Warrington and Halton Teaching Hospitals NHS Foundation Trust

TRUST BOARD - 26 May 2021

ITEMS FOR APPROVAL

ITEMS FOR NOTING FOR ASSURANCE

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/21/05/74**	
SUBJECT:	Quality Priorities 2021-22	
DATE OF MEETING:	26 May 2021	
AUTHOR(S):	Layla Alani, Deputy Director 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.	x
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF):		
EXECUTIVE SUMMARY ***(KEY ISSUES):***	Quality priorities for 2021/22 will be aligned with the Trust Quality Strategy and Annual Business Plan. This paper provides a summary of the proposed Quality Priorities for 2021/22 following stakeholder events gathering feedback from: • Patient groups • Healthwatch • Clinical Commissioning Group • Equality and Diversity Groups • LGBTQ+ Groups • Trust Non -Executive Directors • Trust Governors • Executive Team • All staff groups • Disability partnership Information was also gathered from: • Analysis of internal data intelligence; incidents, complaints and risk data • Identification of national priorities and requirements • Identification of regulatory priorities and requirements. The quality priorities for 2020-2021 are detailed below; **Patient Safety** • DNACPR- Improve communication with family/patients with effective communication, documented discussion and inclusive decision making. • COVID Recovery- robust waiting list management, with clear clinical oversight to avoid and recognise potential patient harm. • A reduction in Gram Negative Bloodstream Infections (GNBSI) – ensuring that there is a 5% reduction in Bloodstreams infection.	

	Clinical Effectiveness • Medical Examiner- embed the service across the acute setting and act as the pilot site for community roll out. • Evidence-based Interventions- Ensure effective decisions about health care are based on the best available, current, valid and reliable evidence. • CBU Governance- to be strengthened ensuring consistency across the organisation. **Patient Experience** • End of Life – Serious Illness Programme; Better Communication and Better Care for those sadly reaching the end of life. • Learning Disabilities and Mental Health Strategies - Implementation of the Trust Learning Disability Strategy. • Improve patient experience by enhancing the standard and timely delivery of nutrition. **National Indictors** NHS England has released further guidance dated 15 January 2021, stating that NHS Foundation Trusts are not required to include national quality indictors within their proposed quality priorities due to the on-going global pandemic.

PURPOSE: ***(please select as appropriate)***	Information	Approval	To note x	Decision
RECOMMENDATION:	The Board of Directors is asked to note the report			
PREVIOUSLY CONSIDERED BY:	**Committee**	Quality Assurance Committee		
	Agenda Ref.	QAC/21/04/95		
	Date of meeting	4 May 2021		
	Summary of Outcome	Noted		
FREEDOM OF INFORMATION STATUS (FOIA):	Choose an item.			
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	Choose an item.			

REPORT TO BOARD OF DIRECTORS

SUBJECT	Quality Priorities 2021-22	AGENDA REF:	BM/21/05/75

1. BACKGROUND/CONTEXT

The Quality Account is an annual report submitted by NHS providers describing the quality of services provided. A requirement of the Quality Account is that Trusts should identify areas for continual improvement in the quality of services provided.

The Trust has selected 3 improvement priorities;

Priority 1 - Patient Safety: The Trust is committed to developing and enhancing its patient safety and learning culture where quality and safety is everyone's top priority.

Priority 2 - Clinical Effectiveness: Ensuring practice is based on evidence so that we do 'the right things the right way to achieve the right outcomes' for our patients.

Priority 3 - Patient Experience: By focusing on patient experience, we want to place the quality of patient experience at the heart of all we do, where "seeing the person in the patient" is the norm.

In order to embed the above improvement priorities, we will establish local quality indictors to support their implementation.

Due to the pandemic, the large stakeholder events had to be scaled back. However, in order to determine these priority areas, we conducted a series of consultations and feedback mechanisms to ensure feedback was captured from a wide group of stakeholders:

- Online survey distributed to all staff groups
- Online inpatient survey distributed to patient groups
- Presentation to Governors
- Presentation to Commissioners
- LGBTQ+ groups
- Disability partnership
- Analysis of incidents, complaints and risk data
- Identification of national priorities and requirements
- Identification of regulatory priorities and requirements

2. KEY ELEMENTS

The information detailed below provides a summary of the quality priorities and indicators for 2021/22.

Patient Safety
• **Gram Negative Bloodstream Infections** • **Executive Lead:** Kimberley Salmon Jamieson, Chief Nurse and Director for Infection Prevention and Control • **Lead: Lesley McKay, Associate Director Infection Prevention**

There is a national ambition to reduce healthcare associated Gram-negative blood stream infections (healthcare associated GNBSIs). This priority links in with our Quality Strategy as we committed to developing and enhancing our patients' safety.	A reduction in Gram Negative Bloodstream Infections (GNBSI). **How will progress be monitored and reported?** • Infection Prevention and Control Sub Committee. • Patient Safety & Clinical Effectiveness Sub-committee / Board of Directors. • A quarterly Quality Report will track milestones for the Quality Account priorities. • Annual Quality Account. • GNBSI Quality Improvement Collaborative.
• **Do Not Attempt Cardiopulmonary Resuscitation** **Executive Lead**: Alex Crowe, Executive Medical Director **Lead:** James Wallace	
Why did we choose this priority?	**What will success look like?**
Communication is fundamental in the decision-making process regarding DNACPR, and how options and recommendations for DNACPR are discussed with patients, carers and their families.	Improvement in the communication processes for DNACPR by a reduction in the number of complaints and incidents citing DNACPR communication as a concern. Improvement in the number of wards compliant in relation to documented discussions on DNACPR in medical records. **How will progress be monitored and reported?** • Patient Safety & Clinical Effectiveness Sub-committee / Board of Directors. • Quarterly audit of DNA CPR documentation. • Monitoring of themes from incidents and complaints.
• **COVID Recovery – Ensure a robust process for the proactive management of waiting lists and early**	
Why did we choose this priority?	**What will success look like?**
The COVID-19 pandemic has challenged the NHS in	A clear process of clinical triage of waiting lists for

many different ways, including operational delivery, capacity and capability. The Trust will continue to ensure that a robust and proactive process for the management of waiting lists is in place to avoid unnecessary delays to clinical review and treatment potentially resulting in clinical harm.	each speciality Three weekly meeting or more frequent if necessary to review any potential harm and follow existing governance process for investigation. Referral to Treatment Time (RTT) wait times minimised.
	How will progress be monitored and reported?
	• Monthly Patient Safety & Clinical Effectiveness Sub-committee / Board of Directors report to ensure clear oversight maintained. • Monitor RTT performance • Clinical harms monitored and reported through weekly meeting of harm, Patient Safety & Clinical Effectiveness Sub-committee / Board of Directors

Clinical Effectiveness	
• **Medical Examiner** **Executive Lead: Alex Crowe** **Lead**: James Williamson, Chief Medical Examiner / Alison Talbot, Head of Clinical Effectiveness	
Why did we choose this priority?	**What will success look like?**
The Medical Examiner (ME) role was introduced in April 2019 following the Harold Shipman inquiry. The Medical Examiners function is designed to provide a voice to those who have sadly lost a loved one and ensure that families are able to ask questions to answers that they may need. By further embedding this role across the Trust, the ME can enhance the governance and regulatory systems by scrutinising deaths of patients not under review or inquest by the coroner and recommend actions and areas for improvement. This will also include acting as the pilot site for the implementation into community	Embed Medical Examiner system across the Trust. 100% of deaths will be reviewed. Early identification of patient safety issues, highlighted to Governance and the Mortality Review Group, with appropriate actions taken for improvement. A reduction in the number of inquests when the service is fully embedded. Enhanced family experience and explanations on how their loved one died, improving the experience for families.

services.	Enhance the support already provided by the bereavement service.
	How will progress be monitored and reported?
	• Mortality Review Group. • Quarterly report - Patient Safety & Clinical Effectiveness Sub-committee / Board of Directors. • Medical Examiners Key Milestone plan. And performance for review of deaths • Reduction in number of inquests
• **Evidence-Based Interventions** **Executive Lead:** Kimberley Salmon Jamieson, Chief Nurse **Lead**: Alison Talbot, Head of Clinical Effectiveness	
Why did we choose this priority?	**What will success look like?**
We aim to do the right thing for patients by ensuring decisions about health care are based on the best available, current, valid and reliable evidence. This priority seeks to reduce the number of inappropriate interventions patients receive by utilising on NICE, NICE-accredited or specialist society guidance and audits. Compliance will reduce avoidable harm to patients, deliver safer patient care, address unwarranted variation and to ensure that clinicians are supported to provide the best care for patients, and free up limited resources. GIRFT's model of analysing data to uncover best practice supports the identification of ideal service pathways and provides case studies for trusts to adapt to their own needs. GIRFT has continued to help specialties refocus within the constraints of COVID, adopting changes that did not seem possible before the pandemic.	Participate in all relevant national clinical audits that we are eligible to. Review all published national audit reports and produce a management summary and action plan, where relevant. Complete an annual programme of local clinical audits. Ensure NICE guidance is reviewed and, where relevant, implemented and embedded into everyday clinical practice. Over 90% compliance to be achieved for NICE guidance. Implement recommendations arising from National Confidential Enquiries (NCE's), where relevant to the Trust. Implement recommendations and action plans from the Getting it Right First Time Programme (GIRFT).
	How will progress be monitored and reported?

	• Patient Safety & Clinical Effectiveness Sub-committee • Board of Directors.
• **CBU Governance** **Lead**: - Alison Talbot, Head of Clinical Effectives.	
Why did we choose this priority?	**What will success look like?**
Good governance is a key component in supporting the delivery of quality healthcare. As such, regular developmental reviews of governance structures are good practice. Robust governance arrangements are in place to operate effectively at Care Group, CBU and Specialty level. This priority focuses on ensuring that the governance processes are further strengthened and lessons are widely shared for learning. This is a continuation of a 2020/21 Quality Priority.	Reduction in harm via incident reporting. Increase in incident reporting to show a culture of open and transparency. Clear governance arrangements, with appropriate levels of accountability established. Clearly documented discussions at local CBU governance meetings and clearly defined actions. No duplication or gaps in assurance. A key focus on key quality issues. Open and transparent challenge at Care Groups, CBU and Specialty level. Robust risk registers in place and action plans for high scoring risks. Promoting just culture amongst staff. SMART action plans for incidents and complaints.
	How will progress be monitored and reported?
	• CBU Governance Meetings. • Quarterly report Patient Safety & Clinical Effectiveness Sub-committee / Board of Directors. • Incident Dashboards. • SMART actions plans. • Triangulated learning alongside Mortality Review Group

Patient Experience	
• **End of Life – Serious Illness Programme** **Executive Lead: Alex Crowe** **Leads**: Judith Raper, Consultant and Alison Coackley, Consultant.	
Why did we choose this priority?	**What will success look like?**
The Serious Illness Care Programme - Better Communication, Better Care - is a system-level intervention designed to improve the lives of people with a serious illness by optimising the timing, frequency and quality of serious illness conversations. Comprising clinical tools, training, support, and systems innovations, and the programme empowers patients to actively participate in planning for the future with their illness. It enables clinicians and other professionals in the wider healthcare system to personalise care according to the goals and priorities of individual patients. Effective communication is key to ensuring that a patient feels empowered to input into their healthcare needs and to ensure that they understand the discussion that has taken place.	There will be organisational processes in place for regular screening of patients at risk of death within 12-24 months. Increased number of patients screened for risk of death within 12-24 months. Pilot areas have scheduled and preparation processes in place. Patient, family and clinical tools in place and being utilised. 100% of serious illness conversations are documented in the agreed template. 75% of patients are satisfied with the serious illness conversation. **How will progress monitored and reported?** • End of life steering group. • Patient Safety & Clinical Effectiveness Sub-committee / Board of Directors • Patient experience survey • Reduction in incidents and complaints
• **Learning Disabilities and Mental Health** **Executive Lead:** Kimberley Salmon Jamieson, Chief Nurse **Leads**: John Goodenough, Deputy Chief Nurse.	
Why did we choose this priority?	**What will success will look like?**
The NHS Long Term Plan has detailed that NHS staff will receive information and training on supporting people with a learning disability and/ or autism. Sustainability and Transformation Partnerships (STPs) and integrated care systems ICSs will be expected to make sure all local healthcare providers are making reasonable	Implementation of the Trust Learning Disability Strategy will ensure that the needs of people with learning disabilities and autism are met to the highest standard, optimising clinical outcomes and patient experience.

adjustments to support people with a learning disability or autism. Over the next five years, national learning disability improvement standards will be implemented and will apply to all services funded by the NHS. These standards will promote greater consistency, addressing themes such as rights, the workforce, specialist care and working more effectively with people and their families. By 2023/24, a 'digital flag' in the patient record will ensure staff know a patient has a learning disability or autism. The implementation of the Trust Learning Disability Strategy and Mental Health Strategy will improve the care delivered to this patient group.	**How progress will be monitored and reported** • Safeguarding Committee. • Patient Safety & Clinical Effectiveness Sub-committee / Board of Directors. • Patient experience survey
Improve patient experience by enhancing the standard of nutrition and hydration. **Executive Lead:** Kimberley Salmon Jamieson **Leas**: John Goodenough, Deputy Chief Nurse.	
Why did we choose this priority?	**What will success look like?**
Varied, food and hydration are an integral part of a patient's treatment, giving the nutrients and fluids needed to support recovery from illness or surgery. Meeting the nutritional and hydration needs for all patients is also a CQC regulatory requirement (Regulation 14). In doing so we will enhance the patient experience and ensure that patients' needs are met.	• Nutritional Steering Group. Implementation of the recommendations and actions in the Trust Nutritional Care Strategy 2019-22. • New menus designed with an extended choice of meals. • Board members to undertake 2 food tasting sessions for assurance of food standards. • Reduction in the number of complaints/concerns raised in relation to quality and accessibility of food. • Improved patient experience, patient experience survey. **How will progress be monitored and reported?** • Patient Experience Sub-committee. • Friends and Family Testing. • National patient survey.

3. ACTIONS REQUIRED/RESPONSIBLE OFFICER

The Board of Directors are asked to note the quality priorities 2021/22.

4. IMPACT ON QPS?

The content of this report demonstrates that we are working to ensure that our patients receive high quality, safe care and an excellent patient experience.

5. MONITORING/REPORTING ROUTES

The Quality Priorities will be reported on Quarterly. This report is submitted to the Patient Safety & Clinical Effectiveness Sub-Committee prior to the Board of Directors.

6. ASSURANCE COMMITTEE

Board of Directors.

7. RECOMMENDATIONS

The Board of Directors is asked to note the report.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/21/05/75**			
SUBJECT:	**Maternity Incentive Scheme Year 3** **Progress Report CNST**			
DATE OF MEETING:	25 May 2021			
AUTHOR(S):	Debby Gould, Interim Head of Midwifery			
EXECUTIVE DIRECTOR SPONSOR:	Kimberley Salmon-Jamieson, Chief Nurse & Deputy Chief Executive			
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	SO1 We will.. Always put our patients first through high quality, safe care and an excellent patient experience. SO2 We will.. Be the best place to work with a diverse, engaged workforce that is fit for the future. SO3 We will ..Work in partnership to design and provide high quality, financially sustainable services.			
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): **(*Please DELETE as appropriate)***	#1135 Failure to deliver an emergency and elective healthcare service caused by the global pandemic of COVID-19 resulting in major disruption to service provision. #1124 Failure to provide adequate PPE caused by failures within the national supply chain and distribution routes resulting in lack of PPE for staff. #115 Failure to provide adequate staffing levels in some specialities and wards. #134 Financial Sustainability a) Failure to sustain financial viability, #1134 Failure to provide adequate staffing caused by absence relating to COVID-19 resulting in resource challenges and an increase within the temporary staffing domain. #1114 Failure to provide essential, optimised digital services in a timely manner in line with best practice governance and security policies, caused by increasing and competing demands upon finite staffing resources whom lack emerging skillsets, sub-optimal solutions or a successful indefensible cyber-attack, resulting in poor data quality and its effects upon clinical and operational decisions / returns and financial & performance targets, reduced operational efficiencies, denial of patient access to services, inferior quality of care including harm, failure to meet statutory obligations (e.g. Civil Contingency measures) and subsequent reputational damage. #224 Failure to meet the emergency access standard. #125 Failure to maintain an old estate caused by restriction, reduction or unavailability of resources resulting in staff and patient safety issues, increased estates costs and unsuitable accommodation. #145 a. Failure to deliver our strategic vision. #145 b. Failure to fund two new hospitals. #1126 Failure to potentially provide required levels of oxygen for ventilators caused by system constraints resulting in lack of adequate oxygen flow at outlets. #241 Failure to retain medical trainee doctors in some specialties by requiring enhanced GMC monitoring resulting in a risk service disruption and reputation.			
EXECUTIVE SUMMARY *(KEY ISSUES):*	Final update on CNST progress for sign off.			
PURPOSE: *(please select as appropriate)*	Information	Approval	To note	Decision For sign off

RECOMMENDATION:	Board to sign off CNST progress for submission.	
PREVIOUSLY CONSIDERED BY:	**Committee**	Quality Assurance Committee
	Agenda Ref.	QAC/21/05/120
	Date of meeting	4th May 2021
	Summary of Outcome	
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	Choose an item.	

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Maternity Incentive Scheme Year 3

Progress Report

Quality Assurance Committee

Thursday 14th May 2021

Debby Gould, Professional Midwifery Advisor (Head of Midwifery)

Deborah Carter Project Director

Maternity incentive scheme year 3: revised conditions

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- Trusts must achieve all 10 safety actions.
- **The Board declaration form must be signed and dated by the Trust chief executive to confirm:**

✓ **The evidence of achievement of the 10 safety actions meets the required safety actions' sub-requirements**

✓ **The content of the Board declaration form has been discussed with the maternity service commissioner(s)**

✓ **There are no external maternity service reports that may provide conflicting information to the declaration (e.g. Care Quality Commission (CQC) inspection report, Healthcare Safety Investigation Branch (HSIB) investigation reports etc.)**

- Board must permit the chief executive to sign the form, confirming that the Board are satisfied that the evidence provided meets the required safety action standards
- Submissions will be externally verified by MBRRACE UK, NHS Digital, NNRD and HSIB for safety action 1, safety action 2 and safety action 10 respectively
- Submissions will be sense checked with the CQC

- NHS Resolution will investigate concerns raised about performance and Trusts will be asked to re-review their submission. If a Trust re-confirms compliance with all ten safety actions the evidence submitted to Trust Board will be requested for review. If the Trust is found to be non-compliant, it will be required to repay any funding received and asked to review previous years' MIS submissions

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Key points

- Return signed **active electronic** Board declaration form to MIS@resolution.nhs.uk from Monday 12th July 2021 to 12 noon on Thursday 15th July 2021
- Electronic acknowledgment will be provided within 10 working days of submission by NHSR
- Further details still to be published by NHSR on results, appeals and payment processes

- Reporting on Safety Actions was paused from March 2020 to October 2020

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The10 Maternity Safety Actions

- Safety Action 1: Use of the National Perinatal Mortality Review Tool
- Safety Action 2: Submitting data to the Maternity Services Data Set
- Safety Action 3: Transitional care services to support Avoiding Term Admissions Into Neonatal Units Programme
- Safety Action 4: Effective systems of clinical workforce planning
- Safety Action 5: Effective system of midwifery workforce planning
- Safety Action 6: Demonstrating compliance with Saving Babies Lives Care Bundle v2
- Safety Action 7: Gathering service user feedback and working with Maternity Voices Partnership to co produce local maternity services
- Safety Action 8: Multi professional maternity emergencies training
- Safety Action 9: Maternity Safety Champions
- Safety Action 10: Reporting of qualifying cases to HSIB and NHS Resolution Early Notification Scheme

Safety action 1: Are you using the National Perinatal Mortality Review Tool (PMRT) to review perinatal deaths to the required standard?

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	Required Standard	Evidence	Comments	RAG
1a	From 11/01/21, all perinatal deaths to be notified to MBRRACE-UK within 7 working days and the surveillance information completed within 4 months.	Q2, Q3, Q4 PMRT Reports 01/07/20-31/03/21. Evidence of parents comments is included in PMRT reports *Shadow validation by NHSR to cross reference data from MBRRACE-UK for standards a, b and c*	0 perinatal cases to report to MBRRACE-UK from 01/01/21 to 22/04/21	*Compliant*
1b	PMRT review of 95% of all deaths of babies, using the PMRT, from 20/12/19 -15/03/21 will have been started before 15/07/2021.		All cases have been reviewed within the timescale. Dec 2019 – 1 case reviewed 2020 - 17 cases reviewed 2021 - 0 cases for review	Compliant
1c	50% of all deaths of babies from 20/12/19 to15/03/21 will have had a PMRT at least a draft report generated.		18 cases have been reviewed 15 cases have completed reports 3 cases have draft report	*Compliant*
1d	For 95% of all deaths of babies from 20/12/19, parents will have been told that a review will take place, and their perspectives about the care sought.		Bereavement MW supports parents to submit questions and comments to the PMRT case review	*Compliant*
1e	Quarterly reports will have been submitted to the Trust Board from 01/10/ 2020 onwards	PMRT reviews are reported in the Maternity Safety Champion Reports to QAC **2020** - 07/01, 03/03, 07/07, 01/09, 06/10, 03/11 **2021** - 02/02	Q1 -Apr-Jun 2020 Quarterly PMRT Report presented in the Maternity Safety Champion report to QAC, 04/08/2020 Q2, Q3, Q4 reports to be presented in May 2021 Maternity Safety Champions Report.	*Compliant*

Safety action 2: Are you submitting data to the Maternity Services Data Set to the required standard?

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	Required Standard	Evidence	Comments	RAG
2.1 2.2 2.4 - 2.13	This relates to the quality, completeness of the submission to the Maternity Services Data Set (MSDS) and ongoing plans to make improvements.	2.1, 2.2, 2.4 – 2.13 all complete. December 2020 MSDS Data Scorecard confirmed full compliance. Scorecard shared at Women's Health Governance Meeting 23/03/2020 and Maternity Safety Champions report to QAC March 2021. Items 1, 2, 4-13 were assessed by NHS Digital and included in the MSDS scorecard for December 2020 data submission	NHS Digital MSDS December 2020 Scorecard confirmed full compliance with standards. MSDS Scorecards presented to QAC as part of the Maternity Safety Champions report.	*Compliant*
2.3	Trust Boards to confirm to that they have fully conformed with the MSDSv2 Information Standards Notice, DCB1513 Amd 10/2018, or that a locally funded plan is in place to do this, and agreed with the maternity safety champion and the LMS. This should include submission of the relevant clinical coding in MSDSv2 in SNOMED-CT.	MSDS ISN nonconformity letter sent to NHS Digital Feb 2021explaining the limitations of the current maternity information systems ability to conform to the Digital Maternity Records standards and the impact on the MSDSv2 ISN	Plan in place : New maternity information system under procurement. New system will be compliant with MSDSv2 Implementation plan at Maternity Digital Meeting May 2021, plan to implement by end Q3 2021 Digital Midwife and Consultant in place	*Compliant*

Safety action 3: Can you demonstrate that you have transitional care services to support the Avoiding Term Admissions Into Neonatal units (ATAIN) Programme?

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	Required Standard	Evidence	Comments	RAG
3d	Commissioner returns for Healthcare Resource Groups 4/XA04 activity as per Neonatal Critical Care Minimum Data Set have been shared, on request, with the Operational Delivery Network and commissioner	BadgerNet supports MSDS and NNCCDS submissions to ODN Dashboard. ODN 2020 Q2 NNCCDS Report received March 2021.	Returns do not need to be made routinely unless requested by the ODN and/or commissioner. No requests to share data have been received	*Compliant*
3e	A review of term admissions to the neonatal unit and TC during the Covid-19 period (01/03/20 – 31/08/20) is required to identify the impact of: •closures or reduced capacity of TC •changes to parental access •staff redeployment •changes to postnatal visits leading to an increase in admissions	Audit review completed 30/11/20. Summary of review included in the Maternity Safety Champion Report to QAC 01/12/20	Findings included in ATAIN Action Plan (3f)	*Compliant*
3f	An action plan to address findings from ATAIN reviews, including those from point in e above has been agreed with the maternity and neonatal safety champions and Board level champion.	ATAIN action plan in progress and presented at Women's Health Governance Meetings. Action plan presented monthly as part of Safety Champion QAC report **2020** - 03/03, 07/07, 04/08, 01/09, 06/10, 03/11, **2021** - 02/03		*Compliant*
3g	Progress with the revised ATAIN action plan has been shared with the maternity, neonatal and Board level safety champions.			*Compliant*

Safety action 4: Can you demonstrate an effective system of clinical workforce planning to the required standard?

