1	2	7
Total Stillbirth Rate >24 weeks	**1.55**	**5.20**	**3.59**	**3.11**	**2.86**
Number of intrapartum still birth rate	0	0	0	0	0
Number of stillbirths >37 weeks	0	0	1	1	2

2.2 WHH Neonatal deaths

- During 2022 8 neonatal deaths were reported. WHH neonatal mortality rate for 2022 was 0.8 per 1000 live births.
- The North West Neonatal Operational Delivery Dashboard (NWODN) shows a mean neonatal mortality rate for 2022 across the ODN of 0.6 per 1000 live births.

The NWODN will flag when trusts are identified as an outlier in relation to neonatal mortality. WHH has not been identified as an outlier.

Of the eight neonatal deaths, five were babies born before 24 weeks gestation. MBBRACE data and comparator rates for 2022 will be available in Summer 2024. MBBRACE data does not include neonatal deaths before 24 weeks gestation.

Of the eight neonatal deaths in 2022, five met the criteria for review via the PMRT tool. Three were babies born at the threshold of viability where standard practice was followed. These cases are reviewed via internal governance processes.

2.3 2022 PMRT Review Panel Key Findings

11 PMRT panels took place during 2022 reviewing 13 cases of stillbirth or neonatal death.

Table 3: 2022 PMRT Grading of Stillbirth and Neonatal deaths:

PMRT grading	Care provided up to the point that the baby was confirmed as having died	Care provided following confirmation of the death of the baby
PMRT grade A The review group concluded that there were no issues with care identified	4	8
PMRT grade B The review group identified care issues which they considered would have made no difference to the outcome	8	3
PMRT grade C The review group identified care issues which they considered may have made a difference to the outcome	1	1
PMRT grade D The review group identified care issues which they considered were likely to have made a difference to the outcome		1
Not Graded	-	-
Total Cases	13	13

2.3.1 Key learning and good practice

Learning and actions:

In the majority of cases care was graded as A or B, however learning is collated in all cases. As a result of PMRT panel reviews, 40 actions in total were identified. Of these 22 have been completed. 18 are ongoing and progress is monitored. Many of the actions relate to sharing learning in response to the findings of the panel reviews as well feeding back to individual teams in relation to incidental learning. All actions identified following PMRT reviews are recorded in full on the Datix incident reporting system and monitored through Women's and Children's Governance Meetings.

Good Practice:

- All reportable cases have been notified and surveillance completed within the required timescale.
- Following the grading of care in both stillbirth and neonatal death cases, only one review identified a grading of C or D i.e. identified an issue with care which may have or identified as likely to have changed the outcome up to the point that the baby was confirmed as having died. Care was graded as A or B in 12 of the 13 cases.
- Good bereavement care was in recorded in all cases. In 8 of the cases this was graded as A.
- Parental perspective was sought in all cases.
- In one case a family requested to be able to take their baby for a walk in their pram and this was facilitated. This learning has been shared with the national bereavement care steering group as evidence of good practice and has been adopted by other trusts.
- The quality of individual care from specialist Bereavement Midwives, Obstetricians, community based midwives and wider multidisciplinary team was commended in a number of cases.
- MIAA undertook an external audit of PMRT processes in June 2022. MIAA were assured by the processes and governance of the PMRT process and pathways at WHH.
- WHH is compliant with all measures included as part of Maternity Incentive Scheme Safety Action 1 (MIS Year 4 standards)

3. SUMMARY

- WHH stillbirth ate for 2022 is 2.86 per 1000 births compared to the MBRRACE-UK national stillbirth rate for 2022 of 3.51 per 1000 births
- WHH neonatal mortality rate for 2022 was 0.8 per 1000 live births.

- The North West Neonatal Operational Delivery Dashboard (NWODN) shows a mean neonatal mortality rate for 2022 across the ODN of 0.6 per 1000 live births.
- WHH has not been identified as an outlier for stillbirths or neonatal mortality in 2022
- All care in cases of stillbirth or neonatal mortality is graded using the Perinatal Review Tool which was implemented nationally to standardise the reviews of stillbirths and neonatal deaths.
- Where cases do not meet the criteria for review via the PMRT tool cases are reported and surveillance completed via other governance systems.
- Where learning is identified this is recorded and monitored via the Datix system.

4. RECOMMENDATIONS

The Quality Assurance Committee is asked to note this paper and share the findings with the Trust Board for information and note.

QUALITY ASSURANCE COMMITTEE

AGENDA REFERENCE:	**QAC/23/04/82**
SUBJECT:	**Bi Annual Update – Patient Experience Sub Committee**
DATE OF MEETING:	11th April 2023
AUTHOR(S):	Ali Kennah, Deputy Chief Nurse; Jen McCartney, Head of Patient Experience and Inclusion
EXECUTIVE DIRECTOR SPONSOR:	Kimberley Salmon-Jamieson, Chief Nurse & Deputy Chief Executive
LINK TO STRATEGIC OBJECTIVE:	SO1: We will... Always put our patients first delivering safe and effective care and an excellent patient experience.
EXECUTIVE SUMMARY	This paper details an update of workstreams progressed by the Patient Experience sub-committee in line with the objectives set out in the Patient Experience Strategy 2020 - 2023. The Patient Experience Strategy 2023 – 2025 is currently in draft following extensive engagement both internally and externally whilst also serving to complement the overarching Trust Strategy. The revised draft Patient Experience Strategy 2023 – 2025 will be presented at the Patient Experience Sub Committee for approval in April 2023 and submitted to the Quality Assurance Committee in May 2023 for final approval. Within the paper updates are provided in relation to: - Patient Feedback - Volunteers - National Adult Inpatient Survey results. This paper also includes evidence of good practice in support of the Trust mission to be outstanding including details of - Patient property project - Patient activities - Patient stories This paper highlights improvements within the Patient Experience portfolio.