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	Required Standard	Evidence	Comments	RAG
4	**Anaesthetic Medical Workforce** An action plan is in place and agreed at Trust Board level to meet Anaesthesia Clinical Services Accreditation standards 1.7.2.5, 1.7.2.1 and 1.7.2.6	Audits of elective caesarean section delays completed. Anaesthetic staffing guideline in place Copy of Anaesthetic staffing rota available	ACSA preliminary assessment completed 03/03/21. Action plan in place to meet ACSA standards and Rotas compliant.	Compliant.
	Neonatal Medical Workforce The neonatal unit meets the British Association of Perinatal Medicine (BAPM) national standards of junior medical staffing. If this is not met, an action plan to address deficiencies is in place and agreed at board level	Trust wide review of medical workforce underway. Findings from the review will inform business case to increase neonatal/paediatric medical workforce. Action plan in place to meet national standards of junior medical staffing	WHTH not compliant with BAPM Tier 2 medical staff training standards. Trust wide review of medical workforce underway. Findings from the review will inform business case to increase neonatal/paediatric medical workforce. Action plan in place to go to board before submitting to the ODN 02/06/21	Compliant
	Neonatal Nursing Workforce The neonatal unit meets the BAPM national nursing standards. If this is not met, an action plan to address deficiencies is in place and agreed at board level	Staffing review completed in line with BAPM and Dinning Review Tool standards. Report included in WHTH Nursing and Midwifery Bi Annual Staffing Review. Presented to Workforce Committee Feb 2021	Staffing levels in accordance with BAPM . No action plan required.	*Compliant*

Safety action 5: Can you demonstrate an effective system of midwifery workforce planning to the required standard?

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	Required Standard	Evidence	Comments	RAG
5a	A systematic, evidence-based process to calculate midwifery staffing establishment is complete.	Birthrate Plus completed 2015 and 2018. No recommended timescales for BR+ reviews. Outcome of BR+ review updated in Trust Bi Annual Nursing and Midwifery Staffing Review, presented to Workforce Committee Feb 2021 Supernumerary status of labour ward coordinator included as part of Matron daily walkarounds 1:1 care in labour monitored as part of the internal dashboard. Currently reporting 100% compliance	Elements a-d covered in Midwifery Workforce Report included as part of Trust Bi Annual Nursing and Midwifery Staffing Review, presented to Workforce Committee Feb 2021 Action plan to be developed to support 100% compliance of supernumerary shift leader and plan to add Maternity Red Flags to e-roster	*Compliant*
5b	The midwifery coordinator in charge of labour ward must have supernumerary status; to ensure there is an oversight of all birth activity within the service			Compliant
5c	All women in active labour receive one-to-one midwifery care			*Compliant*
5d	Submit a 12 monthly midwifery staffing oversight report that covers staffing/safety issues to the Board.			*Complaint*

Safety action 6: Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle version two?

	Required Standard	Evidence	Comments	RAG
SBL E1	Recording of carbon monoxide reading on Maternity Information System and inclusion in MSDS submission. Audit of percentage of Carbon Monoxide measurement at booking is recorded and percentage of CO measurement at 36 weeks is recorded.	CO monitoring suspended from March 2020 – Jan 2021. CO monitoring recommenced Jan 2021. CO readings recorded on Lorenzo Birth Summary and data extracted for MSDS reporting.	Audit of element 1 complete	*Compliant*
SBL E2	Percentage of pregnancies where a risk status for fetal growth restriction is recorded at booking. Women with a BMI>35 kg/m2 are offered ultrasound assessment of growth from 32 weeks' gestation In high risk pregnancies uterine artery Doppler flow velocimetry is performed by 24 completed weeks gestation There is a quarterly audit of the percentage of babies born <3rd centile >37+6 weeks' gestation.	FGR risk status recoded on Lorenzo Booking History SGA pathway and algorithm in place for USS routines in complex pregnancy Quarterly Audit completed and results presented at Women's Health Governance Meeting Feb 2021	Audit of element 2 complete	*Compliant*
SBL E3	Audit of percentage of women who had received fetal movement leaflet/information by 28+0 weeks. Audit of percentage of women who attend with RFM who have a CTG.	Fetal movements leaflet included in maternity hand held records	Audit of element 3 complete	*Compliant*

Safety action 6: continued

	Required Standard	Evidence	Comments	RAG
SBL E4	Audit of percentage of staff training on intrapartum fetal monitoring Audit of percentage of staff who have completed mandatory annual competency assessment	K2 fetal monitoring training package in place Fetal Surveillance Midwife supports staff training and monitors compliance March 2021 Maternity Safety Champions report to included request for Trust Board to minute a written commitment to facilitate local, in person MDT training when permitted. Note : NHSR have removed 90% training threshold requirements for compliance	WHH maternity team trajectory to reach 90% of staff trained by July 2021 continues to be followed. Training compliance as of 14th May 2021 is : Consultant obstetricians 90% Other doctors 88% Midwives 90% NHSP 83%	*Compliant*
SBL E5	Audit percentage of singleton live births (less than 34+0 weeks) receiving a full course of antenatal corticosteroids, within seven days of birth. Percentage of singleton live births (less than 30+0 weeks) receiving magnesium sulphate within 24 hours prior birth.	Clinical guideline in place Audit of element 5 complete to be presented at Women's Health Departmental Audit Meeting 28/06/21	Audit of element 5 complete to be presented at Women's Health Departmental Audit Meeting 28/06/21	*Compliant*
1-3	Trust Board consideration of how it is complying with SBLCBv2	Quarterly care bundle surveys 1, 2 and 3 returned to NHSE Chief Nurse and LMS. Quarterly Care Bundle reports included in Maternity Champions Report to QAC		*Compliant*

Safety action 7: Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services?

Warrington and Halton Teaching Hospitals NHS Foundation Trust

	Required Standard	Evidence	Comments	RAG
	Demonstrate a mechanism for gathering service user feedback, and that you work with service users through Maternity Voices Partnership (MVP) to coproduce local maternity services? Evidence requirements • MVP Terms of Reference •A minimum of one set of MVP meeting minutes demonstrating how feedback is obtained and the involvement of Trust in coproducing service developments based on feedback •Evidence of service developments resulting from coproduction with service users • Written confirmation from the service user chair that they are being remunerated for their work •Evidence that the MVP is prioritising women from Black, Asian, Minority Ethnic backgrounds and women living in areas with high levels of deprivation, as a result of UKOSS 2020 coronavirus data.	MVP Chair appointed March 21 First MVP meeting 25/03/21 minutes available Purchase order number available to confirm finances for remuneration Evidence of co-production of The Nest Birth Centre, using social media to consult with service users during the pandemic	MVP Toolkit to be completed to cover all compliance elements. Verbal update presented at May Patient Experience Sub Committee. MVP co-chair appointed Sarah Jackson Consultant Nurse to provide more formalised support for the MVP Chair.	Compliant

Safety action 8: At least 90%* of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session since the launch of MIS year three in December 2019 (*note 90% threshold removed by NHSR March 2021)

	Required Standard	Evidence	Comments	RAG
8a	Covid-19 specific e-learning training has been made available to the multi-professional team?	PROMPT e-learning package in place with scheduled online training sessions for MDT team. PDM training report completed, confirming training achievements of individual MDT groups	PDM training report to presented at May 2021 Women's Health Governance Meeting with supporting action plan to achieve 90% training compliance Neonatal training report to be presented at Child Health Governance Meeting May 2021. The neonatal team have been designated as an NLS training Centre. There are neonatal resuscitation updates in place.	*Compliant*
8b	Team involved in immediate resuscitation of the newborn and management of the deteriorating new born infant have attended in-house neonatal resuscitation training or Newborn Life Support (NLS) course since the launch of MIS year three in December 2019?	Separate training databases for neonatal and maternity workforces record details of staff training.		*Compliant*
8c	There is a commitment by the Board to facilitate multi-professional training sessions, including fetal monitoring training once when this is permitted.	March 2021 Maternity Safety Champions report to included request for Trust Board to minute a written commitment to facilitate local, in person MDT training when permitted. Face to face training resumed Sept 21	WHH maternity team trajectory to reach 90% of staff trained by July 2021 continues to be followed. Training compliance as of 14th May 2021 is : Consultant obstetricians 90% Other doctors 88% Midwives 90% NHSP 83%	*Compliant*

Safety action 9: Can you demonstrate that the trust safety champions (obstetrician and midwife) are meeting bimonthly with Board level champions to escalate locally identified issues?

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	Required Standard	Evidence	Comments	RAG
a	A pathway has been developed to describe how frontline and Board safety champions share safety intelligence from floor to Board and through local LMS and Patient Safety Networks.	Pathway completed 26/02/2020	Safety Champions noticeboard to be developed to ensure names of safety champions visible to all staff.	*Compliant*
b	Board safety champions are undertaking sessions for staff to raise concerns, including those relating to Covid-19 service changes and can demonstrate that progress with actioning staff concerns.	Walkaround dates scheduled for 2021 Flyer with dates distributed to all ward areas Last walk around March 2021	"You said we did" feedback to be shared with staff and findings to be presented at May Women's Health Governance Meeting. Safety Dashboard data to be circulated to all staff and published on dedicated Safety Champions noticeboard.	Compliant
c	Board safety champions have reviewed continuity of carer action plan in the light of Covid-19, considering risks for Black, Asian, minority ethnic and vulnerable groups. Action plan describes a minimum 35% of women being placed onto a continuity of carer pathway, prioritising women from the most vulnerable groups.	CoC action plan presented in Maternity Safety Champion Report to QAC **2020** - 07/01, 03/03, 07/07, 04/08, 01/09, 06/10, 03/11, 01/12 **2021** - 02/02, 03/03	WHH Trust Board have invested circa £500K recurrent in CoC. Women who do not have English as their first language are cared for by CoC Team River. In April WHH reported 100% in area women on CoC pathway so minority ethnic women will receive CoC. This exceeds the national target, and WHH are leaders regionally in this work.	*Compliant*

Safety action 9 continued

	Required Standard	Evidence	Comments	RAG
d	Frontline and Board safety champion and MatNeoSIP Networks has reviewed local outcomes in relation to: Maternal and neonatal morbidity and mortality rates including women who delayed or did not access healthcare in the light of Covid-19, following recommendations made by UKOSS, MBRRACE –UK and NHSE Chief Nurse.	Review of maternal and neonatal morbidity cases completed 30/11/2020 CoC Action plan updated to include changes to service provision following Covid-19 pandemic and increased risk to BAME and vulnerable groups. Separate action plan completed in response to the recommendations made in the 2 named reports Action plans presented in Maternity Safety Champions Report 02/02/21	Maternal and neonatal morbidity case review paper to be presented at Women's Health Governance meeting May 2021	*Compliant*
e	Board Level Safety Champion actively supporting capacity (and capability) building for staff to be involved in the following areas: • Maternity and neonatal quality and safety improvement activity, including response to Covid-19 safety concerns • Specific national improvement work and testing lead by MatNeoSIP	Good Day Collaborative information using SCORE data presented in Maternity Safety Champions Report to QAC 07/07/2020	Details of Board level safety champion attendance at a minimum **of two** engagement events such as Patient Safety Network meetings –MatNeoSIP webinars and/or the annual national learning event held in March 2020 by 30 June 2021 required events have been attended.	Compliant

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Safety action 10: Have you reported 100% of qualifying cases to HSIB and (for 2019/20 births only) reported to NHS Resolution's Early Notification (EN) scheme?

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	Required Standard	Evidence	Comments	RAG
a	Reporting of all outstanding qualifying cases for the year 2019/20 to NHS Resolution's EN scheme.	6 HSIB cases accepted for investigation 2019	Final report of qualifying EN and HSIB cases complete.	*Compliant*
b	Reporting of all qualifying cases to the Healthcare Safety Investigation Branch (HSIB) for 2020/21.	4 HSIB case reported for Investigation 2020 NHSR Early Notification Report available for cases prior to 31/03/2020 HSIB Notification Report for cases 01/04/2020 onwards. HSIB update report included in 02/02/2021 Safety Champions Report to QAC HSIB quarterly report presented at Women's and Children's CBU governance meeting 22/04/21	Report to be included in Maternity Safety Champions Report May 2021 Report includes DoC and HSIB parent information. Shadow validation by NHS Resolution to cross reference Trust reporting against HSIB database and the National Neonatal Research Database for the number of qualifying incidents recorded and externally verify that standard a) and b) have been met	
c	For qualifying cases which have occurred between 01/10/20 to 31/03/21 the Trust Board are assured that: 1. the family have received information on the role of HSIB and the EN scheme; and 2. there has been compliance with duty of candour.	Copy of DoC letter to parents. Copy of HSIB information leaflet sent to parents		

List of Evidence

NHS
Warrington and Halton Teaching Hospitals

Safety Action 1	Safety Action 6
• PMRT Quarterly Report • PMRT Letters to parents • PMRT Action Tracker • Maternity Safety Champion Quarterly PMRT Reports • Maternity Safety Champions Reports, Jan 2020 – March 2021	• SBLCBv2 Quarterly Survey Reports 2020-2021 • Fetal Monitoring Training Action Plan • Governance Meeting minutes as evidence of monitoring • GAP/GROW SGA Detection Report • Individual Audit Report for Elements 1,2,3 and 5
Safety Action 2	**Safety Action 7**
• CNST Scorecard – December 2020 Data received Match 2021 • Letter to NHS Digital Feb 2021 • MIS Implementation plan	• Completed MVP Toolkit • MVP report to PESC Meeting describing progress of MVP • Email confirming Purchase Order Number and source of funding for expenses
Safety Action 3	**Safety Action 8**
• Copy of ODN quarterly Reports • Copy of CBU Governance Meetings where report has been discussed • Covid-19 Neonatal Service review of Term Admissions, final report • ATAIN Action Plan • Maternity Safety Champions Reports Jan 2020 – March 2021	• PROMPT Digital Training Materials • PDM HLBP outlining training compliance • NLS Training Database for Obstetrics, Midwives, Neonatal Nurses and Medical staff. • Minutes from QAC confirming Trust Board support for face to face training.
Safety Action 4	**Safety Action 9**
• ACSA evidence to be submitted for assessment • Paediatric Medical Workforce Action Plan • Neonatal Nursing Workforce Paper within Trust Biannual Nursing and Midwifery Staffing Report • Copy of Workforce Meeting minutes where report was discussed	• QAC Minutes for Safety Champions Reports Jan 2020 - present • Safety Champions Pathway • Safety Champions Walkaround Posters with 2020 and 2021 Dates • COC Action Plan • BAME Covid-19 Action Plan
Safety Action 5	**Safety Action 10**
Midwifery Workforce Paper within Trust Bi Annual Nursing and Midwifery Staffing Report Copy of Workforce Meeting minutes where report was discussed	Completed HLBP

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NHS Warrington and Halton Teaching Hospitals NHS Foundation Trust

Safety Action No	Maternity Safety Action Requirements	Current Status of Evidence Available	Actions Required to Achieve Full Compliance	Deadline	Action Lead
	Safety Action 4: Can you demonstrate an effective system of clinical workforce planning to the required standard?				
4	**Neonatal Medical Workforce** The neonatal unit meets the British Association of Perinatal Medicine (BAPM) national standards of junior medical staffing. If this is not met, an action plan to address deficiencies is in place and agreed at board level	WHTH do not meet BAPM Tier 2 neonatal medical workforce training requirements for Tier 2 staffing levels. Action plan developed to meet BAPM standards. Long term locums appointed to support neonatal workforce rota provision. Short term locum provision as required. Trust wide Medical staffing workforce review underway with support of Deputy Medical Director. Business case to be developed to support increase in paediatric and neonatal medical workforce.	Action Plan to be presented at Quality Assurance Committee 02/06/2021 before submission to ODN.	02/06/2021	SH DG
	Safety Action 6: Can you demonstrate compliance with all five elements of the Saving Babies Lives care bundle version 2?				
6 **E 4**	**Element 1-5 4:** Audit of process and outcome indicators for each element of Saving Babies Lives v2 Care Bundle	Quarterly SBLCB returns completed and returned to NHSE Element 1-5 individual audit of process and outcome indicators completed.	SBL audits scheduled for presentation on 28/06/2021 at Departmental Audit meeting.	28/062021	AG
	Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services				
7	Mechanism to demonstrate gathering of service user feedback and co-production of maternity services is contained within the Maternity Voices Toolkit.	MVP toolkit in progress to record all elements of compliance Minutes of MVP meetings Purchase order number And evidence of Co-production included in the toolkit.	MVP Chair and Co-Chair to approve final evidence folder during meeting scheduled for 24/05/21	24/05/21	AG GD SJ

	Can you evidence that at least 90% of each maternity unit staff group have attended an "in-house" multi-professional maternity emergencies training session within				
8 a+b	Action plan to achieve 90% training compliance for both multi professional training and neonatal resuscitation.	All staff receive invitations to training. Attendance is monitored by practice development midwife New starters are allocated training dates for NLS and PROMPT training sessions. Quarterly training compliance reports are presented to CBU governance meetings.	Training trajectory in place to capture staff who have not attended training. Escalation of non-attendance to senior managers and clinical leads. Additional training schedule for June 2021	30/06/21	JC

Summary: The purpose of this action plan is to optimise neonatal medical staffing following the recommendations made by BAPM,2018 and The Neonatal Critical Care						
Recommendation	**Current Provision**	**Further Action Required**	**Lead Person(s)**	**Target Date for Completion**	**Progress of Action**	**Date of Completion**
1. Review and Invest in Neonatal Capacity	➢ Designated LNU status for singleton births after 26+6 weeks and multiple births after27+6 weeks. ➢ 3 ICU cots ➢ 3 HDU cots ➢ 12 SC cots ➢ NNU Co-ordinator monitors acuity and capacity hourly ➢ Unit capacity monitored daily at Safety Huddle ➢ Activity recorded on BadgerNet ➢ Consultant identifies outlying babies who can safely be repatriated and with obstetric review of women who would benefit from in utero transfer where more complex or intensive neonatal acer is	➢ Fully implement Transitional Care on Ward C23. ➢ Ongoing review of TC models to support service provision. ➢ Consider Nursery Nurse staffing levels to support TC staffing requirements. ➢ ANNP and NNU Ward Manager supports role of Senior Nurse Lead for TC to provided parents /family link, and monitor variation and care outcomes ➢ Monitor activity through BadgerNet daily reporting ➢ Monitor adherence to ODN care pathways	Matron for Child Health	31/12/2021	➢ TC Task and Finish Group implementing TC offering for ward C23.TC offering launched 01/01/21 with dedicated 4 bed bay on ward C23 ➢ Currently reviewing TC modelling to consider “in reach” provision. ➢ TC Nursery Nurse post already recruited to. ➢ NNU capacity and activity is reported quarterly to ODN ➢ Monthly ATAIN meetings review unanticipated term admissions to NNU and identify where learning and improvement can be made. ➢ Incident review process. ➢ ANNP Lead acts in a supportive capacity as TC lead.	

	anticipated.					
2. Develop the Neonatal Nursing Workforce	➢ QIS wte in post 15.79 + 2 wte registered nurses identified for training. ➢ Registered Nurses in budget = 26.61 wte. In post = 21.3 wte ➢ Nursery Nurses in post =5.22 wte ➢ ANNP in post = 2 ➢ ANNP in training wte= 0 ➢ Enhanced Neonatal Practice + 1 wte to commence training 2021. ➢ Safe staffing levels recorded on BadgerNet and monitored using BAPM and Dinning Tool standards	➢ Recruit to vacant QIS and Registered Nurse posts within establishment ➢ Develop recruitment network and pathway with ODN support. ➢ Identify key staff for ANNP training as part of medical staffing review. ➢ Review Nursery Nurses role and competency to release trained staff to provide more complex levels of care. ➢ Continue to report NNU Nurse staffing compliance to Workforce Committee biannually.	Matron for Child Health	31/12/2021	➢ Establishment and vacancy tracking is monitored monthly ➢ Medical staffing review and ANNP training under review with options appraisal under consideration. ➢ Links with ODN established to review recruitment pathways within the Region. ➢ Review role of NNU qualified nursing staff to identify ways to release trained staff to provide more complex levels of care.	
3a. Optimise Medical Staffing ***Mon – Fri 9-5***	➢ Dedicated NNU Tier 1 staffing hours in place ➢ Combined Paediatric and NNU Tier 2 staffing hours in place ➢ No availability of dedicated Neonatal Unit Tier 2 cover ➢ Tier 3 staffing hours in place ➢ 2 ANNP supporting	➢ Medical staffing review in progress. ➢ Business case under development to support increase in medical workforce. ➢ Increase and upskill ANNP posts to support Tier 2 as part of the medical staffing review. ➢	CBU Manager Consultant Neonatologist / Paediatrician	31/12/2021	➢ Long term locum paediatric consultant cover in place. ➢ Medical staffing review in progress and findings of the review have been used to support a business case for increased medical workforce. ➢ Findings of the review and details of the business cases is being collated into a trust wide medical workforce paper with support from Deputy Medical Director.	

	medical staff rota ➢ Agency staffing available for short term and long term and short-term cover as required.					
3b. Optimise Medical Staffing ***Out of Hours***	Min cover out of hours: ➢ 1 x Tier 1 for neonates only ➢ 1x Tier 2 shared with paediatrics, ➢ 1 x Tier 3 shared with paediatrics. Present from 17.30 – 22.00 hours and then on call from home. ➢ Agency staffing available for short term and long-term cover as required. ➢ Senior staff "act down" for short term unexpected sickness ➢ When no suitable medical cover is available option to close unit and suspend NNU service	➢ Monitor number of times NNU services are suspended ➢ Develop NNU Dashboard to support monitoring ➢ Limited ANNP support weekend out of hours cover. ➢ Middle grade cover also available out of hours at weekends.	CBU Manager Consultant Neonatologist / Paediatrician	31/12/2021	➢ Long term locum paediatric consultant cover strengthens senior medical cover provision. ➢ Monitoring of incidents or complaints related to staffing shortages. No reported incidents.	
4. **Develop Strategies for the Allied Health Professions**	Dedicated time allocated to: ➢ Speciality paediatric and neonatal specific Pharmacist in post over 5 days ➢	Review time required to support dedicated support from ➢ Physiotherapists ➢ Speech and Language Therapists ➢ Psychologists ➢ Dieticians ➢	CBU Manager	31/12/2021	➢ Review allied therapy provision within current NNU service to be scheduled. Review referral pathways	

5. Develop and Invest in Allied Professional Support for Parents	Dedicated time allocated to: ➢ Pharmacist	Review time and funding required for dedicated support from ➢ Physiotherapists ➢ Speech and Language Therapists ➢ Psychologists ➢ Consider business case following discussion with CCG over current service requirements. ➢	CBU Manager	31/12/2021	➢ Review allied therapy provision within current NNU service to be scheduled. Review referral pathways	
6. Develop and Invest in Support for Parents	➢ Currently working towards BFI full accreditation ➢ Family Integrated Care strategies implemented and lead in post. Working toward accreditation ➢ 2 Parents Rooms recently upgraded to provide onsite accommodation.	➢ Band 7+6 RN lead BFI accreditation process. ➢ Training and educational programme to be fully developed. ➢ FICI - working toward accreditation. Band 7 RN in place. ➢	Matron for Child Health	31/12/2021	➢ Working with ODN to achieve BFI and FICI ➢ BLISS Charter in progress ➢ WIRE Warriors Peer Support ➢ Review of findings of Neonatal Family and Staff Together Audit. Further work required to offer parents psychological support is a regional project which WHTH are participating in.	

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/21/05/76**			
SUBJECT:	**Clinical Recovery Oversight Committee (CROC) Cycle of Business 2021-2022**			
DATE OF MEETING:	26 May 2021 2021			
AUTHOR(S):	John Culshaw, Trust Secretary			
EXECUTIVE DIRECTOR SPONSOR:	Simon Constable, Chief Executive			
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	SO1 We will.. Always put our patients first through high quality, safe care and an excellent patient experience. SO2 We will.. Be the best place to work with a diverse, engaged workforce that is fit for the future. SO3 We will ..Work in partnership to design and provide high quality, financially sustainable services.			
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): (*Please DELETE as appropriate)*	All			
EXECUTIVE SUMMARY *(KEY ISSUES):*	In accordance with the Foundation Trust's Constitution 'Board of Directors – Standing Orders' the Board and Committees of the Board are required to review their Terms of Reference and Cycles of Business on an annual basis. The Cycle of Business for the newly established Clinical Recovery Oversight Committee is attached for consideration and approval.			
PURPOSE: *(please select as appropriate)*	Information	**Approve √**	To note	Decision
RECOMMENDATION:	The Trust Board is asked to review and approve the 2021-2022 Cycle of Business for Clinical Recovery Oversight Committee			
PREVIOUSLY CONSIDERED BY:	**Committee**	Clinical Recovery Oversight Committee		
	Agenda Ref	CROC/21/04/14		
	Date of meeting	27 April 2021		
	Summary of Outcome	Approved		
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: *(if relevant)*	None			

Clinical Oversight Recovery Committee Cycle of Business 2021-2022

		2021									2022		
	Exec Lead	**14.4.21**	**27.4.21**	**13.5.21**	**25.5.21**	**08.6.21**	**22.6.21**	**xx.x.21**	**xx.x.21**	**xx.x.21**	**xx.x.21**	**xx.x.21**	**xx.x.21**
INTRODUCTION & ADMINISTRATION													
Apologies for Absence	**Chair**	✓	✓	✓	✓	✓	✓						
Declarations of Interest	**Chair**	✓	✓	✓	✓	✓	✓						
Minutes of the last meeting	**Chair**	✓	✓	✓	✓	✓	✓						
Matters Arising and Action Log	**Chair**	✓	✓	✓	✓	✓	✓						
Rolling attendance log and cycle of business	**Chair**	✓	✓	✓	✓	✓	✓						
GOVERNANCE & COMPLIANCE													
Committee Terms of Reference – to review in six months	**Trust Sec**	✓											
Committee Cycle of Business – to review in six months	**Trust Sec**		✓										
Minutes/High Level Briefing from Thursday meeting of Clinical Services Oversight Group	**Assurance**		✓	✓	✓	✓	✓						
Committee Effectiveness Review – six months	**Chair/T Sec**												
Committee Effectiveness Review – annual	**Chair/T Sec**												
Risk Register – every other meeting	**Trust Sec**					✓		✓		✓		✓	
PERFORMANCE													
Harm Profile Update	**Chief Operating Officer**	✓	✓	✓	✓	✓	✓						
Review of Waiting Lists and Clinical Harm Review report	**Chief Operating Officer**	✓	✓	✓	✓	✓	✓						
Waiting List update: RTT; Priority Code Waiting Times; Cancer; Diagnostics.	**Chief Operating Officer**	✓	✓	✓	✓	✓	✓						
PLANNING													
Clinical Prioritisation & Scheduling Standard Operating Procedure (SOP) – for information	**Chief Operating Officer**		✓										
Speciality Overview	**Chief Operating Officer**	✓	✓	✓	✓	✓	✓						

Clinical Oversight Recovery Committee Cycle of Business 2021-2022

		2021									2022		
	Exec Lead	**14.4.21**	**27.4.21**	**13.5.21**	**25.5.21**	**08.6.21**	**22.6.21**	**xx.x.21**	**xx.x.21**	**xx.x.21**	**xx.x.21**	**xx.x.21**	**xx.x.21**
Access to Recovery Fund – monthly update	**Deputy Director Finance & Commercial Development**			✓		✓		✓		✓		✓	
TO NOTE FOR ASSURANCE													
Cheshire & Merseyside Elective Restoration update	**Chief Operating Officer**	✓	✓	✓	✓	✓	✓						
CLOSING													
Key issues to the Board	**Chair**	✓	✓	✓	✓	✓	✓						
Any Other Business	**Chair**	✓	✓	✓	✓	✓	✓						
Next Meeting Date & Time	**Chair**	✓	✓	✓	✓	✓	✓						

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/21/05/77**			
SUBJECT:	**Declarations required by General Condition 6 (G6(3)) and Continuity of Service Condition 7 (CoS7) of the NHS Provider Licence**			
DATE OF MEETING:	26th May 2021			
AUTHOR(S):	John Culshaw, Trust Secretary			
EXECUTIVE DIRECTOR SPONSOR:	Simon Constable, Chief Executive			
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	SO1 We will.. Always put our patients first through high quality, safe care and an excellent patient experience.	x		
	SO2 We will.. Be the best place to work with a diverse, engaged workforce that is fit for the future.	x		
	SO3 We will ..Work in partnership to design and provide high quality, financially sustainable services.	x		
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): **(*Please DELETE as appropriate)***	All			
EXECUTIVE SUMMARY *(KEY ISSUES):*	NHS Foundation Trusts are required to self-certify whether or not they have complied with the conditions of the NHS provider licence (which itself includes requirements to comply with the National Health Service Act 2006, the Health and Social Care Act 2008, the Health Act 2009, and the Health and Social Care Act 2012, and have regard to the NHS Constitution), have the required resources available if providing commissioner requested services, and have complied with governance requirements.			
PURPOSE: *(please select as appropriate)*	Information	Approval ✓	To note	Decision
RECOMMENDATION:	The Self-Certification for the items is attached and the Board is asked to approve compliance with NHS Conditions G6 and CoS7			
PREVIOUSLY CONSIDERED BY:	**Committee**	N/A		
	Agenda Ref.			
	Date of meeting			
	Summary of Outcome			
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: *(if relevant)*	None			

This template may be used by Foundation trusts and NHS trusts to record the self-certifications that must be made under their NHS Provider Licence.
You do not need to return your completed template to NHS Improvement unless it is requested for audit purposes.

Self-Certification Template - Conditions G6 and CoS7

Warrington & Halton Teaching Hospitals NHS Foundation Trust *Insert name of organisation*

Foundation Trusts and NHS trusts are required to make the following self-certifications to NHS Improvement:

Systems or compliance with licence conditions - in accordance with General condition 6 of the NHS provider licence
Availability of resources and accompanying statement - in accordance with Continuity of Services condition 7 of the NHS provider licence (Foundation Trusts designated CRS providers only)

These self-certifications are set out in this template.

How to use this template

1) Save this file to your Local Network or Computer.
2) Enter responses and information into the yellow data-entry cells as appropriate.
3) Once the data has been entered, add signatures to the document.

Worksheet "G6 & CoS7"

Financial Year to which self-certification relates 2020/21

Declarations required by General condition 6 and Continuity of Service condition 7 of the NHS provider licence

The board are required to respond "Confirmed" or "Not confirmed" to the following statements (please select 'not confirmed' if confirming another option). Explanatory information should be provided where required.

1 & 2 General condition 6 - Systems for compliance with licence conditions (FTs and NHS trusts)

1	Following a review for the purpose of paragraph 2(b) of licence condition G6, the Directors of the Licensee are satisfied that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts and have had regard to the NHS Constitution.	Confirmed OK

3 Continuity of services condition 7 - Availability of Resources (FTs designated CRS only)

EITHER:

3a	After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate.	Confirmed

OR

3b	After making enquiries the Directors of the Licensee have a reasonable expectation, subject to what is explained below, that the Licensee will have the Required Resources available to it after taking into account in particular (but without limitation) any distribution which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. However, they would like to draw attention to the following factors (as described in the text box below) which may cast doubt on the ability of the Licensee to provide Commissioner Requested Services.	
3c	In the opinion of the Directors of the Licensee, the Licensee will not have the Required Resources available to it for the period of 12 months referred to in this certificate.	

Statement of main factors taken into account in making the above declaration

In making the above declaration, the main factors which have been taken into account by the Board of Directors are as follows:

The Trust recorded a deficit of £11.3m and an adjusted deficit of £6.8m. This adjusted deficit is the value which NHSE/I monitors the Trust against and was achieved.
The response to COVID-19 impacted on Trust expenditure throughout the year with revenue expenditure of £32.6m. In addition, an element of income was impacted relating in the main to car parking and private patient income (£2.9m).
DHSC and NHSI converted all working capital loans to Public Dividend Capital (PDC) under the new cash and capital regime at the start of 2020/21, this equated to £57.8m. The annual capital programme (including external funding) was £26.9m and the actual spend for the year was £25.7m, delivering an underspend of £1.2m.
PDC of £33.7m was provided in March 2021 to support the Trust in continuing to pay creditors promptly in line with guidance. The cash balance at the end of the year was £47.9m which was above plan due to additional income received in March for the annual leave accrual and for non NHS income and for an under spend on capital and delay in capital cash expenditure.
There were no failures in financial governance during the year. The Finance and Sustainability Committee reviewed and scrutinised the financial position and performance of the Trust closely throughout the year and escalated any relevant items to the Board in the Chair's exception report. Furthermore, the Board reviewed the position and challenged forecast outturns and mitigations on regular basis.
Over the last 12 months the Trust has continued to have regular meetings with NHSE/I where the financial position, forecast, COVID-19 expenditure and capital have been discussed, reviewed and challenged.

Signed on behalf of the board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature		**Signature**	
Name	Steve McGuirk	**Name**	Simon Constable
Capacity	Chair	**Capacity**	Chief Executive
Date	26th May 2021	**Date**	26th May 2021

Further explanatory information should be provided below where the Board has been unable to confirm declarations under G6.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/21/05/78**
SUBJECT:	Complaints Annual Report
DATE OF MEETING:	26 May 2021
AUTHOR(S):	Layla Alani, Deputy Director 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.
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF):	
EXECUTIVE SUMMARY *(KEY ISSUES):*	This annual report includes a summary of formal complaints raised by patients or their relatives between 1 April 2020 and 31 March 2021. • 396 complaints were received during the reporting period, a decrease of 45 from 2019/20. • In 2020/2021 the Trust closed 398 complaints during the reporting period of which 131 were Upheld, 148 were Partially Upheld and 107 were Not Upheld. The remaining 8 cases were closed during the Covid-19 pandemic without investigation in line with National Guidance. • In March 2020 the NHS responded to the Coronavirus (Covid19) pandemic. National guidance was issued advising how to respond to complainants during this period. This resulted in 17 low and moderate complaints being closed. • Following triage, 14 complaints were considered to be Serious Incidents (8) or Concise Investigations (6) • 75 complaints were open at the time of reporting, with no breached timeframes. • 3 PHSO cases are currently being investigated. • There has been a 40.5% increase in PALS concerns when comparing 2019/2020 to 2020/2021 (1114 vs 1565). These figures are correct on the date of reporting (15 April 2021).

PURPOSE: *(please select as appropriate)*	Information	Approval	To note	Decision
			x	
RECOMMENDATION:	The Board of Directors is asked to note the report.			

PREVIOUSLY CONSIDERED BY:	**Committee**	Quality Assurance Committee
	Agenda Ref.	QAC/21/05/145
	Date of meeting	4 May 2021
	Summary of Outcome	Noted
FREEDOM OF INFORMATION STATUS (FOIA):	Choose an item.	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	Choose an item.	

REPORT TO BOARD OF DIRECTORS

SUBJECT	Complaints Annual Report	**AGENDA REF:**	**BM/21/05/78**

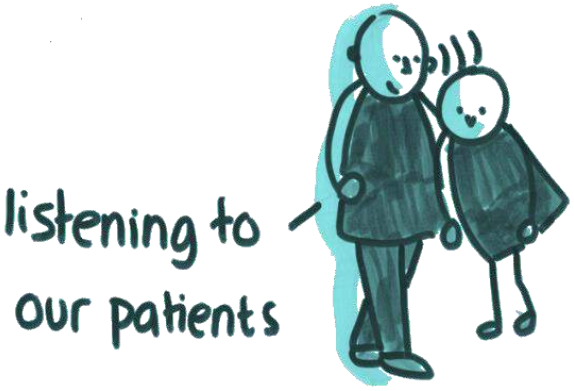
1. Background

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 scheme.

The following key principles must be applied:

- 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.

2. Key Elements

During the last financial year work has focused on:

- Ensuring complaints are fully responded to during the pandemic.
- Maintaining the timeliness of responses to complainants.
- Working collaboratively with CBUs to improve standards of care and complaints responses where necessary.
- Training staff to ensure that they understood their role in relation to the Trust's complaints policies and processes and good complaints handling,
- Improving how the Trust responds to PALS concerns.
- Addressing the concerns of dissatisfied complainants and PHSO referrals.
- Improving the system (Datix) used to log complaints, to make it more accessible and create an environment of visible data, and
- Improving the sharing of learning from complaints and compliance of actions arising through audits.

The successes in 2020/21 have included:

- In 2020/2021 the timeliness of complaints has consistently exceeded the Trust's target of 90%.
- The Trust PALS service has reduced the timeliness of responses to concerns, from 5 working days to 3 working days.
- The Datix reporting system is now embedded and complaints and PALS data is circulated through dashboards to the CBU's and wards.
- The Trust has embedded lessons learned audits, to ensure that learning from complaints and Serious Incidents are implemented.
- Complaints and PALS are now available in live ward dashboards.
- The Complaints Team won a Chief Executive award.
- Each complaint has a designated Complaints Resolution Officer to ensure continuity for Complainants and improve the quality of responses.
- 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.

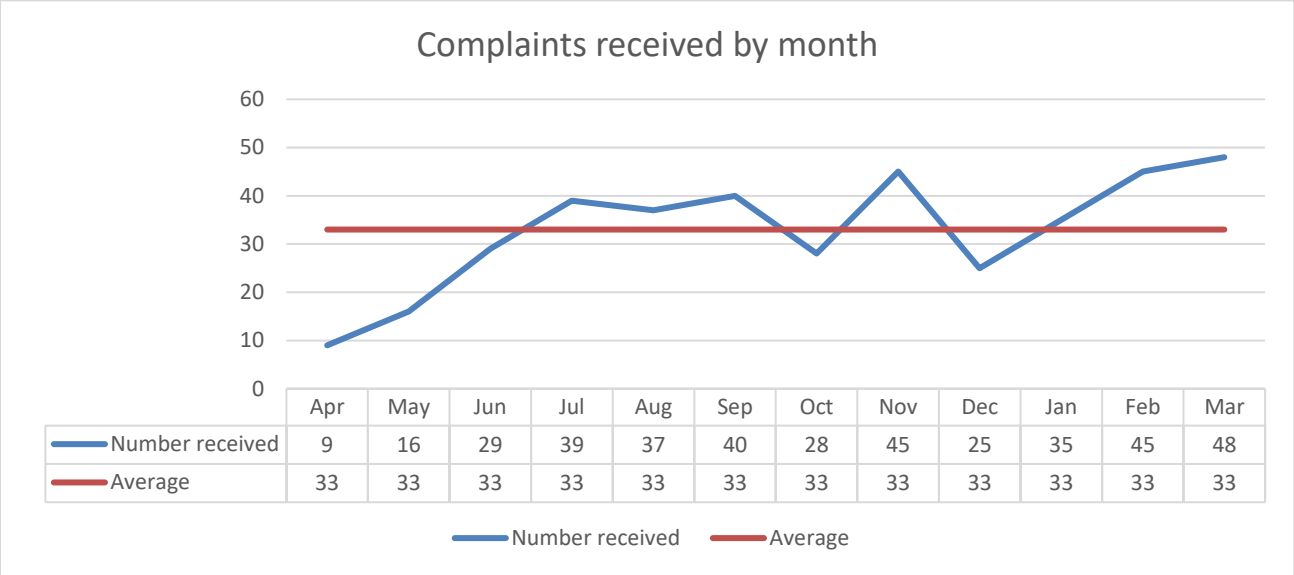
We are guests in our patients' lives

2.1 Complaints received

The Trust uses complaints to listen, learn and improve our services from the feedback given by the service users.

396 complaints were received during the reporting period, a decrease of 45 from the previous year (441). It should be noted that there was a national pause on complaints from 26 March 2020 – 30 June 2020 due to the Covid 19 pandemic. During this time the Trust continued to receive complaints.

The graph below details the number of complaints opened from 1 April 2020 to 31 March 2021. In 2020/2021 the Trust received an average of 33 complaints per month. In March 2021 the Trust received the highest number of complaints (48).



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Number received	9	16	29	39	37	40	28	45	25	35	45	48
Average	33	33	33	33	33	33	33	33	33	33	33	33

2.2 Complaint themes

Formal complaints can be received for a variety of reasons. Table A shows the themes noted for the reporting period. Table B denotes themes from 2019/2020.

Table A

Theme	20/21
Clinical treatment	131
Attitude and behaviour	102
Communication (oral)	52
Admissions / transfers / discharge procedure	36
Personal records	17
Communication (written)	15
Date for appointment	13
Test results	6
Competence	4
Cleanliness / laundry	3
Patient property / expenses	3
Failure to follow agreed procedures	2
Outpatient and other clinics	2
Patient privacy / dignity	2
Aids / appliances / equipment	1
Consent to treatment	1
Date of admission / attendance	1
Premises	1
Shortage / availability	1

Three complaints were withdrawn and are not included in the above count

Table B

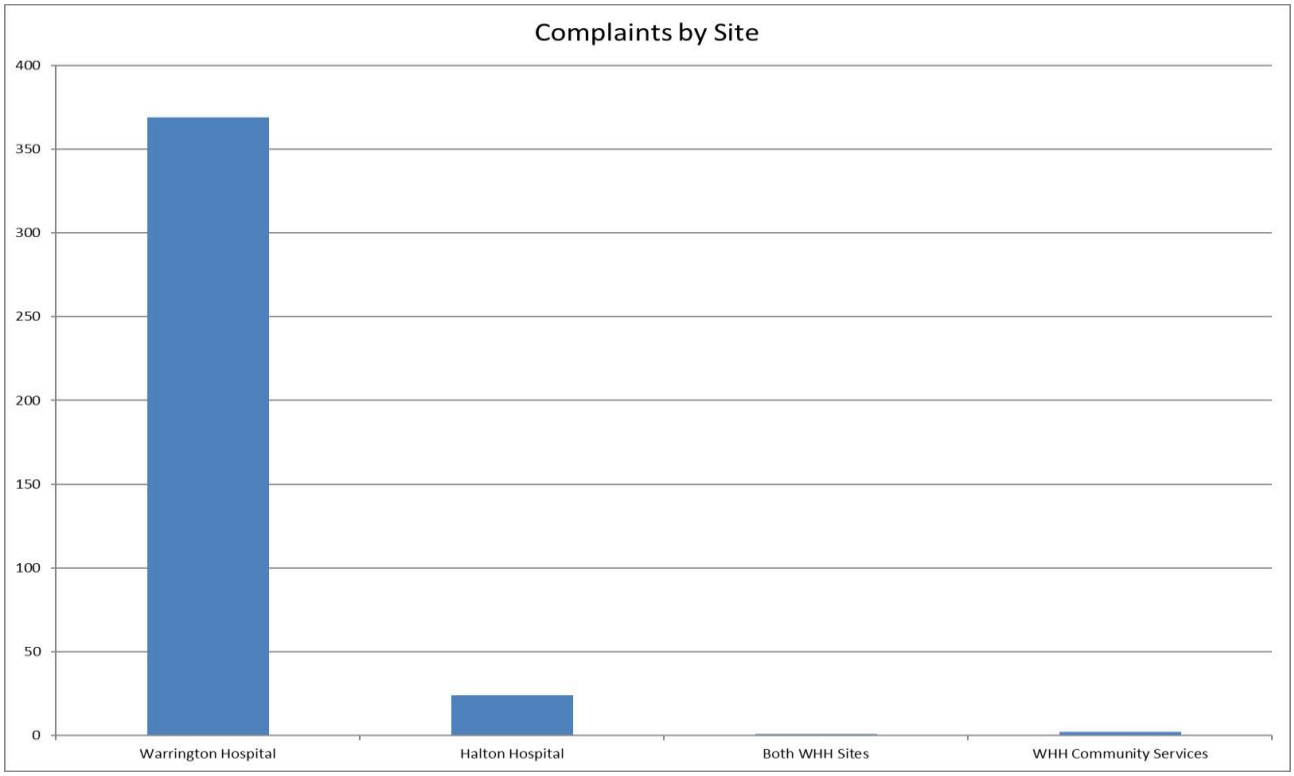
Theme	19/20
Clinical treatment	220
Attitude and behaviour	77
Communication (oral)	26
Admissions / transfers / discharge procedure	22
Communication (written)	16
Personal records	16
Premises	13
Date for appointment	11
Patient property / expenses	6
Competence	5
Failure to follow agreed procedures	5
Date of admission / attendance	4
Aids / appliances / equipment	3
Cleanliness / laundry	3
Patient privacy / dignity	3
Patient status	3
Shortage / availability	2
Outpatient and other clinics	2
Test results	1
Catering	1
Policy & commercial decisions of NHS board	1
Transport	1

The most common cause for people to complain was that elements of clinical treatment or care did not meet their expectations. When comparing the percentage of complaints relating to clinical treatment from 2019/2020 to 2020/2021, there has been a 40.5% decrease in the percentage of complaints received. This indicates that there have been improvements in clinical treatment meeting patients' expectations. This issue may have been impacted by the reduction in surgical procedures due to the Covid-19 pandemic.

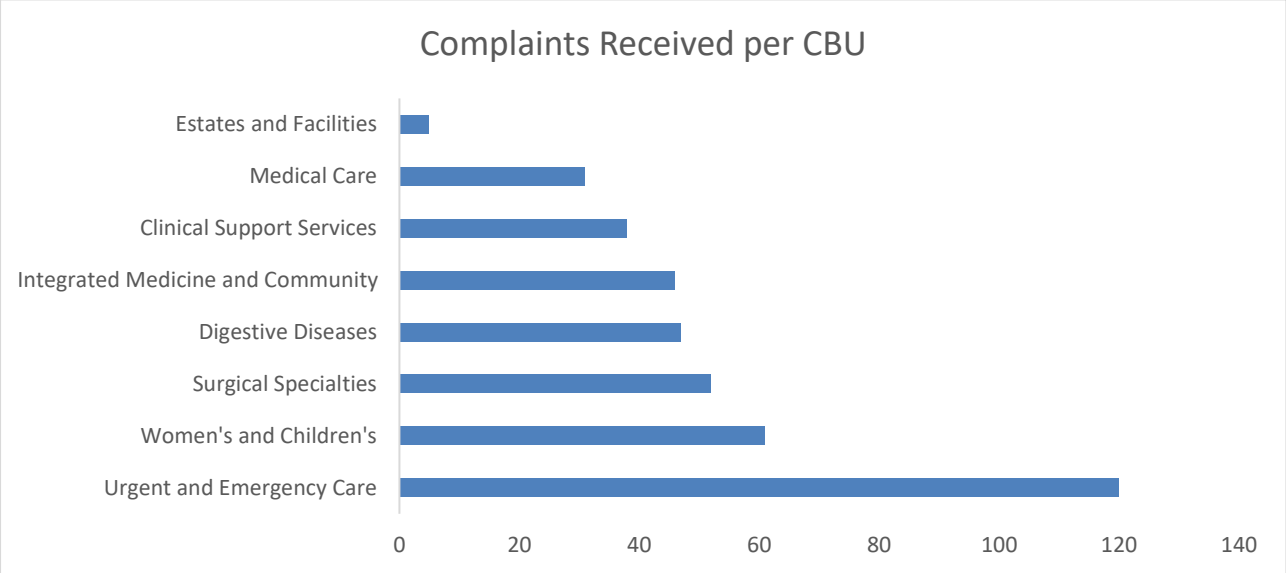
In 2020/2021, attitude and behaviour was also noted in a significant number of complaints. When comparing the percentage of complaints relating to attitude and behaviour from 2019/2020 to 2020/2021 there has been a 56% increase in the percentage of complaints received. Prior to the Covid-19 pandemic, plans were in progress for work to commence involving customer service training. This work is being relaunched as 'First Impressions work', led by the Deputy Chief Nurse and Head of Patient Experience. There is also work underway and available to support staff due to the pandemic.

2.3 Complaints received by Locations/Service

The graph below details that the Warrington hospital site reported more complaints (369). This is to be expected as it is the larger site with significantly more activity.