PURPOSE: (please select as appropriate)	Information	Approval	**To note** *	Decision
RECOMMENDATIONS:	The Quality Assurance Committee is asked to receive and note the contents of this paper.			
PREVIOUSLY CONSIDERED BY:	**Committee**	Patient Experience Sub Committee		
	Agenda Ref.			
	Date of meeting			
	Summary of Outcome			
NEXT STEPS: ***State whether this report needs to be referred to at another meeting or requires additional monitoring***	Choose an item.			
FREEDOM OF INFORMATION STATUS (FOIA):	**Release in Full**			
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	Choose an item.			

QUALITY ASSURANCE COMMITTEE

SUBJECT	**Bi Annual Update – Patient Experience Sub Committee**	**AGENDA REF:**	**QAC/23/04/82**

1. BACKGROUND/CONTEXT

This paper provides an update on the progress made in relation to the Patient Experience Strategy 2020 – 2023 and details the refreshed Patient Experience Strategy 2023 – 2025 for approval.

The paper details an update on workstreams progressed and monitored by the Patient Experience Sub Committee.

2. KEY ELEMENTS

Patient Experience Strategy

The current Patient Experience Strategy concluded in March 2023.

The Patient Experience and Inclusion Team have involved and engaged with a wide range of internal and external stakeholders, including our patients, carers, community partners, advocacy groups, staff and governors in the development of the revised Patient Experience Strategy 2023 - 2025. The Patient Experience Strategy 2023 – 2025 has also been reviewed in line with the overarching Trust Strategy to ensure objectives are aligned.

The strategy is centred around the goal to ensure we place the quality of patient experience at the heart of all we do where "seeing the person in the patient" is our norm by ensuring positive first and lasting impressions.

The Patient Experience Strategy 2023 – 2025 will build on our achievements and focus on four strategic objectives, they are:

- **Actively listen and learn from lived experience** *Communicating in a way that people understand and utilising a shared care approach to learning.*
- **Work together to make an impact** *Working as an internal multi-disciplinary team for effective and inclusive change.*
- **Value our partners to drive and sustain improvement** *Working with our Volunteers and external partners to deliver a more holistic approach to healthcare and wellbeing.*
- **Embed and celebrate good practice** *Celebrate good practice across our hospitals with our workforce and communities to embed lasting impressions.*

To ensure a Trust wide approach in providing an outstanding experience for our patients this strategy will be delivered in conjunction with the following strategies.

- Patient Service User and Carers Diversity, Inclusion and Belonging Strategy 2022 - 2025
- Food and Drink Strategy 2022 – 2025
- Working with People and Communities Strategy 2022 – 2025

The overarching Trust Strategy will be refreshed in 2025. This enabling strategy will be in effect following approval from April 2023 to April 2025 and will be refreshed alongside the Trust strategy.

The revised draft Patient Experience Strategy 2023 – 2025 will be presented at the Patient Experience Sub Committee for approval in April 2023 and submitted to the Quality Assurance Committee in May 2023 for final approval.

An underpinning workplan will be developed to ensure delivery of this strategy with progress monitored by the Patient Experience Sub Committee.

Patient Feedback

Friends and Family Test (FFT) data is a feedback tool used by patients and service users providing an
opportunity to give feedback on their experience. By listening and reviewing the feedback of patients it supports the Trust to identify what is working well and what can be improved. By introducing and promoting a digital method for providing feedback it has ensured the process is accessible for all patients whereby patients can access the system in multiple formats such as:

- Accessible in multiple languages
- Easy read
- Large print

The Trust has consistently achieved a 97% recommendation rate in inpatient areas and 94% recommendation rate in outpatient areas against an internal target of 87%. Recommendation rates for the Emergency Department have not achieved the Trust internal target although a recent improvement is noted as detailed in table 1.

Emergency Department FFT

The Trust achieved 78% positive feedback rating in the Emergency Department against an internal target of 87% in February 2023 which is an improved position from recent months

when the positive recommendation rate had decreased to as low as 66% in December 2022. It is pertinent to note that this performance is perpetuated by the super stranded position within the Trust and is mirrored across the Cheshire and Merseyside footprint. Themes identified within the Emergency Department that have impacted upon performance are wait times and staff attitude. Actions taken to improve the recommendation rate in the Emergency Department have included but are not limited to.

- Bespoke customer care training for reception staff.
- Introduction of a volunteer role to the Emergency Department to support nutrition and hydration rounds and holistic needs of patients.
- The Emergency Department now dim the lights at night-time within clinical areas to create a relaxing environment to support patients to rest whilst in the department awaiting an inpatient bed.
- Communication methods including notice board displays are currently under review to ensure patients are fully informed on the progress of their care and know what to expect whilst in the Emergency Department

The Patient Experience and Inclusion Team continue to support the Emergency Department and CBU Triumvirate to ensure continuous improvement measured by positive recommendations rates.