The following graph details the 396 complaints received by the Trust in the reporting period by Clinical Business Unit (CBU) and Trust wide service:



- Complaints can be attributed to more than one CBU

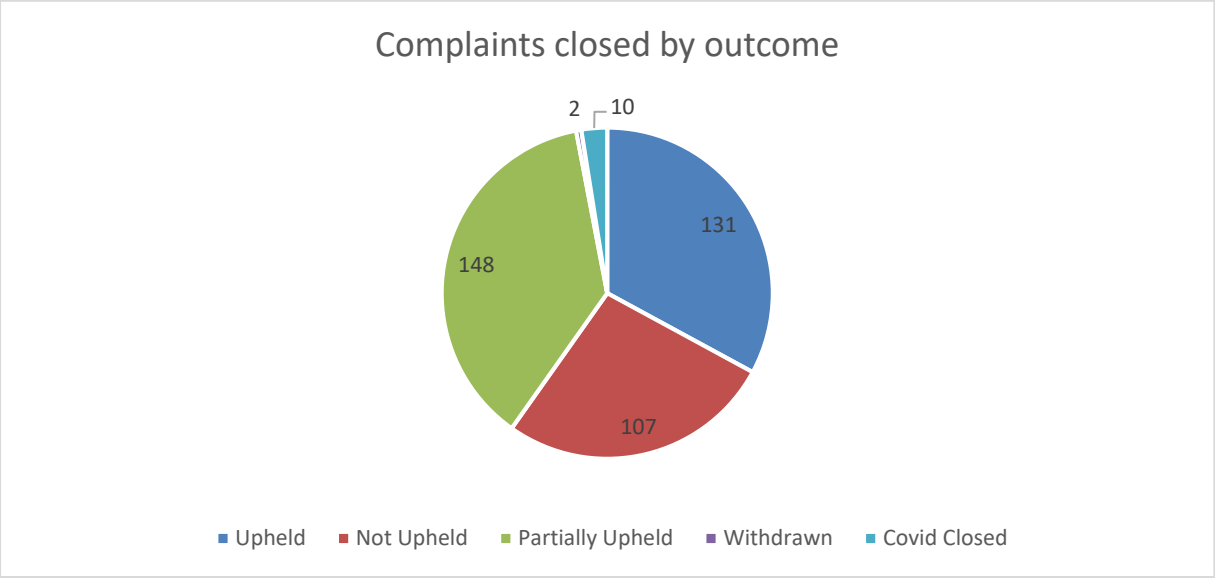
Urgent and Emergency Care received the most complaints followed by Women's and Children's. When comparing 2019/2020 data to complaints received from 2020/2021, there was a reduction from 145 complaints reported 2019/2020 to 120 in 2020/2021 (17.3%). When comparing 2019/2020 data to complaints received from 2020/2021, there was a 40% increase in complaints received within Women's and Children's (42 received 2019/2020 compared to 60 received 2020/2021). Women's and Children's Senior Leadership Team are aware of the increasing trend in complaints received and have devised an action plan to address this in 2021/2022 which includes:

- The CBU are undertaking a range of cultural change interventions to support staff to work and communicate more effectively
- All services in the CBU are participating in the NHS England Quality Improvement Programme, Always Events. The aims is to improve patient experience across the CBU. Areas of focus include, communication, language use and choice, information to support leaving hospital
- As we redesign our services we intend to include elements of patient experience including signage and patient focused information
- Reviewing notice boards across the CBU to better serve patients information needs
- Incorporating the use of QR codes within our service to link to patient information leaflets
- Allocating staff to the Customer Service course
- Developing the patient facing pages of the Internet to focus on patient information and help

2.4 Complaints upheld

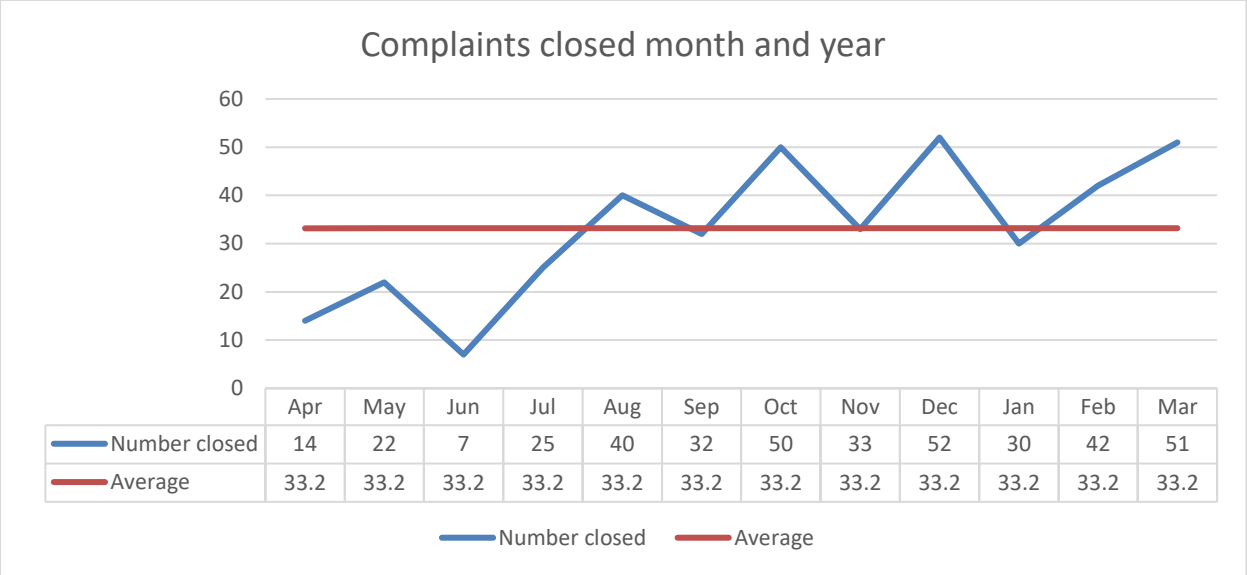
Once a complaint has concluded (either following a local resolution meeting or once a formal written response has been sent) the outcome is recorded in line with the findings of the investigation. Most complaints have outcomes recorded as “upheld”, “partially upheld” or “not upheld”. In March 2020 the NHS responded to the Coronavirus (Covid19) pandemic. National guidance was issued advising how to respond to complainants during this period. This resulted in complainants choosing not to proceed with 17 complaints categorised as low or moderate. 10/17 complaints that were not pursued during the Covid-19 pandemic (10 cases) were recorded as “Covid 19 closed” as they were not proceeded with by the complaint before the investigations concluded.

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



2.5 Complaints Resolved

In the reporting period the Trust closed 398 complaints. The graph below shows the closed complaints over time:



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Number closed	14	22	7	25	40	32	50	33	52	30	42	51
Average	33.2	33.2	33.2	33.2	33.2	33.2	33.2	33.2	33.2	33.2	33.2	33.2

In order to improve the experience of complainants, one of the major initiatives within the Complaints and PALS team has been to provide complainants a designated Complaints Resolution Officer. This has helped to maintain the timeliness of responses and provide complainants with continuity whilst also improving the quality of responses.

The following table shows the timeliness of responding to complaints by each CBU over the reporting period.

Responded to on time	380	95.5
Outside timeframe	18	4.5

Overall the Trust runs at 95.5% for timely responses to complaints. Details per CBU are shown below:

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Totals
Clinical Support Services	**1**	**2**		**1**	**3**	**4**	**1**	**4**	**10**	**2**	**8**	**3**	**39**
Within timeframe	1	2		1	3	4	1	4	10	2	8	3	39
Corporate Nursing										**1**			**1**
Within timeframe										1			1
Digestive Diseases	**1**	**1**		**2**	**7**	**4**	**5**	**4**	**3**	**6**	**5**	**5**	**43**
Within timeframe	1	1		2	6	4	5	3	3	6	5	5	41
Outside timeframe					1			1					2
Estates and Facilities	**1**		**1**	**1**	**1**	**1**		**1**					**6**
Within timeframe	1		1	1	1	1		1					6
Integrated Medicine and Community				**6**	**6**	**6**	**11**	**4**	**3**	**2**	**3**	**4**	**45**
Within timeframe				6	6	5	10	4	3	2	3	4	43
Outside timeframe						1	1						2
Medical Care		**2**	**4**	**2**		**2**	**5**	**5**	**4**		**1**	**6**	**31**
Within timeframe		2	3	2		2	4	4	4		1	6	28
Outside timeframe			1				1	1					3
Surgical Specialties	**1**	**6**		**3**	**6**	**1**	**8**	**6**	**7**	**6**	**5**	**8**	**57**
Within timeframe	1	6		2	6		8	6	6	6	4	8	53
Outside timeframe				1		1			1		1		4
Urgent and Emergency Care	**8**	**10**	**2**	**7**	**9**	**10**	**14**	**6**	**18**	**11**	**12**	**20**	**127**
Within timeframe	8	10	2	7	8	9	12	6	18	10	12	20	122
Outside timeframe					1	1	2			1			5
Women's and Children's	**2**	**1**		**3**	**8**	**4**	**6**	**3**	**7**	**2**	**8**	**5**	**49**
Within timeframe	2	1		3	7	3	6	3	7	2	8	5	47
Outside timeframe					1	1							2
Grand Total	**14**	**22**	**7**	**25**	**40**	**32**	**50**	**33**	**52**	**30**	**42**	**51**	**398**

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 further 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 PHSO has not upheld three of the cases closed during this reporting period and partially upheld one case. Where cases were partially upheld the Trust acknowledged any failings identified and put in place actions to ensure improvements were completed as a result of the findings. The other two cases (recorded above with no value) had different outcomes. In one case the Trust volunteered to undertake further local resolution to try and resolve the complainant's concerns. The other case involved the Trust trialling Early Dispute Resolution, a recently introduced Ombudsman led process, which proved successful.

The Trust currently has three ongoing PHSO complaints.

2.7 Learning from Complaints

It is paramount that the Trust continues to learn from complaints and that this is reflected in service improvements. Detailed below are some examples of how learning from complaints has led to change:

- Addressing delays in triage – The Paediatric team in the Emergency Department have developed and introduced a new flowchart to guide staff through the 15 minute triage process. This includes an escalation process when there is an increase in the volume of patients attending the department.

- Car parking - We have introduced a Car Park Improvement Group to review the car park facilities. Through our procurement process, the group has secured off site car parking facilities for staff members to use. This will enable patients and visitors to park more easily.

- Responding to concerns - The Women's and Children's CBU have produced guidance relating to pregnancy complications for ward attenders and inpatients. The guidance sets out the escalation process and advice for staff to follow to ensure that patients are fully supported.

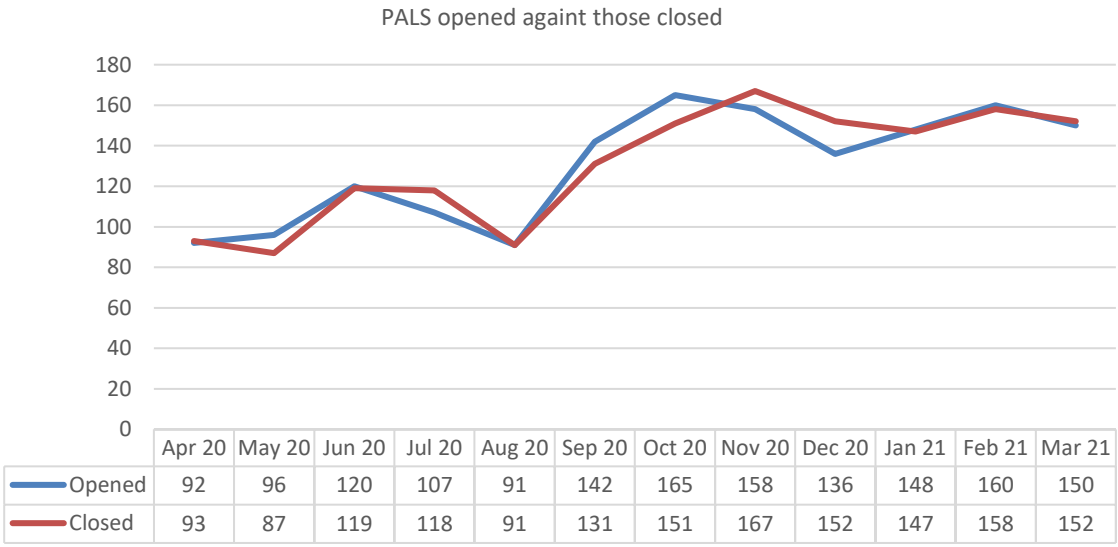
- Departmental changes in the Pandemic – In Urgent and Emergency Care we recognised that prior to the pandemic there had been a self-service area within the Emergency Department with water jugs and cups. However, this had been removed as part of infection control during the pandemic. A replacement offer has now been put in place.

- Adapting to new ways of working in the Pandemic – Telephone appointments were introduced to ensure that clinical contact was maintained with patients. This helped to support patient experience and reduce avoidable delays. We reminded all staff of the importance of trying all contact numbers for patients when undertaking telephone appointments.

2.8 Patient Advice & Liaison Service (PALS)

In the reporting period, PALS received 1565 enquires, which is a 40.5% increase from 2019/20 (PALS received a total of 1114 enquiries). The increase in PALS activity reflects a 100% increase in concerns relating to communication and a 35% increase in concerns relating to dates for appointments impacted by the pandemic and the pause to elective activity in accordance with national guidance.

The graph below shows the PALS cases that have been opened against those that have been closed over the year, which shows we have consistently managed increased activity and closed more cases on 2020/2021 than we received:



	Apr 20	May 20	Jun 20	Jul 20	Aug 20	Sep 20	Oct 20	Nov 20	Dec 20	Jan 21	Feb 21	Mar 21
Opened	92	96	120	107	91	142	165	158	136	148	160	150
Closed	93	87	119	118	91	131	151	167	152	147	158	152

The top 5 themes during this period were:

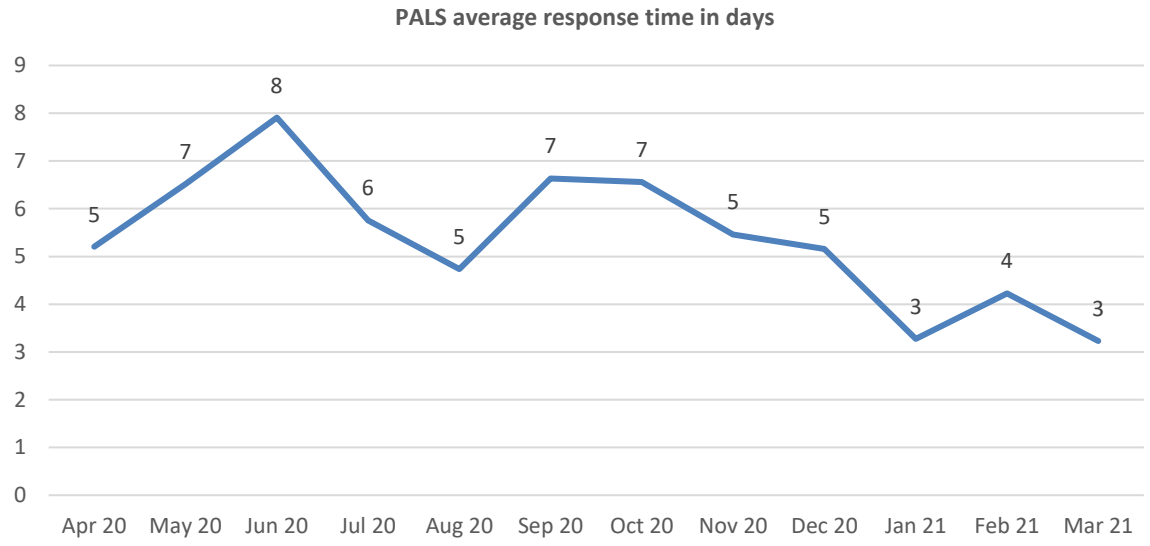
Communication (oral)	518
Clinical treatment	253
Date for appointment	224
Communication (written)	138
Attitude and behaviour	132

The highest number of PALS concerns were reported in:

Surgical Specialties	290
Integrated Medicine and Community	235
Urgent and Emergency Care	231
Digestive Diseases	216
Medical Care	201

The most common area for PALS concerns is Surgical Specialties followed by Integrated Medicine and Community, and Urgent and Emergency Care. The increase in concerns for Surgical Specialities reflects the increase in concerns regarding appointment delays following the delays in appointments as a result of the Covid-19 pandemic. In relation to Integrated Medicine and Community, the concerns recorded have increased by 109%. This increase predominantly links to communication concerns and an increase in concerns regarding lost property. It is important to note that A9 has moved into Integrated Medicine and Community. The Clinical Business Unit are aware of this increase and were in the process of developing an action plan to address this at the time this report was completed.

During the reporting period a total of 1566 PALS were opened and closed. The graph below shows the average response time in days per month.



The Complaints Team have focused on timely responses to PALS case and consistently improved timeliness of PALS responses in quarter 4. At the end of Q4 2020/2021 our average response time was 3 working days meaning we were compliant with regulations. The Trust will continue to ensure that the PALS team aim to resolve as many concerns as possible in a timely manner, ensuring that patients their families and carers feel listened to.

3. Summary and Actions

Throughout the Covid 19 pandemic the Trust maintained the timeliness of responses to formal complaints, as previously set as part of the Trust's Quality priorities in 2019/20. Further work was undertaken in 2020/2021 to improve the timeliness of responses to PALS concerns. In quarter 4 2020/2021 this had improved to 3.3 working days (3 working days is the national expectation).

As set out in our 2019/2020 report, the complaints team monitored both the timeliness and quality of the complaints' responses provided. In quarter 4 we reduced the number of cases reopened (from 16 complaints Q4 2019/2020 to 7 complaints Q4 2020/2021) indicating the quality of response had improved. The complaints team has commenced reporting into the Patient Experience Sub-Committee and continues to report learning in the quarterly learning from experience report, reported via the Quality Assurance Group.

In 2021/2022, there will be greater focus on improving our complaints processes in line with regulatory requirements whilst also focusing upon lessons learned not only within specialities but also across the wider organisation. A programme of learning and engagement will be completed across the Trust to continue the quality of complaints responses and assuring compliance with the Trust policy. Focus will remain on the PALS service to continue to improve early resolution in order to optimise patient experience.

It is important to note that challenges with attitude and behaviour were identified prior to the onset of COVID-19 and work was in progress regarding customer service training. A new refocused workstream has commenced as part of the Trust recovery plans with a focus on specific areas identified through thematic complaints reviews. Appropriate behaviours and communication must be considered an 'always' event to truly offer high quality patient centred care.

4. Assurance Committee

The Quality Assurance Committee

5. Recommendations

The Board of Directors is asked to note the report

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/21/05 79**			
SUBJECT:	**Learning from Experience Report – Q4 2020/21**			
DATE OF MEETING:	26 May 2021			
AUTHOR(S):	Layla Alani, Deputy Director 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.			
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF):				
EXECUTIVE SUMMARY *(KEY ISSUES):*	The following report provides an overview of the Learning from Experience Report. The information within the Learning from Experience report is extracted from the Datix system and other Clinical Governance reports for Incidents, Complaints, Claims, Health & Safety, Mortality and Clinical Audit related to Quarter 4, 2020/21.			
PURPOSE: *(please select as appropriate)*	Information	Approval	To note x	Decision
RECOMMENDATION:	The Board of Directors is asked to note the contents of the report.			
PREVIOUSLY CONSIDERED BY:	**Committee**	Quality Assurance Committee		
	Agenda Ref.	QAC/21/05/126		
	Date of meeting	4 May 2021		
	Summary of Outcome	Noted		
FREEDOM OF INFORMATION STATUS (FOIA):	Choose an item.			
FOIA EXEMPTIONS APPLIED: *(if relevant)*	Choose an item.			

1. Background

This report relates to the period January – March 2021 (2020/21 Q4). It contains a quantitative and qualitative analysis (using information obtained from the Datix risk management system) including Incidents, Complaints, Claims, Health & Safety, Mortality and Clinical Audit. The report includes a summary of the key findings identified in Quarter 4 with specific recommendations.

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

2. Key Elements

2.1. Incident Reporting

In Q4 2020/2021 2310 incidents were reported. A comparative analysis has been undertaken from Q4 2019/2020 (2310 incidents reported) to Q4 2020/2021 and notes there is a 13.9% (275 incidents) increase in incidents reported from previous year, indicating a positive incident reporting culture.

The Governance Department undertook an exercise to review levels of harm as part of the work around good governance. As part of this piece of work all rapid reviews were completed and triangulated with other governance systems, including, claims, mortality review group and complaints. The number of incidents graded as moderate to catastrophic harm in Q4 has increased to 57* (N:19 in Q3); however, this increase can be attributed to the piece of improvement work undertaken to ensure that all incidents awaiting validation older than 40 days was reduced to zero. In addition, the reintroduction of the KPI for rapid reviews (72 hour) being completed within timeframe is being met (this was paused internally during covid) resulting in an increased number of reviews and investigations in this quarter indicating higher levels of moderate harm. This therefore does not reflect that there has been higher levels of harm specific to Q4. Following the additional work around the incident process as part of recovery it is anticipated that the spike will even out. Reviewing and responding to incidents in a timely manner, highlights a culture of open and transparency and with an appetite to ensure learning from safety incidents occurs in a meaningful. Incident reporting within the Trust is in keeping with Trusts rated as outstanding of a similar bed base indicating a positive reporting culture.

The incident policy was also relaunched and an update added to the datix system which gives examples of definitions of harm to those inputting incidents into the system to ensure the incidents are graded appropriately and in addition the Governance Managers along with the Head of Clinical Effectiveness review and validate harm levels on a weekly basis. This is overseen by the Deputy Director of Governance. There are no incidents awaiting validation at the time of reporting.

**12 of these relate to the Clinical Harm Review process.*

2.2. Learning and Actions from Incidents

a) **Intensive Care –** On the intensive care unit in a side room the pressure in the room was incorrectly recorded on a sign whilst a COVID positive patient was being cared for. Under the Covid pathway the area had been recorded as green. If the pressure had been negative pressure, this would not have potentially impacted the surrounding environment. However, as the pressure was positive this represented a risk. At the time all the staff in the area were wearing full PPE and all patients were ventilated via a closed-circuit system. Immediate actions taken were to address this risk.
A Rapid Incident Review was held to identify contributory factors, learning and actions from the incident:

- The process for testing pressures was reintroduced, and the key for the area were the sign was secured was returned to the band 7 office.
- All staff were reminded, via the safety brief to perform daily checks of the positive / negative flow
- All patients within the vicinity were counted as contacts.

b) **Medication -** A patient with Parkinson's disease, had the incorrect clerking of medicines on admission resulting in not being prescribed and administered apomorphine daily infusion for the full length of stay. This was only noted at the point of discharge.

A Rapid Incident Review was held to identify contributory factors, learning and actions from the incident:

- The pharmacists /pharmacy technician involved all completed reflective learning.
- The lead consultant fed back to trainees the importance for checking if critical meds are required when patients are admitted
- The incident and the learning were shared at the Trust Safety Brief
- A single point lesson was created regarding correct clerking

c) **Women's Health -** There was a delay for a woman who had a postpartum haemorrhage (PPH) and perineal haematoma in the midwife led unit, The Nest.

A Rapid Incident Review was held to identify contributory factors, learning and actions from the incident:

- Any clinical findings that need obstetric review must be transferred to Birth Suite as the woman is no longer exclusively midwife led.
- Where any transfer is taking place, a Midwife must be present on that transfer. Where activity is such that a Midwife cannot leave the Nest, the receiving Midwife from Birth Suite must come to collect the woman and receive SBAR handover on the Nest.
- If a woman is requiring cannulation, she should not remain on the Nest. Immediately following cannulation, transfer should be arranged and facilitated at the very earliest opportunity.
- Blood loss of 500mls or more is a PPH and the woman should be transferred immediately from The Nest to Birth Suite.
- All members of the multi-disciplinary team to engage in simulations/Drills on The Nest.

d) Pressure Ulcer incidents, actions from learning:

- Following an increase in pressure ulcers the Pressure Ulcer Collaborative programme has recommenced (Phase 4 - Ward's A4, A6 and ICU).
- Accurate documentation on care and comfort charts are being reinforced including prescribed care. Ward Managers and Matrons are auditing documentation.
- Following an increase in pressure ulcers related to anti-thromboembolic stockings an evaluation of an alternative stocking has commenced on Ward A6.
- Following two pressure ulcer incidents from orthotic devices extra education has been implemented on Ward A6 from the orthotists. A device related pressure ulcer care plan is being trialled on Ward A6.
- Robust action plans for the high incidence areas have been produced and are reviewed weekly by Lead Nurse/Matron, Deputy Chief Nurse and Tissue Viability Nurse.
- Face to face pressure ulcer prevention training has recommenced in high incidence areas.
- Matron and Tissue Viability link nurse in ED have commenced Tissue Viability ward rounds and spot checks on documentation. A Tissue Viability newsletter has also been produced and circulated to the ED team.

e) Information Governance:

One set of notes belonging to another Trust were reported missing in the Maternity department. The notes were not received at the other Trust after being sent by mail. Whilst it could not be definitively proven that WHH was responsible for the loss, we improved processes and made sure that the data subject and the owner of the notes were informed.

f) Radiology Incidents

There was a total of 110 incidents reported in Radiology in the period 1st January 2021 to 31st March 2021. Of these, 27 incidents were for images acquired under the incorrect patient name and 12 related to radiation safety incidents. The CBU triumvirate are monitoring incidents and regularly review any emerging trends and themes to mitigate risk.

2.3. Complaints and PALS

- Over the 2019/20 financial year, all Clinical Business Units made significant improvements in responding to complaints on time achieving 100% of responses within timeframe.
- The Trust had a target to respond to 90% of complaints on time and in Q4 the Trust achieved 100%.
- There was a 30.93% increase in complaints opened Trustwide in Q4 (97 in Q3 vs 127 in Q4).
- Themes identified in complaints related to clinical treatment, attitude and behaviour and communication. In PALS these themes mirrored in relation to communication and clinical treatment with the additional theme of dates for appointments.
- Actions from complaints are monitored through specialty governance meetings, CBU meetings, the Associate Director of Governance and the Clinical Governance Department, reporting to the Complaints Quality Assurance Group. Complaints action reports are also made available Trustwide on a weekly basis.

2.4. Mortality

- The Summary Hospital Mortality Indicator (SHMI) and Hospital Standardised Mortality Ratios (HSMR) remained within expected range.
- The Mortality Review Group continues to be held as a virtual meeting during the period of Covid-19 to ensure assurance and oversight. Deaths are reviewed and discussed at the group which continues to have external representation from our Commissioning bodies.
- MRG 'Case of the Month' continues.

2.5. Clinical Audit

- There are a number of audits ongoing across the Trust. For Q4, this briefing makes reference to the National Paediatric Diabetes Audit. This audit concluded significant assurance.

3. Items for Escalation From Quarter 4

3.1. Clinical Incidents

- Work has been undertaken to review the levels of harm reported and to strengthen existing processes with a refreshed Clinical Incidents policy.
- 11 moderate harm cases have been reported as a result of the Clinical Harm Review process.
- There are no incidents awaiting validation.

3.2. Complaints and PALS

- Staff attitude and behaviour complaints remain a theme in Q4. 'First impressions' work is underway.
- Concerns regarding clinical treatment received via PALS have increased by 27% in Q4.
- 13 concerns received via PALS were referred to complaints, an increase of 6 compared to the previous quarter. Work has commenced with the team to strengthen initial resolution of concerns.

3.4. Claims

- Payments for clinical claims settled with damages totalled £554,016.00 (excluding costs)
- 3 employer Liability Claims closed with damages (totalling £7,615.00 (excluding costs)
- Learning continues to be shared regarding claims at the claims monthly meeting.

3.5. Clinical Audit

- The key findings of the National Paediatric Diabetes Audit (NPDA) was established to compare the care and outcomes of all children and young people with diabetes receiving care from Paediatric Diabetes Units (PDUs) in England and Wales. It focuses on ensuring children with diabetes receive appropriate health checks.

- The key findings were:

  For six of eight indicators the Trust performed above the North West and England and Wales average.

  In one indicator (thyroid) the Trust performed above the England and Wales average but below the North West average.

  For eye screen the Trust performed just below the North West average (1.8% below) and below the England and Wales average.

4. Recommendations

The Board of Directors is asked to note this report and accompanying slides.

NHS
Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Learning From Experience Q4 Report

Layla Alani

Deputy Director of Governance

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April 2021

Overview

The following slides provide an overview of the information extracted from the Datix system and other clinical governance reports for Incidents, Complaints, Claims, Health & Safety, Mortality and Clinical Audit related to Quarter 4, 2020/21. They should be viewed in conjunction with the High Level Briefing Report.

Incident Headlines Q3 vs Q4

How many staff are raising incidents Q3 vs Q4?

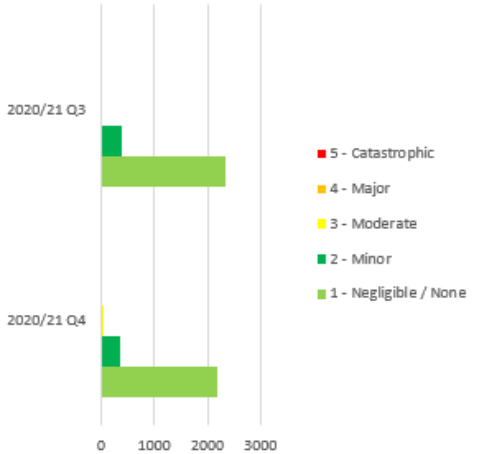
- There was a 6.31% decrease in incident reporting within the Trust in 2020/21 Q3 (2759 in 2020/21 Q3 vs 2580 in Q4).
- There was an **increase** in incidents causing Moderate to Catastrophic harm in Q3 (19 in Q3 vs 57 in Q4)
- The number of no harm incidents reported decreased by 7.57% in Q4 following incident reporting returning to normal levels. The 'Report to Improve' campaign was relaunched following the first-wave of the pandemic to enable this.

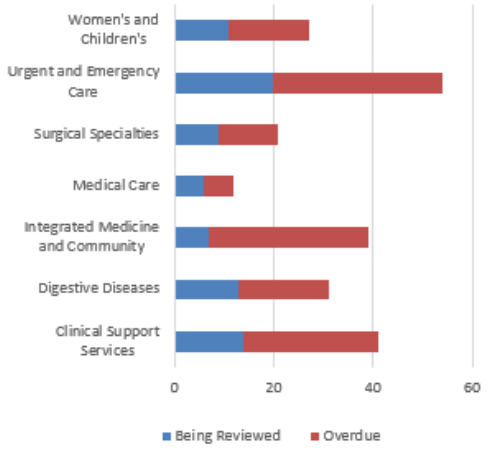
How many incidents are open Q3 vs Q4?

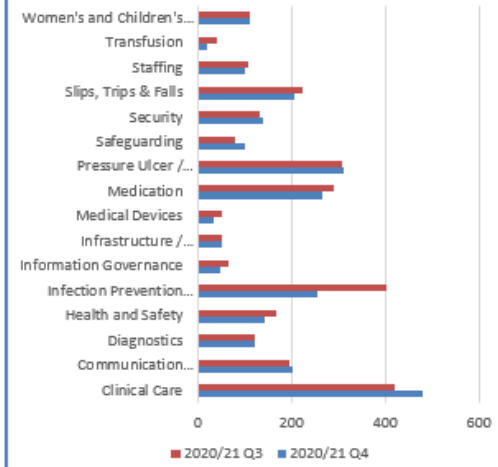
- The Trust reported 221 incidents open in CBUs in the Q3 LFE. To date that has increased to 253. The graph below shows the 7 CBUs with open incidents and the number of which are overdue.
- Providing feedback and closing incidents in a timely manner remains an important focus and work will continue to ensure that performance continues to improve and CBUs are supported during the Covid-19 pandemic.

What type of incidents are we reporting Q3 vs Q4?

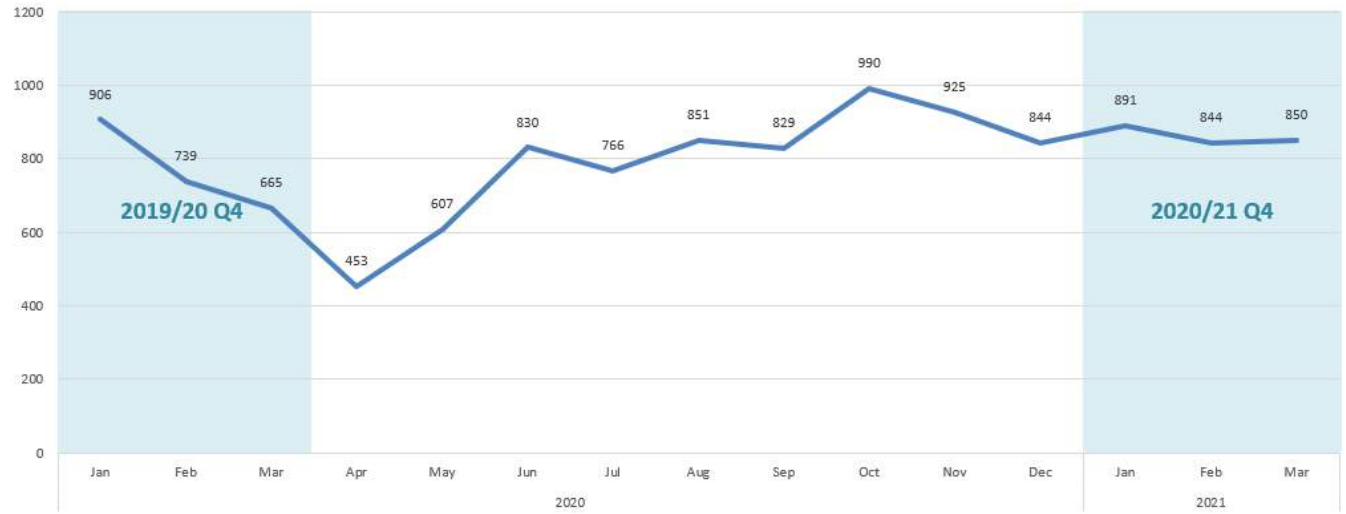
- As stated, there was a decrease in the amount of incidents reported. Incidents relating to infection prevention, medication and Health and Safety decreased in Q4.
- Incidents relating to clinical care and safeguarding increased in Q4.





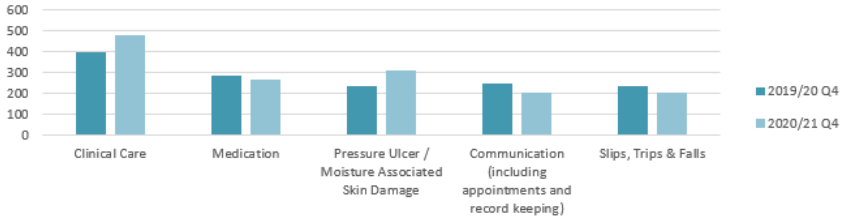


Incident Reporting 2020/21 Q4 vs 2019/20 Q4



In 2020/21 Q4 there was a 11.9% increase in incident reporting when compared to 2019/20 Q4.

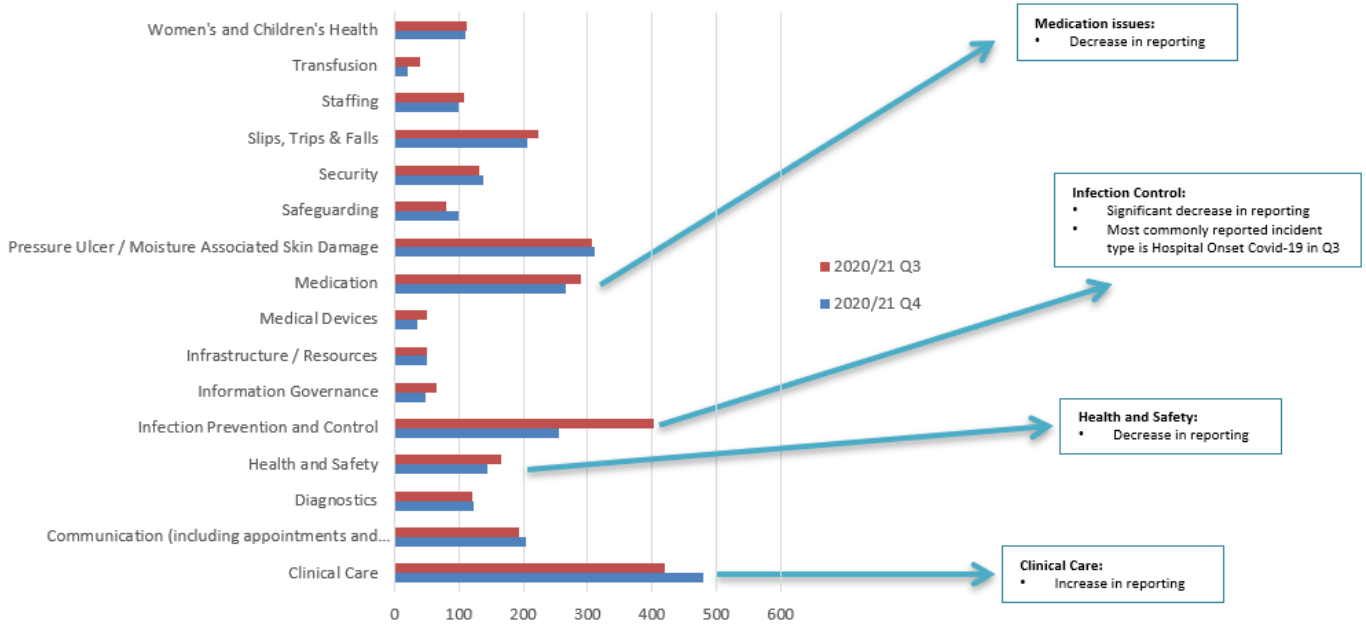
Comparison of Top 5 Incidents Reported



Incident Category Analysis Q3 vs Q4

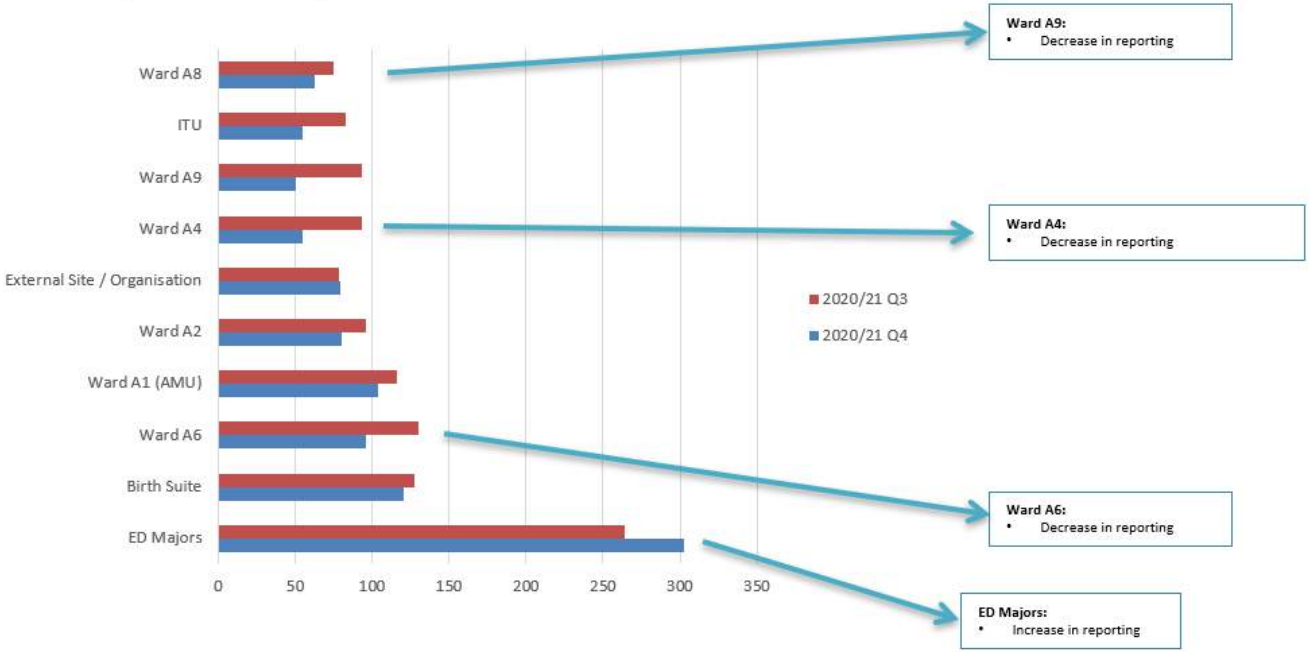
Warrington and Halton Teaching Hospitals NHS Foundation Trust

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



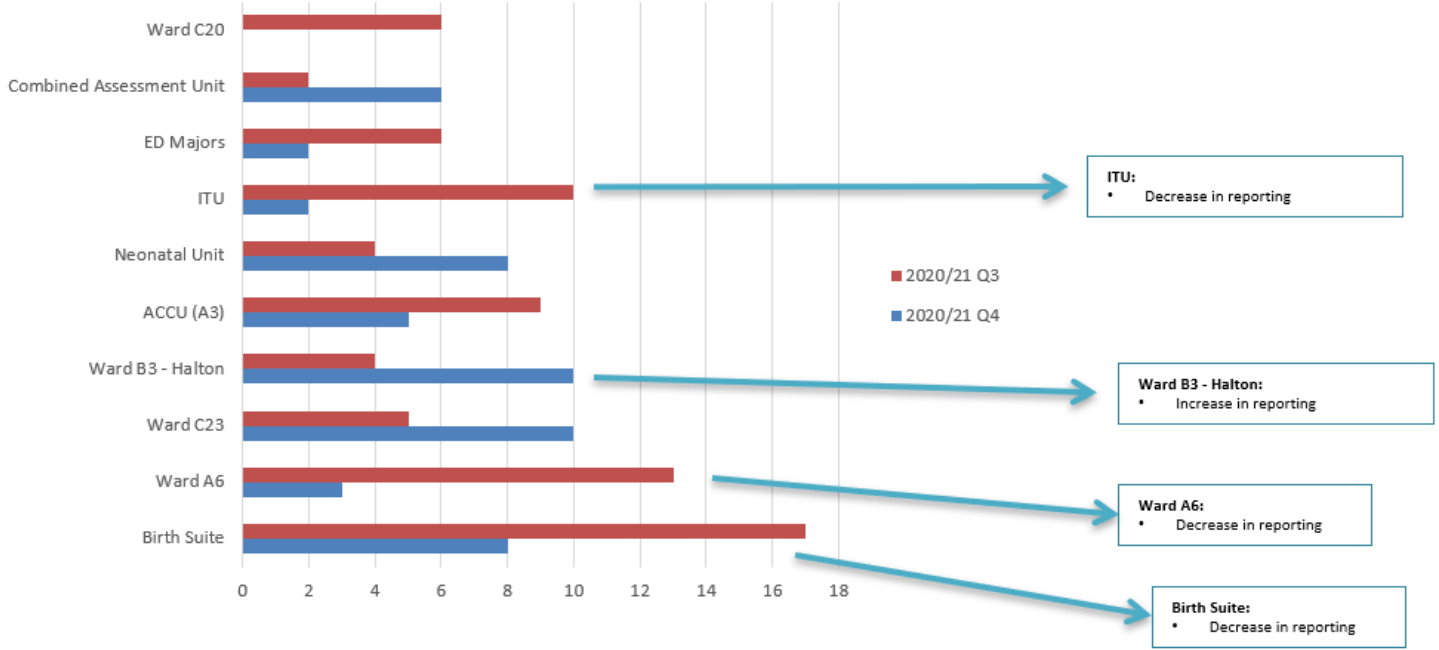
Incident Location Analysis Q3 vs Q4

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



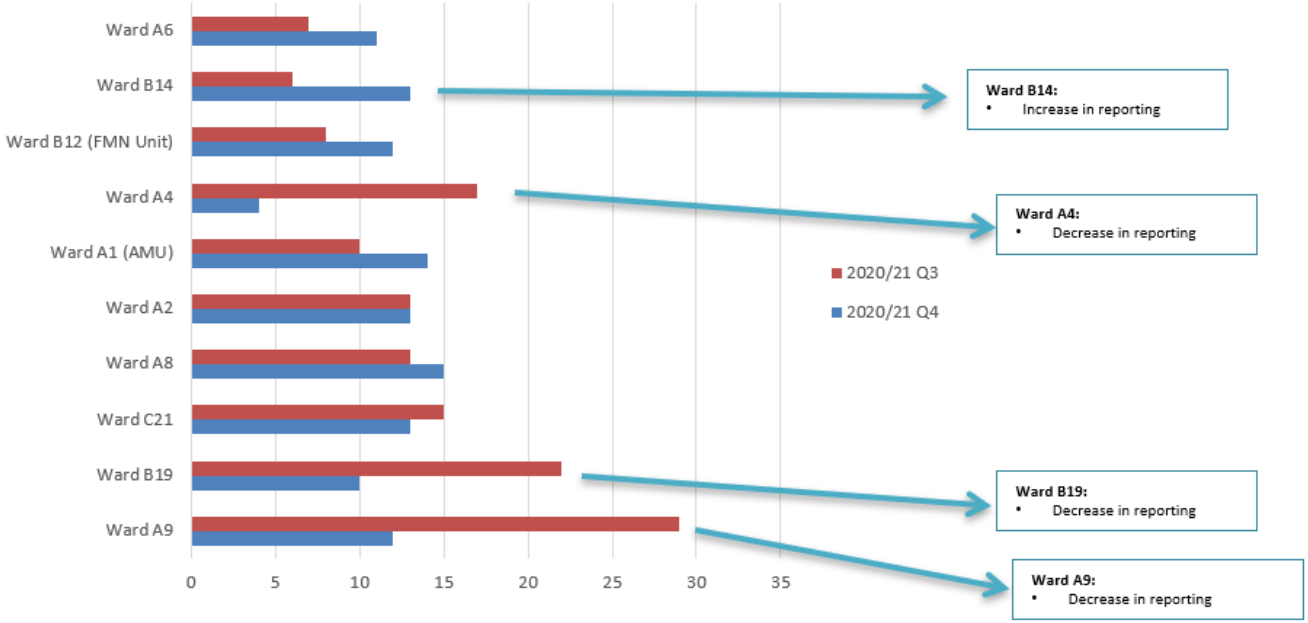
Staffing Incidents Location Analysis Q3 vs Q4

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



Patient Falls Location Analysis Q3 vs Q4

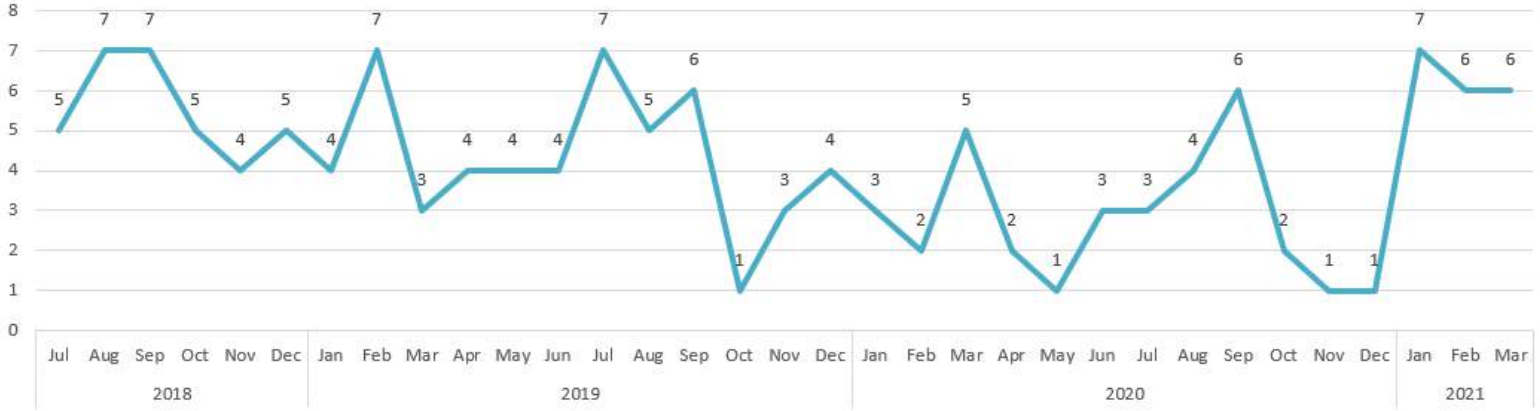
The information shows the top reporting locations in relation to patient falls and how they differ between the 2 quarters.



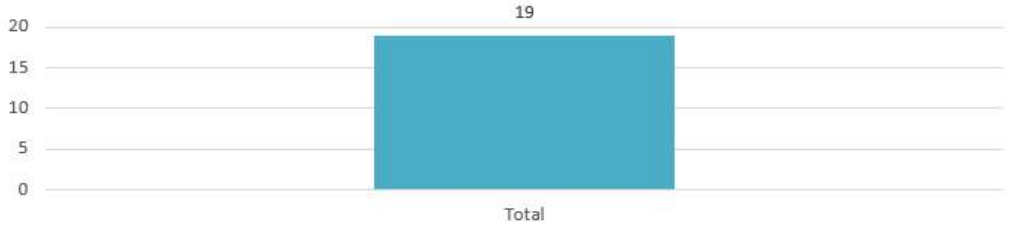
Serious Incident (SI) Reporting

Warrington and Halton Teaching Hospitals NHS Foundation Trust

SIs reported by Month



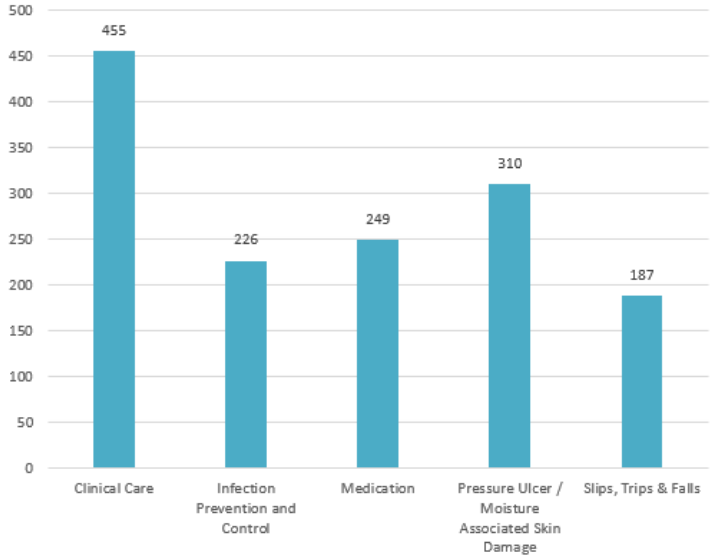
SI Cause Groups Q3

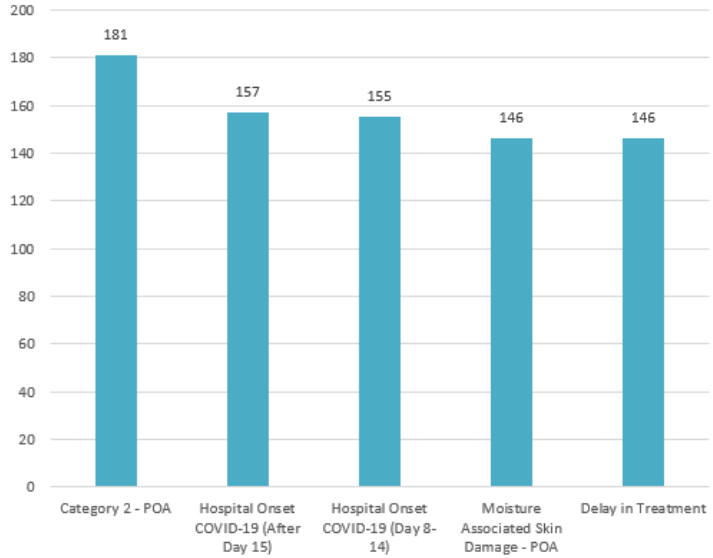


Across the 7 CBUs in Q4

A total of 2585 incidents were reported across the 7 CBUs in Q4, this has decreased from 2759 from Q3.

The top 5 categories and subcategories in Q4 were reported as follows:





Learning from Incidents – Medical Care

We found....

On the intensive care unit it was noted that a side room with a COVID positive patient was set to "positive pressure" even though the laminate used to indicate the pressure showed a "negative pressure". The rest of the area was green (previously red but following a full deep clean changed to green). Fortunately all the staff in the area were wearing full PPE and all patients were ventilated via a closed-circuit system.
Immediate actions taken were: the room was switched to a negative pressure on advice from the senior nurse and the error escalated to the consultant in charge and the infection control team.