Table 1 below details the FFT improving feedback ratings for the Emergency Department.

Table 1: Friends and Family Test Emergency Department Positive Recommendation Rate

Month	Emergency Department	Internal WHH Target Ste	Cheshire & Merseyside Average
April 2022	68%	87%	74%
May 2022	72%	87%	75%
June 2022	70%	87%	76%
July 2022	70%	87%	74%
August 2022	72%	87%	77%
September 2022	72%	87%	75%
October 2022	74%	87%	73%
November 2022	71%	87%	74%
December 2022	66%	87%	73%
January 2023	84%	87%	84%
February 2023	78%	87%	Data not yet published

Volunteers

In support of the volunteer service insourcing in August 2022, a full benchmark review against the 'Recruiting and Managing Volunteers in NHS Providers' report has been completed. Although actions have been highlighted it is pertinent to note the review has found that all legal and contractual requirements are in place at WHH. To enable successful monitoring of the report recommendations, an action plan is in place which is monitored via a Volunteer Sub-Group of the Patient Experience Sub-Committee.

A review of existing systems and processes to ensure effective onboarding and support for volunteers has taken place. This has included the streamlining of the onboarding process resulting in a reduction from approx. 12 weeks to 4 weeks for a volunteer to be cleared to work. A streamlined induction and training programme has been introduced in line with guidance and feedback from existing volunteers. The induction, e-learning and any necessary training is, where possible, combined into one session. This has been very well received by all new volunteers as it avoids them making multiple trips to the hospital.

Since August 2022 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. The Trust is currently supported by 108 volunteers who carry out roles in a number of departments within the Trust.

➢ Wayfinder / Welcome Desk Support ➢ Hospital Radio ➢ Emergency Department ➢ Gardening ➢ WHH Charity ➢ PALS Team	➢ Bereavement ➢ Discharge Lounge ➢ Forget Me Not Ward ➢ Chaplaincy ➢ CANtreat Centre Support

The Volunteer Team are actively recruiting new volunteers within the community and are linking in closely with wards and departments to increase the presence of volunteers within the organisation.

This has resulted in:

- 31 existing Volunteers returning to support the Trust.
- 5999 hours of support provided to the Trust by Volunteers.
- 86 new Volunteers recruited to support the Trust.

In November 2022 WHH held a joint recognition event at the Park Royal Hotel, which saw the WHH Staff Long Service awards combined with a Celebration for WHH Volunteers. This was very well received by the volunteers.

The wayfinding volunteers were winners at the Trust Thankyou Awards held in March 2023.

National Adult Inpatient Survey Results.

The results of the National Adult Inpatient Survey 2021 have been received and analysed.

By way of an overview the response rate for WHH for the National Inpatient Survey 2021 was 39%. This was in line with National average response rate (39%) however is a 2% decrease in comparison to the 2020 response rate (41%)

Results demonstrated an improvement in areas such as noise and light at night, help from staff at mealtimes and communication pre and post operations and procedures. Areas for improvement were noted in relation to communication at discharge.

The results included an analysis on how each participating Trust compares against other Trusts within the Northwest region. It provided details of the lowest and highest scoring Trusts within each section of the survey.

Warrington and Halton Teaching Hospitals were featured in two of the sections as follows:

- Highest score in the Northwest Region - WHH is noted as the top 5 performing Trust in the region for feedback on the quality of care.

- Lowest Scores in the Northwest Region - WHH is noted to be in the bottom 5 Trusts in the region for admission to hospital. It is pertinent to note all top performing Trusts were specialist hospitals.

The CQC survey results were also reviewed at a national level to ascertain the Trust performance in a larger scale. Nationally themes relating to where WHH performed better than other Trusts are detailed below:

- Staff helping patients at mealtimes.
- Consistent communication by staff members about patients care and treatment.

There were no instances were WHH performed worse than other Trusts nationally with other areas scoring about the same.

An action plan is in development to address areas for improvement, actions will also be taken to celebrate positive scores both internally and externally, the action plan will be monitored via the Patient Experience Sub Committee.

A full analysis of the survey and action plan will be presented to the Quality Assurance Committee in May 2023.

Governors Observation Round

The Patient Experience Sub Committee receive monthly reports detailing outcomes from Governors Observations Rounds.

Actions and findings identified from observations are shared with the relevant ward teams, Clinical Business Unit (CBU) Triumvirate, PESC members and the Head of Patient Experience and Inclusion. Actions are monitored via CBU high level briefs monthly to ensure observational learnings are implemented in practice and positive findings are celebrated within the team.

Themes relating to improvement include.

- Environmental issues that have been supported and resolved by estates and ward teams. E.g., bathrooms needed attention on ward C23 which has now been resolved.
- Food temperatures not adequate for patients. This has ensured focused attention from ward managers and catering managers to resolve.
- Choice of food at lunch time for patients. Feedback has been included in a lunch time trial for hot food and an extended menu. This trial is currently under review with the catering team supported by the Head of Patient Experience and Inclusion and in line with the objectives set out in the Food and Drink Strategy 2022 – 2025.

Moving to Outstanding – examples of Patient Experience Improvements within the Care Groups

Virtual tours

A number of virtual tours have been created and published to support accessibility to services. These have included Main Outpatients, Children's Outpatients and Neonatal Services. Neonatal services have also included a flip book of information for parents detailing what to expect from the service and support available. Children's Outpatients services included children and young people as the guides for the video ensuring the tour is relatable to children and young people using the service.