We Acted....

- ✓ There is a process in place for testing the pressures daily but this has become difficult to maintain during the current Covid pandemic as the key required to perform the checks for the positive / negative flow is maintained outside of the donning and doffing area whilst the lock is within the area so the key had been left in the lock. The process was reintroduced and the key was returned to the band 7 office.
- ✓ All staff were reminded, via the safety brief to perform daily checks of the positive / negative flow
- ✓ All patients within the vicinity were counted as contacts.

We found....

Incident submitted as: patient with sepsis secondary to cellulitis on right leg, Anaemia, AKI 3. Transferred to HDU, TVN referral completed. After 3 days the patient was stepped down to the ward. Reported as no medical review -not suitable to outlie. Was reviewed by renal consultant- continued to deteriorate became acidotic/an uric required transfer to RLUH for possible renal replacement therapy.

Review found: Patient was in renal failure from admission awaiting a renal review / transfer likely. Had a full review prior to transfer clearly documented can be stepped down – no organ support required. The morning after step-down a follow up was completed by the ITU medic who clearly documented; unable to contact medical outliers via switch. Details given to med reg - needs medical team review today - review completed 2 hours later.

We Acted....

- ✓ Reviews are often hampered or delayed due to difficulty trying to discover what occurred this is an example of excellent documentation making it easy to trace what had occurred and that all actions required had been completed. Feedback sent to the individual clinician.
- ✓ Feedback from the bed meeting / medical registrar should have highlighted to the outlier team the patient's presence on the Ward. Details shared with the relevant teams.
- ✓ Transfer was planned for the morning but occurred during the night which is a policy breach but required due to pressures. Breaches of this nature are monitored.

Learning from Incidents – Integrated Medicine and Community

1. We found....

Patient = history of chronic type 2 respiratory failure on NIV transferred to Ward A8. Swapped to LTOT. SOB - sats dropped to 71% - NIV required.
Staff on Ward A8 have no formal training on NIV, assisted by A7 Ward sister who advised management of O2 requires titrating hourly dependant on sats readings.

We Acted....

- ❑ Inappropriate admission
- ❑ Patients on NIV should not be placed on wards other than the respiratory wards managed by resp consultants only.
- ❑ A full team of staff is required to maintain NIV patients.
- ❑ The business continuity plan for NIV if there are no on A7 beds is HDU admission
- ❑ The incident was discussed with the Associate Chief Nurse for Unplanned Care and the patient flow team were informed that patients requiring NIV should be nursed in A7 / HDU only

2. We found....

Type 2 IDM BG check 11.50hrs - hypoglycaemic, treated but the BG was not checked again until 5 hours later. During this time there was no clear documentation of what was given and when. The patient remained hypoglycaemic until approx. 22:00 hrs. During this time the BG was checked 8 times during which the patient was eating less than usual, taking the same doses of insulin fortunately remaining alert and well though hypoglycaemic.

We Acted....

- ❖ The patient was a cardiology patient awaiting transfer to LHCH following an unsuccessful cardioversion and focus was directed to monitoring.
- ❖ this concern.
- ❖ The patient highlighted to staff his dietary intake had reduced during this admission, but this did not highlight the need for a further review of the insulin regime which had been amended twice already due to persistent hypos.
- ❖ The diabetic nurse sent a safety brief to the ward to include hypoglycemic management- monitoring and treatment as per WHH guidelines
- ❖ A reflection was completed by the nurse providing care on the day
- ❖ The individual involved is to complete a diabetes management course

Learning from Incidents – Clinical Support Services

We Found…

A patient with Parkinson's disease, had the incorrect clerking of medicines on admission resulting in not being prescribed and administered apomorphine daily infusion for the full length of stay. Only noted at the point of discharge.

We Acted….

- The pharmacists /pharmacy technician involved all completed reflective learning.
- The lead consultant fed back to trainee's the importance for checking if critical meds are required when patients are admitted
- The incident and the learning were shared at the Trust Safety Brief
- A single point lesson was created regarding correct clerking

We Found…

A Patient referred for MRI LS spine, both femurs and hips by GP. completed 31/01/21 delayed result to 19/02/21 -revealed bilateral sacral and Left superior and inferior pubic rami fractures, urgently referred to the fracture clinic.

We Acted….

Two separate issues for review. 1. should not have had an MRI should have been a simple X-ray - 2. The images taken were not uploaded onto the PACS system into the correct folder.
The incident to be shared for learning amongst the Radiology team.
incident to be sent to the GP to ask why an MRI was requested and not an x-ray, also to advise the best mode of imaging for incidents like this
The incident was sent to a T&O Consultant to ensure the management would not have been any different if the concerns had been detected earlier.

Learning from Incidents – Radiology

We Found….

A patient attended from a care home via ambulance, without an accompanying member of staff.

The patient had a recent stroke and was unable to speak well, they were in a wheelchair but could walk short distances.

The examination proceeded without incident and the patient was waiting for the ambulance to collect them.

The patient was observed to be restless, pacing around the waiting room and was also seen leaving the department by a member of staff. The member of staff did not feel able to intervene and ask the patient why they were leaving.

The alarm was not raised until the ambulance team came to collect the patient.

The staff were unsure how to manage the situation and were unaware of the bleep number for security.

Due to delays in highlighting the incident it was some time before it was possible to observe the patient leaving the site on CCTV. The police were contacted and the patient was found safe two days later.

It was felt there were numerous missed opportunities both to prevent the incident and to manage it more effectively.

We Acted….

As the patient had difficulty communicating it was felt it would have been appropriate to request an escort from the care home, as this would most likely have prevented the incident.

Radiology have now introduced a checklist to be completed for all care/nursing home patients where we check the patient's mobility, capacity and communication skills and determine if an escort is required.

The form is then stored on the Radiology Information System.

We have also produced an interactive 'reflective exercise' for Radiology staff which can be used for learning and CPD either by a single member of staff or in groups.

This was presented and discussed at the staff meeting to encourage staff to reflect on their own practice and consider how they would act in this type of scenario to prevent and/or more effectively managed incidents of this type.

We have shared the learning from the incident via the Radiology Team Brief and informed staff of how to contact security in an emergency.

Learning from Incidents – Urgent & Emergency Care

What staff told us.....	Learning
6 y/o with mosaic downs syndrome attended ED following a 111 triage and advised to attend within hour as vomiting and bruising over body (previous history of vomiting and ? blood clotting). Mum described bruising and 111 submitted a safeguarding referral querying physical and or sexual abuse. Upon attendance in ED reviewed by consultant who advised for paediatric review and sent to B11. At B11 the patient was reviewed by an ED reg who reviewed the injuries with a nurse and concluded they were not suspicious of NAI and had no concerns. The patient was discharged and no social worker referral or body map was completed. Social worker contacted safeguarding to advise re 111 submission that a child protection review was required and the patient's mother was declining any further review. The social worker visited the house and completed the review at home and closed the case as there were no ongoing concerns.	• Although this was a no harm incident there was a missed opportunity to communicate/ make the referral. If a referral is required this should be followed up by the staff member who has made the plan or appropriately delegated. • To avoid potential diagnostic overshadowing the learning includes a lower threshold for paediatric review when there is a suspicion raised of NAI in a child with a learning disability.
50 y/o male patient was admitted reporting SOB and feeling unwell, PMH of type 2 diabetes. Patient was admitted and treated with antibiotics, fluids and had review by diabetes specialist due to uncontrolled diabetes. Patient self-reported weight to be over 130kg. Patient was not weighed during admission and required enoxaparin during admission. The patient was prescribed 40 mg enoxaparin once daily and was discharged following a four day inpatient stay. Patient was brought back to ED following a collapse upon arrival at usual residence and following unsuccessful resuscitation died in ED. A coroner referral was made.	• An investigation has begun into the case and a lesson learned at the initial review is that patients must be weighed upon admission. • A patient weighing more than 100kg should be prescribed 40mg enoxaparin twice daily.

Learning from Incidents - Surgical Specialities

Warrington and Halton Teaching Hospitals NHS Foundation Trust

What Happened?	Learning action points
Patient admitted with extremely low HB attributed to a bleeding cancer. Patient did not have VTE risk assessment Enoxaparin was prescribed. Seen by pharmacy staff who asked for the dose to be increased to 40mg BD as patient >100kg. Hb was 56 at this point and notes stated patient was bleeding from the cancer. It probably was not appropriate for the patient to be on enoxaparin at all. Dr had actioned the request from pharmacy and increased the dose. Chart sent to pharmacy for tranexamic acid and conflict of need for tranexamic acid and being on enoxaparin noted.	• VTE risk assessments to be completed for all patients on admission • Pharmacists to ensure VTE risk assessments are checked as per role • Prescription of enoxaparin for patients with low HB or known bleeding to be escalated immediately for review
Patient who was living with dementia noted to be in a side room this was due to the patient being Covid-19 positive and unavailability of cohort bed in other areas. Unable to move closer to the door for visual observations due to the need for oxygen at the bedside. Patient was spitting at staff when entering the room and staff felt uncomfortable due to the infection control risk of this with Covid-19.	• If as a last alternative a patient with a cognitive impairment is nursed in a side room enhanced observations must be increased to be more frequently. • Staff to ensure use of eye protection and full PPE when entering into areas to nurse patients who are at risk of spitting etc.

Learning from Incidents - Digestive Diseases

What happened...	Learning action points
Complaint received noting concerns about transfer to multiple ward and care received. Patient sadly passed away unexpectedly a short time after discharge. Rapid review completed to review care and although care given was appropriate there were some findings in relation to: Therapy plans- this lady was seen by multiple teams due to frequent ward moves and plan never changed despite her abilities changing. DNACPR/ceilings of care documentation. Only documentation found in notes stated DNACPR signed, daughter states not aware.	• When patients are with us for an extended length of time and are seen by multiple therapy teams, plans for therapy discharge should be reviewed more frequently based on patients' current abilities. • Conversations with patients/NOK regarding COC/DNACPR should be thoroughly documented in the notes
Nurse took handover from day staff . On doing her checks at the beginning of her shift she found the arterial line had sodium chloride 0.18% and Glucose 4% IV running through Instead of sodium chloride to keep the line patent. Patient was also on a sliding scale for insulin. Actions were taken immediately and no harm to the patient was found.	• All IV fluids used in theatres to be signed for by 2 trained staff to confirm correct fluids

Learning from Incidents – Children's Health

What happened…	Learning action points
Baby attended NNU for IV antibiotics. Was due just Cefotaxime but Teicoplanin was given as well (this was another antibiotic that the baby was receiving but was not due). Remedial action: Checked Toxbase, Informed ward pharmacist and advised to get clinician looking after patient to monitor baby for agitation. Recommended to perform FBC and U+E's and ensure adequate hydration as well as monitor urine output.	Learning: Important to make sure IV antibiotic times are checked on the prescription prior to administration by both members of staff. Staff reminded of the importance of handing over the babies due antibiotics on C23 at the end of each shift. Neonatal natter and safety brief utilised to discuss learning.
Patient was coming out of bathroom pushing drip and struggling to get through the door. She was asked if she needed help and then she became unresponsive and fell to floor. Parent informed staff that patient prone to fainting but staff hadn't been informed on admission. Only father present on ward so unable to support his daughter going to the toilet.	Staff asked to be vigilant and offer to escort female patient to the bathroom when they have a male parent/carer.
Recent incidents regarding Cannulas and fixations. IV cannulations can be difficult especially with preterm/ex-preterm babies. When cannulas secured, there have been incidents where the hub from the T-Piece had left a significant mark on the skin underneath. There has not been a major skin injury, however there is a potential for complaint from parents. The trust use /advise duoderm on the skin underneath the hub to prevent the pressure from imprinting. However the use of duoderm is very inconsistent and hence the incidents.	There is availability of duoderm on cannula trolleys for its usage by the staff. All medical and nursing staff asked keep in mind the possibility of pressure ulcer from the T-piece while fixing the cannulas. Staff asked to make sure the VIP score is filled at the time of cannula insertion.

Learning from Incidents – Women's Health

What happened…	Learning action points
Emergency buzzer testing or simulation training completed when a patient was in theatre having procedure.	Notify staff in theatres if emergency buzzer drill to take place or training simulation that will involve emergency buzzer so that patient safety is not compromised. No patient safety was compromised in this incidence. Learning was shared for good practice moving forward
There was a trend in PPH incidents in 2020. There has been a MDT focus on addressing these. All have been reviewed in MDT forums and there has been a significant in terms of appropriate drugs administered, women risk assessed for risk factors and prophylactic infusions ready, good MDT early involvement. On-going areas of learning in focus:	Staff are asked to include on the PPH Proforma: Document who was present Document the drugs and time they are given Ensure PPH proforma is fully completed. Contemporaneously weigh swabs and pads Consider use of tranexamic acid alongside other drugs Involve the MDT immediately.
Learning from Concise Investigation on The Nest. There was a delay for a woman who had a postpartum haemorrhage (PPH) and perineal haematoma in the midwife led unit, The Nest.	•Any clinical findings that need obstetric review must be transferred to Birth Suite as the woman is no longer exclusively midwife led. •Severe perineal pain is suggestive of a haematoma and the woman must receive an immediate obstetric review. •Where any transfer is taking place, a Midwife must be present on that transfer. Where activity is such that a Midwife cannot leave the Nest, the receiving Midwife from Birth Suite must come to collect the woman and receive SBAR handover on the Nest. •If a woman is requiring cannulation, she should not remain on the Nest. Immediately following cannulation, transfer should be arranged and facilitated at the very earliest opportunity. •Blood loss of 500mls or more is a PPH and the woman should be transferred immediately from The Nest to Birth Suite. •It is not good practice to provide food to a woman prior to the suturing of a complex tear. This is to prevent anaesthetic complications if the woman needs to be transferred to theatre. •All members of the multi-disciplinary team to engage in simulations/Drills on The Nest.

Learning from Medication Incidents

Warrington and Halton Teaching Hospitals NHS Foundation Trust

We found.....	We acted.....
A patient who was on a continuous subcutaneous infusion of apomorphine via an apomorphine pump during waking hours was not prescribed or administered her apomorphine for the whole of her inpatient stay (10 days). Apomorphine is a critical medicine which is used in Parkinson's disease.	• A Rapid Incident Review was held to identify contributory factors, learning and actions from the incident. • The incident was taken to the Trust Safety Huddle with key learning provided in a single point lesson on Apomorphine. • The incident was taken to the Pharmacy Safety Huddle with key learning for medicines reconciliation when a patient is admitted on apomorphine. • A Trust guideline providing key information on the prescribing and administration of apomorphine to be written and made available on the Extranet.

A patient was prescribed an IV insulin infusion for hyperkalaemia over 30 minutes. For clinical reasons the doctor decided to increase the duration of the infusion to 60 minutes. The prescription was amended and the actions in the warning pop ups were not followed by the doctor and the nursing staff. The patient consequently received both the original and amended infusion.	• A Safety Alert was taken to the Trust Safety Huddle with recommendations for:
	  ○ The prescribing doctor when making an amendment to a prescription for an IV infusion.
	  ○ The nursing staff when identifying a prescription for an IV infusion has been amended without the patient's nurse being informed first.
	• A Single Point Lesson was shared at the Trust Safety Huddle on Making Amendments to IV Infusions on EPMA and what you can do as a prescriber and nurse to avoid errors.
	• A meeting was held with DXC to raise safety concerns with the amendment of prescriptions for IV infusions on EPMA with Lorenzo.

In Quarter 4, there were 3 incidents reported on Datix where the wrong preparation of oxycodone was administered to a patient. This is a recurring incident reported on Datix.	A Single Point Lesson was shared at the Trust Safety Huddle on how to avoid these errors: • Check the release profile of the oxycodone preparation to be administered against the Medication Administration Chart. • Extra care must be taken when selecting modified release and immediate release formulations of oxycodone, particularly when they are prescribed together. • To ensure the second check is completed independently.

Learning from Incidents – Pressure Ulcers

- The Pressure Ulcer Collaborative programme has recommenced (Phase 4 - Ward's A4, A6 and ICU).
- Accurate documentation on care and comfort charts to be reinforced including prescribed care. Ward Managers and Matrons auditing documentation.
- Following an increase in pressure ulcers related to anti-thromboembolic stockings an evaluation of an alternative stocking has commenced on Ward A6.
- Following two pressure ulcer incidents from orthotic devices extra education has been implemented on Ward A6 from the orthotists. A device related pressure ulcer care plan is being trialled on Ward A6.
- Robust action plans for the high incidence areas have been produced and are reviewed weekly by Lead Nurse/Matron, Deputy Chief Nurse and Tissue Viability Nurse.
- Face to face pressure ulcer prevention training has recommenced in high incidence areas.
- Matron and Tissue Viability link nurse in ED have commenced Tissue Viability ward rounds and spot checks on documentation. A Tissue Viability newsletter has also been produced and circulated to the ED team.

Learning from Incidents – Information Governance

We Found	We Acted....
The Trust receives NHS Cyber alerts (formerly careCERTS) from NHS Digital alerting WHH to potential high severity cyber threats to our IT infrastructure. One such high severity threat was received in April alerting WHH to potential vulnerabilities with the Microsoft Exchange Server	• We used a system called IT Health which produces dashboards to report on the state of our cyber defences to establish whether this cyber alert was a serious threat to the WHH IT infrastructure • Our investigation determined that we were not threatened and the results from our assurance dashboard were distributed to the Chief Information Officer and Chief Clinical Information Officer/Medical Director to provide assurance • Due to implementation of the IT Health system we were able to rapidly action this high severity cyber alert within the NHS Digital target of 48 hours.
One set of notes belonging to another Trust were reported missing in the Maternity department. The notes have not been received at Whiston hospital after being sent by mail. Whilst it cannot be definitively proven that WHH was responsible for the loss we improved processes and made sure that the data subject and the owner of the notes were informed	• Mail handling processes changed within Maternity as a result of the incident in order to prevent a re-occurrence. • Whiston hospital informed that a set of their notes could not be located. • Information Commissioner's Office informed of the circumstances but will not be taking action due to measures already taken.

Complaints Headlines Q3 vs Q4

Warrington and Halton Teaching Hospitals NHS Foundation Trust

How many people are raising complaints Q3 vs Q4?

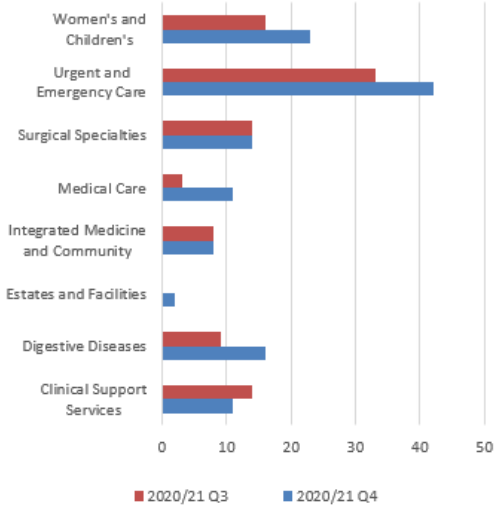
- There was a 30.93% increase in complaints opened Trustwide in Q4 (97 in Q3 versus 127 in Q4).
- Women's and Children's, Urgent and Emergency Care, Medical Care, Estates and Facilities and Digestive Diseases saw an increase in the complaints received.
- Clinical Support Services saw a decrease in their complaints.

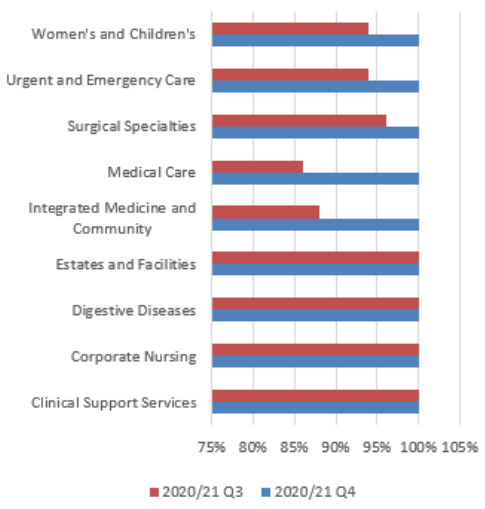
Are we Responsive Q3 vs Q4?

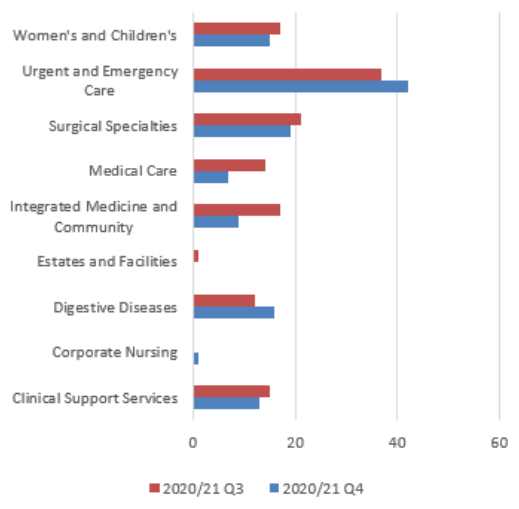
- There was a significant increase in the number of complaints meeting timescales during Q4.
- Women's and Children's, Urgent and Emergency Care, Surgical Specialties, Medical Care, Integrated Medicine and Community have improved the number of complaints closed on time.
- The Trust had a target to respond to 90% of complaint on time and in Q4 the Trust achieved 100%.
- The Trust currently has 0 breached complaints and there are no complaints over 6 months old.

How many complaints has the Trust closed Q3 vs Q4?

- There was a decrease in the number of complaints closed in the Trust in Q4 (134 in Q3 versus 122 in Q4).
- Urgent and Emergency Care, Corporate Nursing, Digestive Diseases have increased in the number of complaints closed in Q4.
- Women's and Children's, Surgical Specialties, Medical Care, Estates and Facilities, Clinical Support Services have decreased in the number of complaints closed in Q4.
- Integrated Medicine and Community has seen the highest decrease.

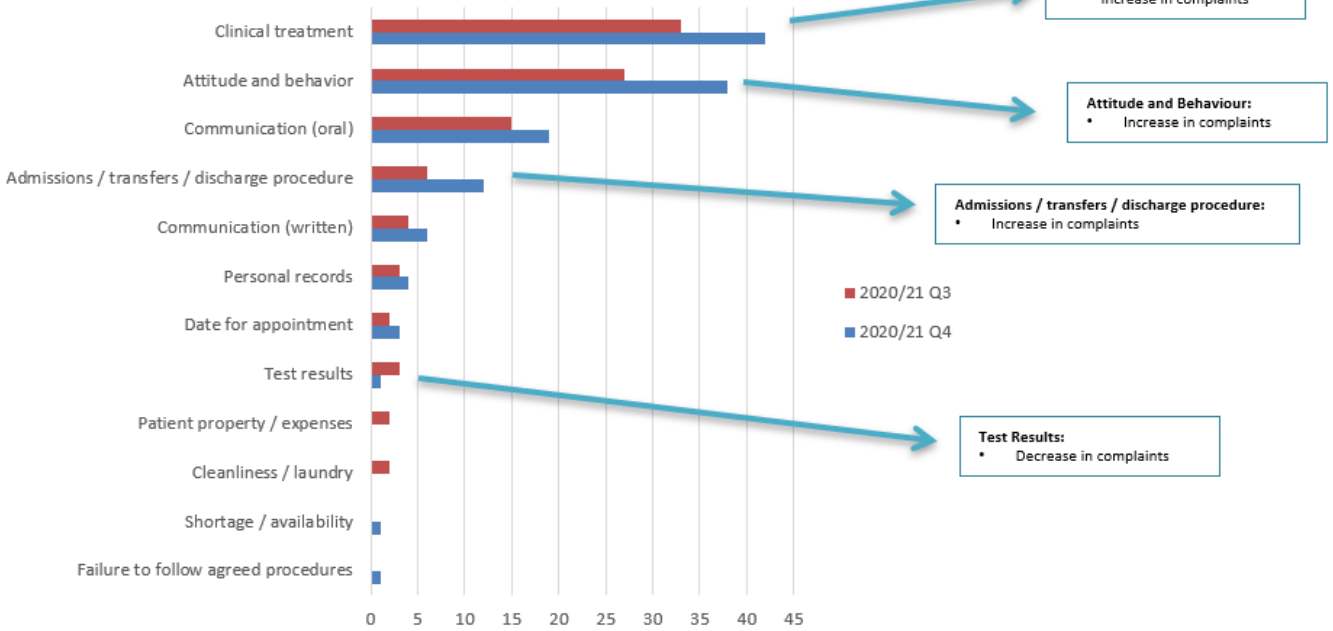






Complaints Analysis Q3 vs Q4

The information shows the top subjects in complaints in Q3 vs Q4.
Note: Complaints can have more than one subject.