Patient Property

Patient Property remains a priority for the Trust and sustained improvements have been made following immediate action in line with the implementation of the patient property and valuables improvement plan in August 2021.

Improvements to date include communication via the Trust Intranet, safety briefings and computer home page screen, the Trust has strengthened the availability of patient information on property and valuables. This has been supported with the production of a patient information leaflet and poster, supplemented with information on the public website, all been having been shared in a social media campaign.

Staff training and resources, including single point lessons, property check lists and the introduction of property champions in the clinical areas to share and cascade information (appendix 1) has supported the Trusts improvement plan and help reduced the number of lost property items and complaints and incidents in the last 12 months as detailed in charts 1 and 2.

Chart 1 – Patient property Incident data

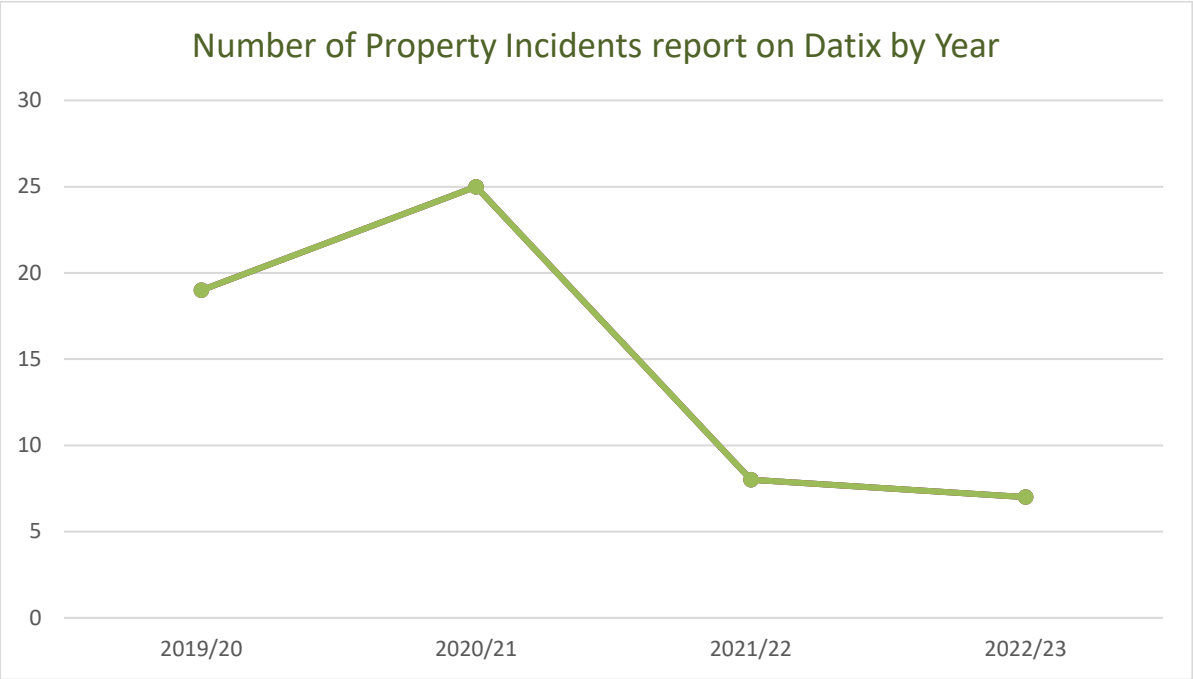
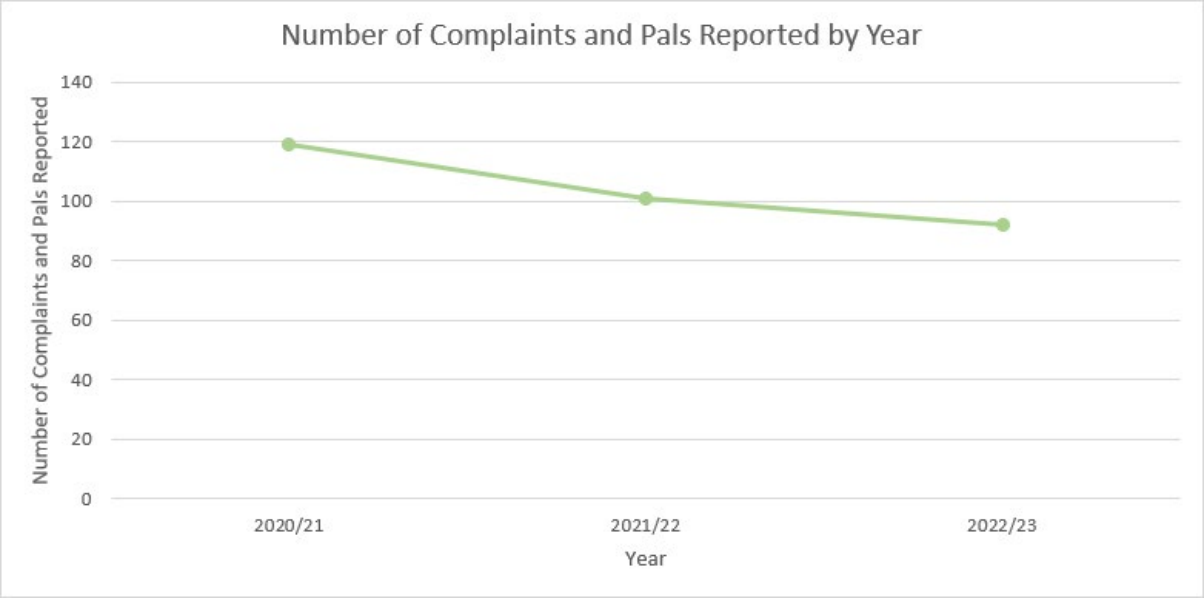


Chart 2 – Patient Property complaints and PALS data



A deep dive of the complaints and PALS data has taken place and identified ward areas have significantly reduced the number of complaints received. Both the Emergency Department and Acute Medical Unit continue to receive a high number of complaints at 42 and 10 respectively over a 12-month period from April 2022 to March 2023. Focused attention will

now take place in these areas to further reduce the complaints received by the Trust in relation to patient property.

Following a successful pilot in the Intensive Care Unit in August 2022, property of deceased patients is now sent to the Bereavement Suite to enable relatives to collect their loved ones items in a sensitive and private area away from the ICU and ward areas. In most circumstances property and valuable items should be given to relatives on the ward or department, however on occasions when this is not possible the items will be sent to the Bereavement Suite for collection.

To support this initiative the Trust now provide property bags for property items of deceased patient, these are available on the Intensive Care Unit and can be collected from the Bereavement Suite for other areas.

Patient Activities

In support of the Trust Active Hospital campaign which aims to change the physical activity culture within WHH to encourage patients to move more and remain active during their hospital stay, activity timetables have increased on wards which has been particularly successful with patients living with dementia. As an example, ward A6 have commenced an activity timetable.

Patient Stories

Clinical business units each share examples of lived experience of patients during their stay in hospital. There are many examples where the wards have demonstrated they are actively listening to their patients to support their wellbeing and holistic needs in addition to clinical needs.

One example details support for a 25-year-old patient admitted to B18 who had a background of complex respiratory conditions and learning disabilities. Some of the ways the team supported this patient included hand massages, painting her nails, meeting mini mouse and Barney, carol singers and birthday presents from the team. These activities not only provided an outstanding patient experience but enhanced trust between the patient and the team caring for her ensuring she felt calm and safe whilst in their care.

3. RECOMENDATIONS

The Quality Assurance Committee is asked to receive and note the contents of this paper.

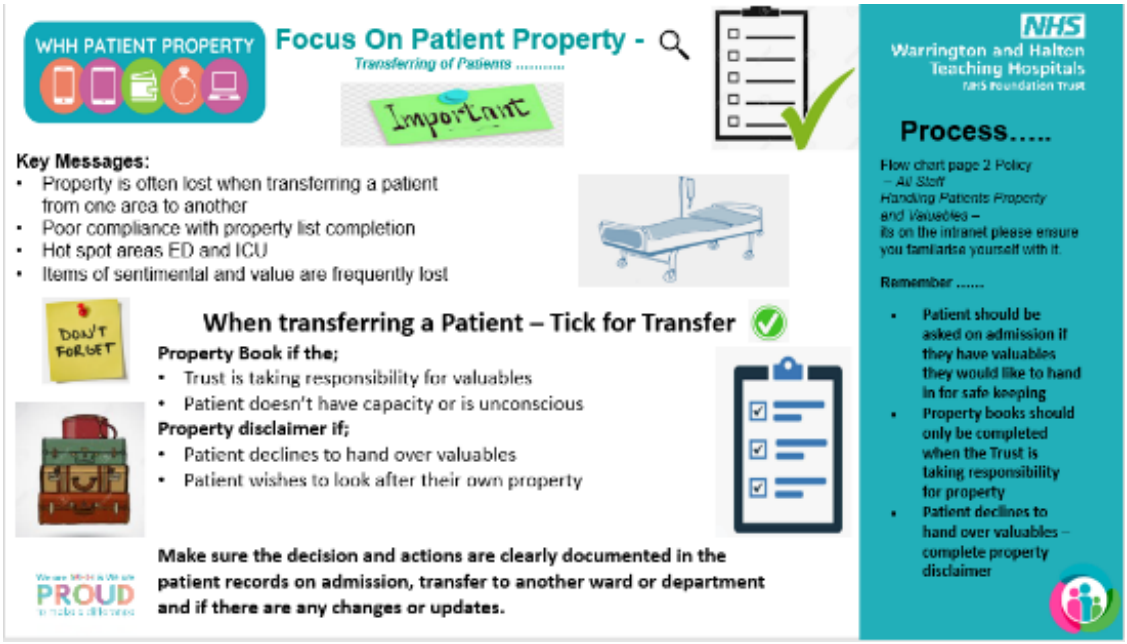
4. Appendix One - Patient Property Resources

The patient property campaign was supported by a number of resources for both staff and patients as detailed below.

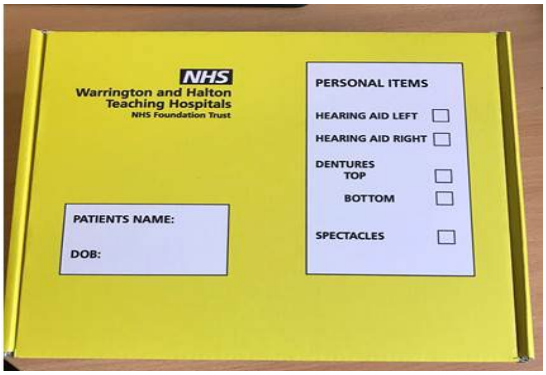
Strengthening patient information on property and valuables with the development of patient information leaflets, information on the public website and a social media campaign.

Development of resources for staff, including single point lessons, property check lists and stickers for notes and property champions in the clinical areas. (Appendix 2 and 3)


WHH PATIENT PROPERTY
Focus On Patient Property
the size of the problem....
All departments have reported incidents
Increase in Incidents in 2020
Items that go missing, teeth, hearing aids and jewellery
Poor compliance with property list completion
Hot spot areas ED and ICU
Transferring of patients and lost property is an issue
Key Messages
Lost Jewellery –
extremely distressing
sentimental value
Loss of a loved one items
Data
Loss of dentures –
nutritional impact
self esteem
pain and discomfort
Hearing Aids –
poor communication
PROUD
NHS
Warrington and Halton Teaching Hospitals
NHS Foundation Trust
Next steps
Policy Update – All Staff
Handling Patients Property and Valuables
its on the intranet please ensure you familiarise yourself with it
A Task and finish group and will be focusing on
Our patient information
Staff resources and information
Establishing a social media campaign on Patient Property
Having a safety brief 'property check in'
Introducing property champions
Get involved – everyone can make a difference to improve this!


WHH PATIENT PROPERTY
Focus On Patient Property -
Transferring of Patients .....
Important
Key Messages:
Property is often lost when transferring a patient from one area to another
Poor compliance with property list completion
Hot spot areas ED and ICU
Items of sentimental and value are frequently lost
DON'T FORGET
When transferring a Patient – Tick for Transfer
Property Book if the;
Trust is taking responsibility for valuables
Patient doesn't have capacity or is unconscious
Property disclaimer if;
Patient declines to hand over valuables
Patient wishes to look after their own property
Make sure the decision and actions are clearly documented in the patient records on admission, transfer to another ward or department and if there are any changes or updates.
PROUD
NHS
Warrington and Halton Teaching Hospitals
NHS Foundation Trust
Process.....
Flow chart page 2 Policy – All Staff
Handling Patients Property and Valuables –
its on the intranet please ensure you familiarise yourself with it.
Remember .....
Patient should be asked on admission if they have valuables they would like to hand in for safe keeping
Property books should only be completed when the Trust is taking responsibility for property
Patient declines to hand over valuables – complete property disclaimer

Review of the current property bags and storage facilities on the wards including a pilot of patient property boxes.



STRATEGIC PEOPLE COMMITTEE

AGENDA REFERENCE:	**SPC/23/07/95**
SUBJECT:	**Annual Report of the Guardian of Safe Working, April 2022 – March 2023**
DATE OF MEETING:	19th July 2023
ACTION REQUIRED:	For approval
AUTHOR(S):	Fran Oldfield, Guardian of Safe Working Hours
EXECUTIVE DIRECTOR SPONSOR:	Paul Fitzsimmons, Executive Medical Director
LINK TO STRATEGIC OBJECTIVES:	SO1: We will ... Always put our patients first delivering safe and effective care and an excellent patient experience. SO2: We will ... Be the best place to work with a diverse and engaged workforce that is fit for now and the future.
EXECUTIVE SUMMARY:	The Guardian of Safe Working is required to report annually to the Strategic People Committee on exception reporting activity, and financial implications. As in previous years the pattern of exception reporting demonstrates increased reporting from junior grades, especially foundation doctors with fewer reports from higher trainees. The overall number of exception reports has increased compared to previous years as we are seeing the result of increased junior doctor engagement and education with regards to the exception reporting process. Exception reporting reduced significantly during the pandemic and therefore, we are now beginning to see true post pandemic levels of exception reporting. Key areas include: • Positive culture changes surrounding exception reporting and sign off • Fines levied by the Guardian of Safe Working • Immediate Safety concerns (ISC) and processes • Themes over the 12 month period - Trauma and Orthopaedics (T&O) - Medical Outliers

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

RECOMMENDATION:	The Strategic People Committee is asked to approve the Annual Report of the Guardian of Safe Working, April 2022 – March 2023.	
PREVIOUSLY CONSIDERED BY:	**Committee**	N/A
	Agenda Ref.	
	Date of meeting	
	Summary of Outcome	
NEXT STEPS: ***State whether this report needs to be referred to at another meeting or requires additional monitoring***	To be presented to Trust Board.	
FREEDOM OF INFORMATION STATUS (FOIA):	Choose an item.	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	Choose an item.	

STRATEGIC PEOPLE COMMITTEE

SUBJECT	**Annual Report of the Guardian of Safe Working, April 2022 – March 2023**	**AGENDA REF:**	**SPC/23/07/95**

1. BACKGROUND/CONTEXT

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

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

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

As part of the monitoring of the 2016 Contract for Junior Doctors, the GSW is also required to submit data relating to the number of trainees hosted by WHH on the 2016 contract to the Lead Employer, who is responsible.

2. KEY ELEMENTS

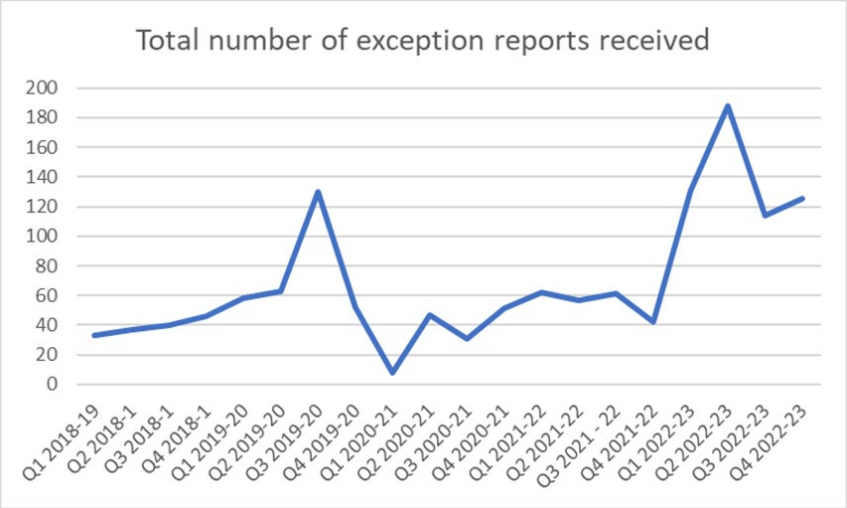
High level data

Number of doctors including training and trust grade (total): 321
Number of doctors in training on 2016 TCS (total): 294

Exception Reporting

A total of 558 exception reports were submitted during the period covered by this report, this is more than double the number submitted in the previous 12 months. The previous year was however, heavily influenced by the COVID 19 Pandemic when exception reporting dropped dramatically (see chart 1) and therefore the years are not comparable.

Chart 1 below illustrates pre and post pandemic reporting trends:



Increasing Numbers of Exception Reports

Over the past 12 months the GSW has worked to promote increased understanding and education regarding the need for exception reporting to support positive evidence-based change. This has been reflected in the higher number of reports submitted compared to pre-pandemic levels. Whilst the number of exception reports continues to increase, this should be viewed as a positive change. During the junior doctors' induction programme in August 2022 a concerted effort was made to increase awareness and understanding of the exception reporting process. Educational sessions have also been held with educational supervisors. It is hoped that if junior doctors feel empowered to report 'minor' concerns then there will be fewer barriers to reporting when significant concerns arise. The GSW will be present at the 2023 induction meetings and will continue to educate regarding the importance of exception reporting.

Fines Levied

The safeguards around working hours of doctors and dentists in training are outlined in the terms and conditions of service (TCS) and are designed to ensure that this risk is effectively mitigated and that this mitigation is assured. The GSW reviews all exception reports and identifies where a breach has occurred which results in a financial penalty as per TCS. There have been £5519.87 of fines levied by the GSW during the period covered by this report (see chart 2).

Chart 2 – Fines levied by the GSW during 2022-2023.

Date fine issued by GOSW	Total fine levied by GOSW	Proportion of fine paid to GOSW	Breach	CBU	Dept	Penalty rate	Comments
21/07/22	£2,770.89	£1,731.80	Max shift length	Surgical Specialties	T&O	FY2	Proportion of the total fine (x1.5) paid to Dr, the remainder is paid to the GOSW
21/07/22	£633.30	£633.30	Missed breaks	Surgical Specialties	T&O	FY2	Total fine is paid to GOSW.
21/07/22	£1,239.50	£774.69	11 hours rest between shifts	Surgical Specialties	T&O	FY2	Proportion of the total fine (x1.5) paid to Dr, the remainder is paid to the GOSW
30/01/23	£235.12	£146.95	Max shift length	Surgical Specialties	T&O	FY2	Proportion of the total fine (x1.5) paid to Dr, the remainder is paid to the GOSW
30/01/23	£304.64	£304.64	Missed breaks	GIM on call	Cardiology	F1 (Enhanced)	Total fine is paid to GOSW.
30/01/23	£31.78	£31.78	Missed breaks	UEC	Acute Medicine	F1 (Basic)	Total fine is paid to GOSW
30/01/23	£304.64	£304.64	Missed breaks	GIM on call	Acute Medicine	F1 (Enhanced)	Total fine is paid to GOSW
27/6/23	£691.61	432.25	Max Length Shift	Digestive Diseases	Gen Surgery	Enhanced (NP1, NP2)	Proportion of the total fine (x1.5) paid to Dr, the remainder is paid to the GOSW
27/06/2023	£412.85	£258.03	Max shift length	Womens & Childrens	O&G	Enhanced (NP2)	Proportion of the total fine (x1.5) paid to Dr, the remainder is paid to the GOSW
27/06/2023	£619.28	£387.05	Max shift length	Surgical Specialties	T&O	Enhanced (NP2)	Proportion of the total fine (x1.5) paid to Dr, the remainder is paid to the GOSW
Total	**£9,077.99**	**£6,839.51**					

For some breaches a proportion of the fine is paid to the individual doctor, the GSW is responsible for the remaining balance, which must be used to benefit the education, training and working environment of the trainees. The GSW should devise allocation of funds in collaboration with the JDF. To date none of these funds have been allocated. The GSW has made it a priority action for the JDF reps to bring suggestions/plans for usage of funds as soon as possible. Money spent will be detailed in future reports.

Immediate Safety Concerns

Immediate safety concern (ISC) ERs were submitted on 12 occasions during the period covered by this report. Two were reviewed by the GSW and not thought to have been any safety concern and therefore downgraded. Of the remaining ISC reports the majority were reports understaffing and concern regarding levels of support available to the junior doctor. One report was regarding an IT access problem with booking certain radiological investigations. All ISCs were escalated appropriately, reviewed, and remedial action implemented to mitigate the risk. Junior doctors reporting the ISCs were given appropriate support by educational supervisors and the GSW. There is a clear process for escalation of ISCs. The GSW is assured that processes are in place to ensure any issues highlighted as an ISC are acted on quickly and diligently.

Themes for April 2022 – March 2023

T&O

In the preceding 12 months 30% of all exception reports were submitted by T&O doctors. Over the course of the year positive improvements have been made as a result of a comprehensive action plan developed via a series of meetings facilitated by the GSW. However, there are ongoing concerns that despite these improvements exception reports including Immediate Safety Concern (ISC) reports are continuing to be submitted in high numbers. Work within the T&O department, supported by Senior Management and the GSW is ongoing and will continue to be monitored via the exception reporting system.

Medical Outliers

At the start of 2022 there were high numbers of exception reports relating to the "Medical Outliers", a trend which had been observed during the previous year. These concerns were escalated by the GSW and substantial changes were implemented. These changes were reviewed and further changes made as required. Following these improvements this issue has been fully resolved with no further reports received. Some of the improvements include changes to the surgical junior doctors Rota ensuring there is a formal schedule for cover of the medical outlier patients, removing the ad hoc nature of previous cover, improved timings of ward rounds and increased communication between junior and senior doctors.

Positive feedback has been received, via the JDF, that these changes have led to improved continuity of care for medical outlier patients, efficiency of ward rounds and increased junior doctor morale. This can be considered an example of successful change implemented as a result of the exception reporting process.

Summary

- Number of exception reports raised = 558
- Number of work schedule reviews that have taken place = 19
- ERs flagged as immediate safety concerns = 12
- Fines that were levied by the Guardian = 7

Exception Reports (ER) over past year	
Reference period of report	01/04/22 - 31/03/23
Total number of exception reports received	558
Number relating to immediate patient safety issues	12
Number relating to hours of working	444
Number relating to pattern of work	13
Number relating to educational opportunities	66
Number relating to service support available to the doctor	35

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

This year has seen an improvement in the sign off of exception reports which is again due to efforts made during the induction programme, ongoing updates at the JDF and regular reminders sent via the Medical Trainee Workforce administrator.

- End of Quarter 1 2022 outstanding reports – 88
- End of Quarter 4 2023 outstanding reports – 39

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

In addition to this, all JDF meeting have been well attended and there has been strong engagement between Junior Doctors' Representatives, the Chief Registrar, the MEM, DME and GSW.

3. MEASUREMENTS/EVALUATIONS

ER outcomes: resolutions	
Total number of exceptions where TOIL was granted	180
Total number of overtime payments	167
Total number of work schedule reviews	19
Total number of reports resulting in no action	39
Total number of organisation changes	15
Compensation	0
Unresolved	80
Total number of resolutions	**420**
Total resolved exceptions	**428**

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

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

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

4. TRAJECTORIES/OBJECTIVES AGREED

1. Exception Reports should be completed ASAP, but no later than 14 days of the Exception being submitted through Allocate.
2. Where the trainee is seeking payment as compensation, the report should be submitted within 7 days.
3. For every ER submitted, either for payment or TOIL, it is the Educational Supervisor who is required to respond to the ER within 7 days. Alternatively, the ES can delegate this to the Clinical Supervisor if appropriate
4. The Junior Doctor needs to indicate their “acceptance” or “escalate” to the next stage (Level 1 Review). It is only following confirmation of acceptance, that the ER can be closed.
5. If an ER is not actioned within 7 days, the MWA will review an issue an email to expedite sign-off in line with the new SOP for exception reporting.

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

5. MONITORING/REPORTING ROUTES

Quarterly and Annual Guardian of Safe Working Hours’ Reports should be provided to the Local Negotiating Committee (LNC). The Annual Report is also required to be included in

the Trust's Annual Quality Account and signed off by the Chief Executive; the contents of both reports may be included or referenced in Annual Reports provided by the Employer to Health Education England (HEE), Care Quality Commission (CQC) and/or the General Medical Council (GMC).

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

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

6. TIMELINES

SPC – GSW - Quarterly Reports, Safe Working Hours Junior Doctors in Training

- Q1 Apr – Jun; Submitted Sept 2022
- Q2 Jul – Sept; Submitted Nov 2022
- Q3 Oct – Dec; Submitted Jan 2023
- Q4 Jan – Mar; Submitted May 2023
- GSW – Annual Report, Safe Working Hours Junior Doctors in Training – Submitted July 2023

Trust Board – GSW – Annual Report Reports, Safe Working Hours Junior Doctors in Training

- 12-month review period Apr 2022 – Mar 2023 – Submitted August 2023

7. ASSURANCE COMMITTEE (IF RELEVANT)

Strategic People Committee receive Quarterly Submissions & Annual Submission, prior to Trust Board
Trust Board – Annual Submissions

8. RECOMMENDATIONS

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