Clinical Treatment:
- Increase in complaints

Attitude and Behaviour:
- Increase in complaints

Admissions / transfers / discharge procedure:
- Increase in complaints

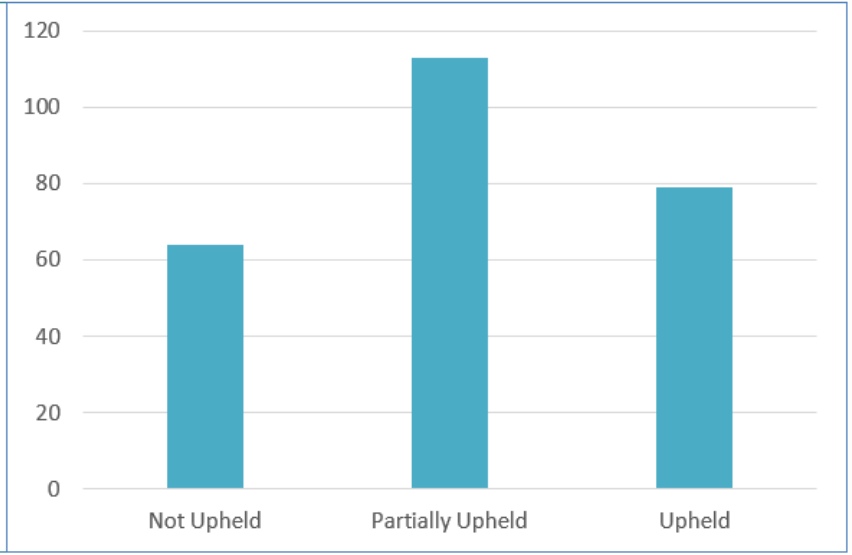
Test Results:
- Decrease in complaints

Complaints Outcomes Q4

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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

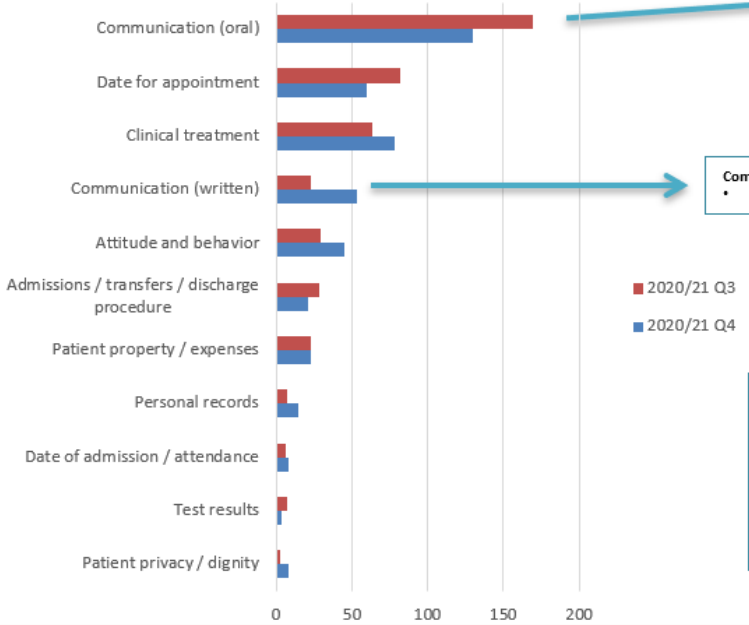
A complaint will be “upheld”, “upheld in part” or “not upheld”.



PALS Analysis Q3 vs Q4

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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



Communication issues:
- Decrease in concerns

Communication issues:
- Increase in concerns

PALS to Complaints:

Q3	Q4
6	13

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

Q3	Q4
7 days	4 days

Learning from Complaints

You Said....	We Did....
A patient was concerned that she was challenged regarding not wearing a mask when she attended an appointment.	We reminded staff in the clinical area of the Trust's expectations and processes when patients do no wear a face mask due to exemptions.
A patient expressed concerns regarding not being able to have her partner with her for an ultrasound scan.	We recognised that staff should have invited the patient's partner in from the start of the scan and to be able to offer support. All staff were reminded of the Trust's expectations to ensure that this does not recur.
A patient's relative expressed concerns that the patient was discharged without her prescribed medication.	We reminded all staff of the importance of ensuring patients have appropriate medication when discharged.

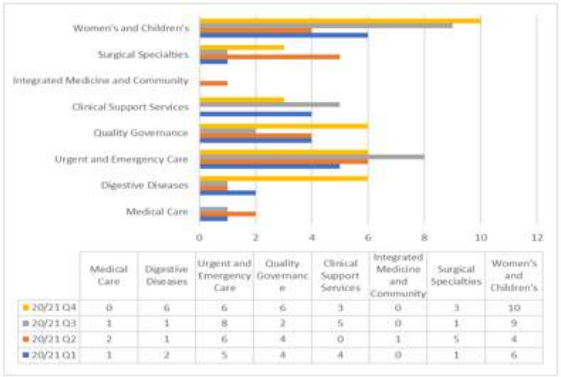
Complaints Headlines

- 127 complaints were opened during Q4 2020/21, which is an increase of 30.93% compared to Q3 (97). The increase reflects our usual complaints activity for the same period of time in the previous financial year.
- In Q4, the number of complaints relating to attitude and behaviour have increased compared to Q3.
- There has also been a decrease in the number of test results complaints in Q4 compared to Q3.
- 458 PALS concerns were received during Q4 2020/21, which is a decrease of 3% compared to Q3.
- There has been an increase in the number of PALS concerns received for written communication and there has been a decrease in the number of PALS concerns received for oral communication.
- The Trust received 7 dissatisfied complaints in Q4 2020/21; which is a decrease of 50% compared to Q3 where there was 14.
- In Q4, 3 complaints were closed and deemed to require an SI investigation.

Analysis of Claims Received Q4 2020-2021

Clinical Claims Received 2020/2021

Q1: 23 Received
Q2: 23 Received
Q3: 27 Received
Q4: 34 Received



	Medical Care	Digestive Diseases	Urgent and Emergency Care	Quality Governance	Clinical Support Services	Integrated Medicine and Community	Surgical Specialties	Women's and Children's
20/21 Q4	0	6	6	6	3	0	3	10
20/21 Q3	1	1	8	2	5	0	1	9
20/21 Q2	2	1	6	4	0	1	5	4
20/21 Q1	1	2	5	4	4	0	1	6

27 Claims received via:

- Litigant in Person 3
- Incident 1
- Letter of Claim 2
- Notice of Funding 1
- Request for notes 26

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

Non-Clinical Claims Received 2020/21

There were no Non-Clinical Claims received this qtr:
Q1: 0
Q2: 5
Q3:v6
Q4: 3

Governance / Patient Safety	
Patient Information (records, documents, test results, scans)	1
Health and Safety	
Accident/Incident that may result in injury / harm	1
Trust Escalation	
Abusive, violent, disruptive or self-harming behaviour	1

Analysis of Claims Closed 2020/2021 Q4

Clinical Claims Closed Q4 2020/2021

7 Claims closed with damages (totalling £554,016.00) (excluding costs))

Clinical Business Unit	Repudiated	Settled with damages	Withdrawn	Grand Total
Clinical Support Services		1	4	5
Digestive Diseases	1		9	10
Medical Care	1		4	5
Unknown			2	2
Surgical Specialities	3	3	18	24
Urgent and Emergency Care	1	2	9	12
Women's and Children's	1	1	16	18
Grand Total	**7**	**7**	**62**	**76**

Non-Clinical Claims Closed Q4 2020/21

3 employer Liability Claims closed with damages (totalling £7615 (excluding costs))

Specialty	Details
Emergency Medicine	Slip
Radiology	Slip
Theatres	Assault

2 Public Liability Claims closed with damages (totalling £4860.00 (excluding costs))

Specialty	Details
Children's OPD	Data Breach
OPD	Slip

Action taken on Clinical Claims

Histopathology

Failure to identify cancer cells	• 12 month retrospective review of histopathology reports on oral specimens undertaken in the Pathology Department, with a further review may becoming necessary depending on the outcome. • Review SOP relating to dual reporting with specific reference to oral lesions • Review casemix undertaken by Associate Specialist • Associate Specialist in Histopathologist to be referred to the Medical Director for further management.

Trauma and Orthopaedic

Failure to carry out post-op instructions	• Consultant raised issue with this team

Gynaecology

Failure to carry out post-op imaging	Product no longer being used

Action taken on Clinical Claims

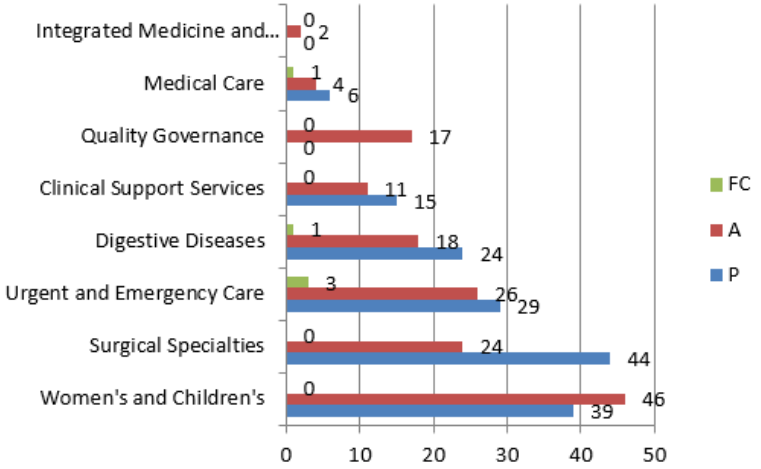
Emergency Medicine

Failure to diagnose fractured hip	An apology was offered to patient once the GP notified the Trust of the fracture. The ENP who saw the patient was contacted to provided individual feedback and the case was also mentioned in the monthly governance email sent to All ED staff so that all colleagues are aware that they should at least consider stress fractures in similar circumstances, especially when weight bearing has become a significant issues. Details also sent to physiotherapy as patient had also attended there.
Failure to supervise	Department exploring other options for cups on the department. Patient dependency discussed at safety brief and huddle
Failure to diagnose fracture of the lateral distal fibula, above the ankle mortice resulting in delay in treatment	Training to be provided to Emergency Department Triage Nurses surrounding requesting x-rays for patients presenting with potential fractures Emergency Department triage nurses who do not have training to request x-rays for patients with potential fractures should, when possible, ask clinicians to assess patients and to request imaging if necessary. Lead Nurse and Matron for the area will communicate this to the team through safety brief Clinical observations are completed and documented regularly as per NEWS2 guidance, as per best practice, and that ongoing nursing documentation is completed for all patients who are waiting for longer periods. Adherence to the NEWS2 policy is being audited in the department Clinicians involved in the incident to complete a reflection on the case Investigation to be shared in the Departmental M + M meeting Evaluation of the process surrounding review radiology alerts within the Emergency Department for patients who have already been given a fracture clinic appointment

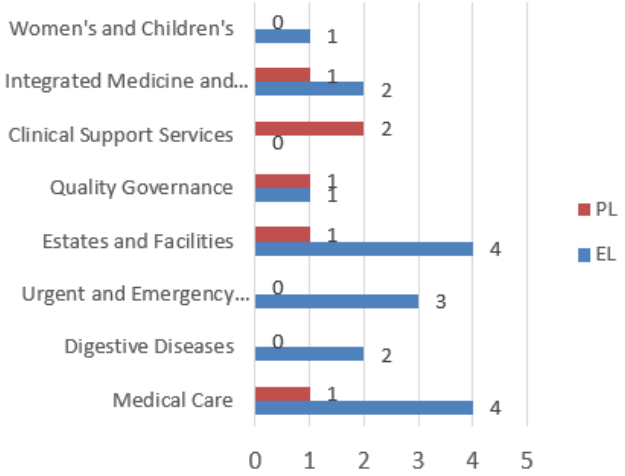
Claims Position – End of Q4

Warrington and Halton Teaching Hospitals NHS Foundation Trust

311 **Clinical Claims** open
158 Actual (Formal Claim) | 148 Potential (Request for notes) | 5 Coroners Funding



23 **Non-Clinical Claims** open
17 Employer Liability |6 Public Liability



Key:
FC – Coroners Funding P – Potential = Request for notes A – Actual = (Formal Claim, Letter of Claim / Proceedings) PL – Public Liability EL – Employer Liability

Headlines of Learning from Deaths Q4

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

Learning from National Audits

NPDA National Paediatric Diabetes Audit

NHS Warrington and Halton Teaching Hospitals NHS Foundation Trust

Summary:

The National Paediatric Diabetes Audit (NPDA) was established to compare the care and outcomes of all children and young people with diabetes receiving care from Paediatric Diabetes Units (PDUs) in England and Wales. The audit's aims are to:

- Monitor the incidence and prevalence of diabetes amongst children and young people receiving care from a PDU in England and Wales
- Establish whether recommended health checks are being received by children and young people with diabetes
- Enable benchmarking of performance against standards of care specified by the National Institute for Health and Care Excellence (NICE) guidance at PDU, regional and national level
- Determine the prevalence and incidence of diabetes-related complications amongst children and young people with diabetes

Key Findings:

The majority of WHTH sample is made up of type 1 diabetes (98.1%), 10-14 year olds make up the biggest proportion of the sample (39.6%) Warrington and (46.2%) Halton, the population ethnicity was predominantly white in both Warrington (97.2%) and Halton (98.9%). An overall health check completion rate for young people aged 12+ was conducted in 93.2% Warrington and 90.6% Halton.

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

Key Care Process	Warrington	North West	England & Wales
Received ALL 7 care processes	**65.5%**	**57.3%**	**55.2%**
HbA1c	100%	99.7%	99.4%
Blood Pressure	100%	96.2%	96.2%
Thyroid	88.3%	91.7%	87.2%
BMI	100%	99.3%	99.2%
Albuminuria	86.8%	82.8%	78.3%
Eye Screening	73.7%	75.5%	77.5%
Foot Examination	100%	88.6%	82.5%

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

Learning from Local Audits Covid cases in CSTM

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Covid-19 remains a worldwide pandemic affect all services of our healthcare. Currently trauma and orthopaedic services have been greatly reduced due to the perceived significant risk of patients contracting covid-19 during their hospital stay. Covid 19 resulted in the shutdown of elective surgery. CSTM closed on:- 23/3/2020 and re-opened on:- 29/6/2020.

Initially 2 theatres were allocated to Elective Orthopaedics and Ambulatory Trauma. Elective orthopaedic patients self-isolated for 14 days prior to admission. Ambulatory trauma patients self-isolated for 3 days prior to admission This created a green and amber pathway.

In January 2021 trauma and orthopaedics was reduced to 1 theatre. The amber pathway was also removed as all patients only need to self-isolate for 3 days prior to admission. In mid-January PACU was opened which will allow more high risk patients to have their surgery in CSTM.
compliance with the Diagnostic Policy.

Key Findings: The length of time the patients were self-isolated prior to surgery did not affect their chance of developing covid during their hospital stay

Recommendations: Patient's need to self-isolate for a minimum of 3 days
Consider asking patients to self-isolate for 14 days. This will allow flexibility to move and bring forward patients ensuring operating lists are fully utilised in the case of short notice cancellations.
Importance PACU availability for vulnerable patients

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

Learning from Local Audits - continued

Standard	Actions required	Action by Date	Person responsible (Name and job title)	Risk Rating (using risk grading matrix what is the risk of the action not being implemented)	Comments (state any problems encountered in facilitating change, reasons for delay etc)
None	None	None	None	None	None

Non-Clinical Incidents Q4

Warrington and Halton Teaching Hospitals NHS Foundation Trust

From 1st January to 31st March 2021, there were 333 non-clinical incidents reported. The top 2 categories were:

Security incidents = 76	Health and Safety incidents = 110
The top sub-categories were: • Aggressive behaviour by patients/relatives • Abuse – verbal • Alarm activation • Loss	**The top sub-categories were:** • Injury to staff • Needlestick Injury • Hit by an object

Late Incident Reporting and Datix

The Trust is committed to achieving high standards of health and safety through the provision of healthy working environments, safe working practices and safe people working therein.

There are times though when incidents do happen, and when this does, an incident reporting form must be completed.

It has been noticed though that there are occasions when there is late reporting. This can range from a few days, a few weeks and on the rare occasion, a few months after the incident has occurred. Not only does this cause late reporting of any potential RIDDOR reportable incidents to the HSE, it also affects any investigations to be carried out as well as any possible repairs/remedial actions that may be required to prevent anyone else from injuring themselves, as well as any learning/sharing from these incidents.

As an action, an article was placed on the front page of the March 2021 Health and Safety Newsletter. The Health and Safety Department also attended the Safety Huddle on 22nd March and presented a single point lesson on late incident reporting and Datix. This information was shared all week through the daily communications. This topic was also discussed at the Health and Safety Sub Committee and added to the High Level Briefing Paper for the Quality Assurance Committee.

During the 2021/22 Health and Safety Audits, this too will be discussed and monitored to ensure the information has been cascaded to the relevant Managers and staff to prevent any future late reporting

Stay Alert – Don't get hurt

Learning from Non-Clinical Incidents

We found....	We Acted....
The supporting pillars along Burtonwood Wing were constantly being hit by vehicular traffic such as tugs and trailers. Plaster was chipping away and they looked unsightly. 	Estates were asked to assist. They resolved this issue by suppling metal corner protectors. These have now been applied to the supporting pillars and look great. 
The Health and Safety Department were asked to inspect the onsite mental wellbeing hub prior to opening. It was noticed that there were large gaps in between the paving flag stones which could be a potential tripping hazard	Estates were asked to fill in the gaps which has since been actioned to provide a safe environment 

Inspections



Since starting the Health and Safety inspection programme in November 2020 and looking specifically at control measures for COVID-19, there has been a marked improvement in many areas. For example, portable screens at tables in rest areas to protect staff, portable stations to clean goggles, areas to hang goggles to dry and posters clearly detailing the step by step process of taking off a mask and replacing with new. Simple measure but very effective

Unfortunately, good practices are not always being adhered to along Hospital corridors. Bedding continues to be left on beds and patient trolleys, the ground floor corridor is narrowed with the storage of beds and trolleys and clinical waste bins are not always being locked with bags being exposed.

Regular communications are circulated to the appropriate areas reminding them that corridors need to be kept clear at all times, bedding removed before taking out for storage and clinical waste bins locked at all times




Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/21/05/80**	
SUBJECT:	**Infection Prevention and Control Board Assurance Framework Compliance Report**	
DATE OF MEETING:	26 May 2021	
AUTHOR(S):	Lesley McKay, Associate Chief Nurse, Infection Prevention + Control	
EXECUTIVE DIRECTOR SPONSOR:	Kimberley Salmon-Jamieson, Chief Nurse + Deputy Chief Executive	
LINK TO STRATEGIC OBJECTIVE:	SO1 We will.. Always put our patients first through high quality, safe care and an excellent patient experience.	√
	SO2 We will.. Be the best place to work with a diverse, engaged workforce that is fit for the future.	√
	SO3 We will.. Work in partnership to design and provide high quality, financially sustainable services.	√
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): **(*Please DELETE as appropriate)***	#1124 Failure to provide adequate PPE caused by failures within the national supply chain and distribution routes resulting in lack of PPE for staff. #1134 Failure to provide adequate staffing caused by absence relating to COVID-19 resulting in resource challenges and an increase within the temporary staffing domain. #125 Failure to maintain an old estate caused by restriction, reduction or unavailability of resources resulting in staff and patient safety issues, increased estates costs and unsuitable accommodation.	
EXECUTIVE SUMMARY (KEY ISSUES):	To provide the Board with assurance on actions in place to meet legislative requirements relating to the prevention and control of infection linked directly to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.	

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

RECOMMENDATIONS:	The Board is asked to note the contents of the report.	
PREVIOUSLY CONSIDERED BY:	**Committee**	Infection Control Sub Committee
	Agenda Ref.	
	Date of meeting	
	Summary of Outcome	
FREEDOM OF INFORMATION STATUS (FOIA):	**Release in Full**	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None	

Infection Control Sub-Committee

SUBJECT	IPC BAF	AGENDA REF:	QAC/21/05/80

1. BACKGROUND/CONTEXT

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

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

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

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

The risk assessment process will be continuous alongside review of emerging information to ensure that as an organisation the Trust can respond in an evidence-based way to maintain the safety of patients, services users and staff.

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

2. KEY ELEMENTS

1. Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks posed by their environment and other service users				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
• infection risk is assessed at the front door and this is documented in patient notes	• Where patients are conveyed by the Ambulance Service with possible or confirmed infection risk for COVID-19 they are risk assessed pre-hospital by the Ambulance staff to inform destination decision. Government guidance for Ambulance Trusts is used for decision making. https://www.gov.uk/government/publications/covid-19-guidance-for-ambulance-trusts/covid-19-guidance-for-ambulance-trusts • ED are pre-alerted by the Ambulance Service of suspected Covid-19 cases • Patient placement government guidance flow chart in place Mandatory surveillance\ncv2019\COVID-19 information\COVID-19 - Effective Patient Placement v2.1.docx • ED reorganized to have Hot and Cold respiratory assessment areas to segregate patients presenting with suspected Covid-19 from other attendees			

1. Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks posed by their environment and other service users				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
	• All patients admitted via ED are screened for Covid-19, data reviewed daily			
	• Electronic infection risk assessment tool in Lorenzo (Electronic Patient Record)	• Compliance with completion of infection risk assessments	• Audit of compliance with admission infection risk assessments	
	• Covid-19 Alert added to Lorenzo for all patients with a positive SARS-CoV-2 swab and updated with additional swab results • **>3229** Covid-19 alerts added to individual patient records on Lorenzo (11/02/2021) • Covid-19 Clinically Extremely Vulnerable Alerts added to Lorenzo	• A small number of screening swabs are not taken	• IT surveillance system in place to track day of admissions, day 3 and day 5 screening. Matrons and Lead Nurses review result daily to ensure Trust Covid-19 screening SOP is adhered to • Re-audit of screening compliance planned	
	• Alerting system in place for other healthcare associated infections: (MRSA; CDT; GRE; CPE; MDROs)			
• there are pathways in place which support minimal or avoid patient bed/ward transfers for duration of admission unless clinically imperative	• SOP for patient placement. Patients are assessed for location of care according to Clinical Frailty Score and WHO Performance Status and clinical specialty need • The Trust is following PHE national guidance with admission screening and repeat swabbing undertaken 3 days and 5 days post admission or sooner if initial test was negative and patient exhibits	• Potential incorrect or change in placement requirements identified • Guidance for 2 negative results before moving patients is	• SOP for patient placement in place which is in line with PHE national guidance • Operational Manager/Silver Command oversight of patient placement at Bed Meetings (4 times per day and frequency increased at times of increased activity/demand)	

1. Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks posed by their environment and other service users				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
	symptoms. Further repeat screening if symptoms develop • Screening data • Safe transfer systems in place, including a transfer team and security escort with corridor clearance to limit exposure risks	under review and implementation plan being developed for use in agreed areas	• Patient Flow Oversight Group establish 12/0/2021 to review operational processes	
• that on occasions when it is necessary to cohort COVID or non-COVID patients, reliable application of IPC measures are implemented and that any vacated areas are cleaned as per guidance	• Covid-19 audits (for aerosol and non-aerosol generating procedures) are in place for all clinical areas • Vacated areas are decontaminated using Hydrogen Peroxide Vapour (HPV). In the event HPV is unavailable areas are decontaminated using a chlorine-based solution of 1,000ppm			
• monitoring of IPC practices, ensuring resources are in place to enable compliance with IPC practice - Staff adherence to hand hygiene - Social distancing across the workplace - Staff adherence to wearing fluid resistant	• Hand hygiene audits weekly • PPE audits • Environmental audits • High impact intervention audits • Supplies monitoring of PPE levels daily • Social distancing check included on the daily Clinical Area Action Card • Spot checks on break rooms	b) Auditing of non-clinical areas	b) Non-clinical area Action Card to be developed	

1. Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks posed by their environment and other service users				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
surgical facemasks (FRSM) in: - a) clinical - b) non-clinical settings				
• monitoring of staff compliance with wearing appropriate PPE within the clinical setting	• PPE (AGP/non-AGP) audit programme in place • Refresh PPE champions role in February 2021			
• consider implementing the role of PPE guardians/safety champions to embed and encourage best practice	• PPE champions implemented with role defined			
• implementation of twice weekly lateral flow antigen testing for NHS patient facing staff, which include organisational systems in place to monitor results and staff test and trace	• Staff screening in place for: symptomatic staff and asymptomatic staff in outbreaks • Occupational Health Service monitor staff cases and areas where clusters of cases are identified are reported to the IPC team • Self-testing – lateral flow implemented November 2020 with electronic test result reporting system including guidance on action to take according to results. Compliance monitored at Tactical meetings			

1. Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks posed by their environment and other service users				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
	• Review underway and plan in progress for introducing LAMP testing • Staff absence monitoring including staff absent following contact by Test and Trace			
• additional targeted testing of all NHS staff, if your trust has a high nosocomial rate, as recommended by your local and regional infection prevention and control/Public Health team	• Additional staff testing as part of outbreak investigation			
• training in IPC standard infection control and transmission-based precautions are provided to all staff	• Local induction and mandatory IPC training includes standard infection control and transmission-based precautions	• Level 2 Training attendance figures are less than 80%	• 3 additional training sessions per week are being provided in addition to induction and mandatory training	
• IPC measures in relation to COVID-19 should be included in all staff Induction and mandatory training	• Induction and mandatory IPC training updated to include guidance on COVID - 19 • Copies of training presentations • Training session have been recorded and information on Covid-19 added to face to face mandatory training session E-learning session is being updated	• Level 2 Training attendance figures are less than 80%	• Additional training sessions are being provided x3 per week	

1. Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks posed by their environment and other service users				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
• all staff (clinical and non-clinical) are trained in putting on and removing PPE; know what PPE they should wear for each setting and context; and have access to the PPE that protects them for the appropriate setting and context as per national guidance	• PPE guidance included in the Covid 19 Policy is line with PHE national Guidance • PPE Trust Board paper • Trust wide risk assessment • Local risk assessments in place for the use of PPE • Infection Prevention and Control Team support staff education for PPE • PPE training records • Face Masks distributed to all Non-clinical areas on Friday 12th June ahead of the change in guidance for PPE to be worn in non-clinical areas • Risk assessments include details on Covid-19 secure and when face masks are required • PPE training for visitors where compassionate visiting requirements are indicated • PPE champions (58) support staff education/face to face training • PPE audit tool developed for aerosol/non-aerosol generating procedures – weekly audit • PPE Audit records • Covid-19 PPE staff information booklet (x2)			

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

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

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

1. Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks posed by their environment and other service users				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
	• Corporate Risks include impact on activity • Local risk assessments in place for the use of PPE • 2 risks on the BAF linked to: - national shortage of PPE - oxygen supply • PPE is a standing agenda item for monitoring levels at the Tactical Meetings and estimated usage rates have been added to all Recovery Plans • Oxygen daily SitRep continued beyond national reporting requirements to provide local assurance • HSIB interim bulletin on oxygen January 2021 is under review			
• robust IPC risk assessment processes and practices are in place for non COVID-19 infections and pathogens	• Existing IPC policies in place: - Chickenpox - Clostridium difficile - Scabies - Shingles - Meningitis - MRSA - Multi-drug resistant organisms - Influenza - TB/ MDR TB - Viral Gastroenteritis			

1. Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks posed by their environment and other service users				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
	- Viral haemorrhagic fevers - Isolation of immunosuppressed patients • SOPs for rapid testing for CPE/ MRSA and enteric and respiratory pathogens • Isolation for other infections and pathogens is prioritised based on transmission route • Clostridium difficile Guidelines (2018) in place and all patients with a C. difficile toxin positive or PCR positive result are isolated • Ribotyping of all community onset healthcare associated and hospital onset healthcare associated cases • Root Cause Analysis investigation for all hospital apportioned cases • Compliance with Mandatory HCAI reporting requirements • Distribution of HCAI surveillance data weekly • Re-establishing the C. difficile Cohort Ward is included in Recovery Plans • GNBSI reduction Action Plan has been revised and work stream is being reinstated			
• the Trust Chief Executive, the Medical Director or	• Sign off process in place for daily nosocomial SitRep			

1. Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks posed by their environment and other service users				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
the Chief Nurse approves and personally signs off, all daily data submissions via the daily nosocomial sitrep. This will ensure the correct and accurate measurement and testing of patient protocols are activated in a timely manner	• Daily data validation process for new admissions and inpatient Covid-19 tests prior to forwarding for sign off			
• this Board Assurance Framework is reviewed, and evidence of assessments are made available and discussed at Trust board	• QAC submission papers • Board Submission papers • Board meeting minutes			
• ensure Trust Board has oversight of ongoing outbreaks and action plans	• Information on outbreaks included in daily executive summary and discussed at the daily Senior Executive Oversight Group Meeting • Learning from Outbreaks included in Nosocomial Board Paper 01 2021			
• there are check and challenge opportunities by the executive/senior leadership teams in both clinical and non-clinical areas	• Matron and IPC Walkarounds • Senior nursing team checks that action cards are being completed • Executive Team walkabouts			

2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
• designated teams with appropriate training are assigned to care for and treat patients in COVID-19 isolation or cohort areas	• SOP for patient placement (agreed ward and critical care locations). Patients are assessed for location of care according to Clinical Frailty Score and WHO Performance Status. Respiratory Step-down Unit SOP • Simulation training • Availability of rapid SARS-CoV2 testing • Ongoing discussion at Nursing and Midwifery Forum, Medical Cabinet and Allied Health Professionals Forum as mitigation • Discussed at the Unplanned Care Group Meeting and action agreed to update guidance • The Matrons provide oversight of staffing levels to ensure all areas are appropriately and safely staffed			
• designated cleaning teams with appropriate training in required techniques and use of PPE, are assigned to COVID-19 isolation or cohort areas	• Task Team and Domestic Assistant training for Covid-19 cohort ward areas has been carried out • Fit Testing for FFP3 masks undertaken for Domestic Assistants in areas where aerosol generating procedures are performed • Task Team support areas where there are Domestic Assistant shortfalls			

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:				
	• Four additional HPV decontamination machines purchased and training on use provided			
• decontamination and terminal decontamination of isolation rooms or cohort areas is carried out in line with PHE and other national guidance	• Terminal cleaning and Decontamination polices in place including guidance on environmental disinfectant required to decontaminate the environment. Decontamination included in the Covid-19 policy • All policies are used in conjunction with any updates provided by COVID-19 national guidance • Terminal Cleaning Guidelines 2018 • Decontamination Policy 2019 • Novel Coronavirus Policy (version 7) • Additional HPV machines purchased			
• assurance processes are in place for monitoring and sign off terminal cleans as part of outbreak management	• Sign off checklist in place for terminal cleans			
• increased frequency, at least twice daily, of cleaning in areas that have higher environmental contamination rates as	• Twice daily cleaning of in-patient areas • Cleaning of frequently touched surfaces is included in cleaning policies • Cleaning audits - Ward/Department audits findings are emailed to the Ward/ Department Managers for action • Domestic Supervisory team ensure standards are adhered to			

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:				
set out in the PHE and other national guidance • cleaning is carried out with neutral detergent, a chlorine-based disinfectant, in the form of a solution at a minimum strength of 1,000ppm available chlorine, as per national guidance. If an alternative disinfectant is used, the local infection prevention and control team (IPCT) should be consulted on this to ensure that this is effective against enveloped viruses • manufacturers' guidance and recommended product 'contact time' must be followed for all	• Additional monitoring of standards during outbreaks • Alternative disinfectant used in CT scanning room. Chlorine based disinfectant diluted to 1,000ppm available chlorine is used for terminal cleaning, wards where C. difficile cases are cared for or Hydrogen Peroxide Vapour for cases of C. difficile • Consultant Microbiologists and IPCNs included in discussions on alternative products to ensure effective against coronaviruses • Information on contact time is included in the decontamination policy	• Issue with using chlorine-based product in the CT scanning room	• CT Manufacturer provided alternative decontamination guidance	

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:				
cleaning/ disinfectant solutions/products as per national guidance: • 'frequently touched' surfaces, e.g. door/toilet handles, patient call bells, over-bed tables and bed rails, should be decontaminated at least twice daily and when known to be contaminated with secretions, excretions or body fluids • electronic equipment, e.g. mobile phones, desk phones, tablets, desktops and keyboards should be cleaned a minimum of twice daily	• Ring the bell it's time for Clinnell campaign • Domestic staff record when they have cleaned areas • Cleaning of workstations is included in the Environmental Action Plan			

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:				
• rooms/areas where PPE is removed must be decontaminated, timed to coincide with periods immediately after PPE removal by groups of staff (at least twice daily)	• Domestic staff time cleaning activity when areas are vacant • Included in ICU Bioquell pod SOP			
• linen from possible and confirmed COVID-19 patients is managed in line with PHE and other national guidance and the appropriate precautions are taken	• Process for managing linen is included in the COVID-19 policy. All linen from COVID-19 possible and confirmed positive patients is treated as infectious and placed in alginate bags which are tied and then placed in a white plastic bag • No DATIX reports on non-compliance with double bagging of used/infected linen			
• single use items are used where possible and according to single use policy	• Decontamination Policy in place which includes single use/single patient use guidance used in conjunction with any updates provided by national guidance in response to COVID-19 • Chlorine releasing agents are the nationally advised method of decontamination • Hydrogen Peroxide Vapour has been used for environmental			

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:				
	decontamination as part of a deep clean programme for vacant patient rooms/wards			
• reusable equipment is appropriately decontaminated in line with local and PHE and other national guidance	• Decontamination Policy in place used in conjunction with any updates provided by National Guidance in response to COVID-19	• Decontamination Meetings suspended	• Date scheduled to reconvene meetings from 17/08/20 • An SOP for decontamination of reusable PPE is in place	
• ensure cleaning standards and frequencies are monitored in non-clinical areas with actions in place to resolve issues in maintaining a clean environment	• Cleaning monitoring programme in place • Monitoring result are circulated to managers for corrective action where standards are not met at time of auditing • Housekeepers accompany monitoring officers where on duty and corrective action is taken at time of auditing or as soon as possible			
• ensure the dilution of air with good ventilation e.g. open windows, in admission and waiting areas to assist the dilution of air	• Windows within the waiting space are opened to ventilate the area and any space having forced ventilation is adequate to keep the area ventilated so windows can be kept closed • Signage on social distancing, hand hygiene and face coverings are displayed in ED waiting areas	• Not all areas will be provided with ventilation or can open windows	• These areas are ventilated by keeping doors and windows open where possible/ patient comfort allows	
• monitor adherence of environmental decontamination with actions in place to	• Programme of cleaning audits in place with feedback requested on action taken to rectify any areas requiring attention			

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:				
mitigate any identified risk				
• monitor adherence to the decontamination of shared equipment with actions in place to mitigate any identified risk	• Programme of cleaning audits in place with feedback requested on action taken to rectify any areas requiring attention			

3. Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance				RAG
Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions	
Systems and processes are in place to ensure:				
• Arrangements around antimicrobial stewardship are maintained	• Consultant Medical Microbiology daily Ward Round in Critical Care • Ward based Pharmacist support • Prescribing advice available by telephone (in and out of hours) • Infection Control Doctor presentations to Medical Cabinet • Formulary review as evidence/guidelines are updated			

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:				
	• Antibiotic prescribing guidelines for COVID suspected patients have been published • Antimicrobial Management Steering Group Meetings will be reconvened from September • C diff outliers ward rounds recommenced in July • Quarterly Point Prevalence audits with concerns discussed at Medical Cabinet and Infection Control Sub-Committe			
• Mandatory reporting requirements are adhered to and boards continue to maintain oversight	• Mandatory reporting of HCAIs has continued • Data on HCAIs is included on the Quality Dashboard • DIPC reports HCAI data at Trust Board			

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:				
	• Information on Data Capture System • Distribution of HCAI surveillance data weekly • HCAI review meetings being reconvened from April 2021			

4. Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
• Implementation of national guidance on visiting patients in a care setting	• Restricted visiting implemented 17 March 2020; Visiting suspended from 26 March 2020; Compassionate visiting arrangements agreed 09 April 2020. Paper on visiting arrangements taken to SEOG • Visiting the dying guideline in place with			

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:				

	training provided by the Palliative Care Team
	• Trust wide Communication via email on visiting restrictions then cessation
	• Environmental Safety Plan includes site lock down to restrict access
	• Compassionate visiting arrangements agreed for the following patient groups where close family and friends visiting may be admitted:
	  • Patients in critical care
	  • Vulnerable young adults
	  • Patients living with Dementia
	  • Autism
	  • Learning difficulties			

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:				
	• Loved ones who are receiving end of life care • Signage at entrances			
• Areas in which suspected or confirmed COVID-19 patients are where possible being treated in areas clearly marked with appropriate signage and have restricted access	• Coronavirus posters with details on Red, Amber or Green pathway, displayed outside areas where patients with suspected or confirmed COVID-19 are cared for • Family Liaison service in place to keep relatives (virtually) updated on care of loved ones			
• Information and guidance on COVID-19 is available on all Trust websites with easy read versions	• Information on COVID-19 is available on the Trust Web Site and at entrances			
• Infection status is communicated to the receiving	• Covid-19 Alert added to Lorenzo for all patients with a positive SARS-			

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:				
organisations or department when a possible or confirmed COVID-19 patient needs to be moved	CoV-2 swab (to date **>3229** alerts added – 11/02/2021) • Covid-19 status included on SBAR form • Covid-19 has been added to e-discharge summary template			
• There is clearly displayed and written information available to prompt patients' visitors and staff to comply with hands, face and space advice	• Information on the Trust website (updated 16/10/2020) • Signage at all entrances • Hand gel and face masks provided at hospital entry points • Entrances are manned (part time) to support visitor compliance – visiting restrictions are currently in place			

5. Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
• Screening and triaging of all patients as per IPC and NICE Guidance within all health and other care facilities must be undertaken to enable early recognition of COVID-19 cases	• Triage in ED includes questions on Covid-19 symptoms/ pre-admission testing results where available • Information provided prior to attending Outpatient Departments and further symptom screening in place on arrival	• Revised Guidance on returning travellers from Denmark and Mink Variant; Brazil and South Africa	• Plan to meet with ED Team to implement screening at Triage • SOP being updated to reflect requirement to transfer returning travellers from countries with SARS-CoV-2 variant and positive result to the Regional Infectious Disease Unit	
• Front door areas have appropriate triaging arrangements in place to cohort patients with possible or confirmed COVID-19 symptoms and to segregate them from non COVID-19 cases to minimise the risk of cross-infection as per national guidance	• Patients conveyed to hospital by Ambulance are pre-assessed to determine where they are taken to in ED • ED reorganised to have Hot and Cold respiratory assessment areas to segregate patients presenting with suspected Covid-19 • Triage in ED and segregated areas for patients suspected to have COVID-19 • Environmental Safety Action Plan with proposal to lockdown 25% of entrances • Manned mask stations at main entrance Warrington site (part time) and mask available at other	• Asymptomatic patients subsequently identified as COVID-19 positive	• Process in place to isolate and close the bay to admissions when exposure incidents occur	

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:				
	entrances with access to hand sanitisers			
• Staff are aware of agreed template for triage questions to ask	• Questions are asked of patients at booking in ED	• Awaiting copy of template	• Plan to meet with ED Team to review screening at Triage • SOP being updated to reflect requirement to transfer returning travellers from countries with SARS-CoV-2 variant and positive result to the regional Infectious Disease Unit	
• Triage undertaken by clinical staff who are trained and competent in the clinical case definition and patient is allocated appropriate pathway as soon as possible	• Senior ED staff are rostered to carryout Triage • POCT (Abbot ID Now) testing introduced in ED			
• Face coverings are used by all outpatients and visitors	• Observational checks carried out in Departments	• Patient refusal or inability to wear a face covering due to an underlying condition	• Social distancing maintained where patients and anyone accompanying them cannot wear a face mask • SOP required to support staff decision making in relation to continuing with procedure with reasonable adjustments to ensure staff safety where patients are exempt	
• Face masks are available for all patients and they are	• Face masks available for all patients	• Some patients are unable to tolerate face masks	• Social distancing maintained where patients and anyone accompanying them cannot wear a face mask	

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:				
always advised to wear them				
• Provide clear advice to patients on use of face masks to encourage use of surgical facemasks by all inpatients in the medium and high-risk pathways if this can be tolerated and does not compromise their clinical care	• Masks are offered to patients where O_2 therapy is not required and 2 metre distancing is not possible • Mask use is recorded in Lorenzo and on care and comfort rounds • Masks are worn when transferring between wards/departments	• Some patients are unable to tolerate face masks	• Use of clear curtains to create a physical barrier	
• monitoring of inpatients compliance with wearing face masks particularly when moving around the ward (if clinically ok to do so)	• Compliance recorded on care and comfort round forms and documented in Lorenzo EPR			
• Ideally segregation should be with separate spaces, but there is potential to use screens, e.g. to	• Estate work has been carried out to install additional doors within ED • Where available, doors are closed on ward corridors to separate Covid and non-Covid areas			

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:				
protect reception staff	• Perspex screens have been installed in reception areas			
• to ensure 2 metre social & physical distancing in all patient care areas	• Some patients cared for in single room • Patients are socially distanced as far as reasonably achievable	• Some bed spaces less than 2 metres apart in bays	• Clear curtains in place to create physical barrier	
• For patients with new-onset symptoms, isolation, testing and instigation of contract tracing is achieved until proven negative	• Symptomatic screening is advised if previous screening results were negative • Routine swabs for Covid have been added to the sepsis screening packs • Isolation facilities are prioritized for patients with suspected infections transmitted by the respiratory route • Contact tracing is including in the Covid-19 Hospital Onset and Outbreak Investigation SOP	• Low number of available side rooms	• Patients are isolated where possible. Clear curtains are used as barriers where isolation rooms are not available • Patients are socially distanced as far as reasonably achievable	
• patients that test negative but display or go on to develop symptoms of COVID-19 are segregated and promptly re-tested and contacts traced promptly	• Repeat patient testing in place where there are on-going concerns about COVID-19 and initial swab was negative • SOP on Covid-19 screening and isolation and PPE in place • Contact tracing is including in the Covid-19 Hospital Onset and Outbreak Investigation SOP	• Low number of available side rooms	• Patients are isolated where possible. Clear curtains are used as barriers where isolation rooms are not available • Patients are socially distanced as far as reasonably achievable	

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:				
	• Letter in place for follow-up of discharged patients who have had contact with Covid-19			
• there is evidence of compliance with routine patient testing protocols in line with Key actions: infection prevention and control and testing document	• Daily monitoring system in place to achieve full screening compliance for admission, day 3 and day 5 swabs • Weekly screening implemented	• RCAs are identifying some routine samples are being missed	• Daily senior nurse oversight to ensure compliance • Electronic systems support identification of patients who have not be screened as per routine testing protocol • Additional control measures put in place to ensure compliance including reminders via daily safety brief, emails to senior staff, electronic monitoring system	
• Patients that attend for routine appointments who display symptoms of COVID-19 are managed appropriately	• Rapid testing available 7 days per week • Routine appointments have been stepped down. Social distancing measures are in place in Outpatient Departments • Recovery plan for Outpatients (28/05/2020) includes providing information not to attend if unwell with Covid-19 symptoms • Risk rated appointment schedule based on clinical priority • Virtual 'attend anywhere' clinics • Rooms identified for shielding patients	• Public compliance with social distancing measures	• Social distancing measures are in place in Outpatient Departments • Signage in place to keep left on corridors, walk in single file and socially distance • Seating arranged in Outpatient waiting areas to support social distancing	

6. Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
• Separation of patient pathways and staff flow to minimise contact between pathways. For example, this could include provision of separate entrances/exits (if available) or use of one-way entrance/exit systems, clear signage, and restricted access to communal areas	• Environmental Action plan in place • Keep left signage in place for internal walkways • Restricted key codes/controlled entry in place • Green pathway for surgical patients at CSTM building and Ward A5 elective • Wards identified for care of patients with Covid-19 as per Trust escalation plan • Signage at ward entrances denotes res, amber or green pathway area			
• All staff (clinical and non- clinical) have appropriate training, in line with latest national guidance, to ensure their personal safety and	• PPE Champions (58), roving training on donning and doffing of PPE • Links to PHE videos have been distributed. Individual booklets on COVID-19 and PPE produced and distributed	• Staff returning to work, including after pregnancy, long term sick leave or due to Extremely vulnerable status may not be fully informed with the latest guidance	• Action plan in place with Unplanned and Planned Care Groups to ensure all staff return to work receive appropriate level of training • Action plans in place with CBUs where there are shortfalls in staff training • IPC Team provide ongoing training to PPE champions on donning and doffing of PPE • Links to PHE videos are available and distributed	

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:				
working environment is safe	• Training records from all CBUs that staff have read the Covid-19 policy, receive the PPE booklet, watched the PHE videos, received face to face training, read the Covid-19 swabbing SOP • PPE training included in mandatory training programme			
• All staff providing patient care and working within the clinical environment are trained in the selection and use of PPE appropriate for the clinical situation and on how to safely don and doff it	• Links to PHE videos have been distributed. Posters are displayed in clinical areas on donning and doffing • Information recirculated to Planned and Unplanned Care Groups • Information circulated on Trust Wide Safety Brief • PPE training included in mandatory training programme	• Posters not displayed in all areas • Staff returning from absence may not be fully informed/ updated with latest guidance • PPE to be maintained on CBU Governance agenda's	• Additional posters ordered and site survey to be completed by IPCNs with PPE champions for each area • IPC team provide ongoing training on donning and doffing of PPE. Links to PHE videos are available and distributed • Request addition via Governance Teams	
• A record of staff training is maintained	• Record of training	• Follow up of staff training records	• Action plan in place with Unplanned and Planned Care Groups to ensure all staff return to work receive appropriate level of training	

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:				
	• Induction and Mandatory training records are held in ESR	required and identify shortfalls	• Action plans in place with CBUs where there are shortfalls in staff training	
• adherence to PHE national guidance on the use of PPE is regularly audited with actions in place to mitigate any identified risk	• Observational audits completed and feedback received from PPE Champions • Electronic Audit Tool developed and launched 15/05/20 • Audits are carried out weekly and repeated in a shorter timescale where issues are identified • Datix reporting of compliance issues • Discussion on the importance of compliance takes place where PPE risks are identified			
• Hygiene facilities (IPC measures) and messaging are available for all patients/ individuals, staff and visitors to				

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:				
minimise COVID-19 transmission such as: - hand hygiene facilities including instructional posters - good respiratory hygiene measures - maintaining physical distancing of 2 metres wherever possible unless wearing PPE as part of direct care - staff maintain social distancing (2m+) when travelling to work (including avoiding car sharing) and remind staff to follow public health guidance outside of the workplace - frequent decontamination of equipment and environment in both clinical and non-clinical areas	• Hand washing signage – wash hands more frequently & for 20 seconds • Catch it Bin It Kill Posters displayed throughout the Trust • Social distancing signage in place Trust-wide • Information provided in staff Covid-19 booklet on safe travel arrangements • Ring the bell cleaning initiative implemented • Office risk assessments in place including use of		• Hand washing technique posters to be refreshed	

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:				
- clear visually displayed advice on use of face coverings and facemasks by patients/individuals, visitors and by staff in non-patient facing areas	masks if not in a single person office			
• Staff regularly undertake hand hygiene and observe standard infection control precautions	• Programme of hand hygiene audits in place – carried out weekly in areas operational. Overall compliance • April =98%; May=98%; June=98%, July=98%, August=99%, September=98%, October 98%, November=98%, December=98%, January=98%			
• The use of hand air dryers should be avoided in all clinical areas. Hands should be dried with soft, absorbent, disposable paper towels from a	• Hand air dryers not in place in clinical areas • Removal of hand driers in public toilets (none in clinical areas) has taken place as part of the			

6. Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
dispenser which is located close to the sink but beyond the risk of splash contamination as per national guidance	environmental action plan • Hand towel dispensers have been installed and waste collection schedule put in place			
• Guidance on hand hygiene, including drying, should be clearly displayed in all public toilet areas as well as staff areas	• Signage on hand washing technique is displayed on all soap dispensers. • HM Government signage has been displayed detailing 20 second handwashing			
• Staff understand the requirements for uniform laundering where this is not provided for on site	• Guidance on home laundering is included in the COVID-19 PPE information leaflets • Scrub Suits have been offered as an alternative to uniforms and are laundered centrally • Trust wide emails with guidance on laundering			
• All staff understand the symptoms of COVID-19 and take	• Staff shielding and screening for COVID-19 is undertaken in line with national guidance			

6. Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
appropriate action (even if experiencing mild symptoms) in line with PHE national guidance and other if they or a member of their household display any of the symptoms	• Monitored by the Occupational Health and Wellbeing Team and overseen by the Workforce and Organisational Development Team			
• A rapid and continued response through ongoing surveillance of rates of infection transmission within the local population and for hospital/ organisation onset cases (staff and patients/ individuals)	• Local statistics included in Tactical meetings agendas • Surveillance on hospital onset patient cases included on the Integrated Performance Report • Information on staff cases/outbreaks reported at Senior Executive Oversight Group by DIPC			
• Positive cases identified after admission that fit the criteria for	• Root Cause analysis investigation requested for all cases ≥ day 8 of admission			

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:				
investigation should trigger a case investigation. Two or more positive cases linked in time and place trigger an outbreak investigation and are reported	• Outbreak reporting protocol in place including to: - Trust board - NW.ICC; PHE; CCG; CQC; NHSE/I via web-based reporting system • Process in place for RCA review with IPCT and Governance Department and terms of reference agreed. • Learning themes from RCA findings are shared with staff			
• Robust policies and procedures are in place for the identification of and management of outbreaks of infection. This includes the documented	• Daily surveillance in place of ≥ day 8 cases and location tested to promptly identifying clusters and initiate outbreak investigation accordingly • Occupational Health and Wellbeing Team monitor for clusters of staff cases			

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:				
recording of outbreak meetings.				

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

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:				
	information to state what this means			
• Patients with suspected or confirmed COVID-19 are isolated in appropriate facilities or designated areas where appropriate	• SOP for patient placement. Patients are assessed for location of care according to Clinical Frailty Score and WHO Performance Status	• Limited number of single rooms for isolation (65)	• Cohorting in place as advised by the Infection Prevention and Control Team • Operational Manager/Silver Command oversight at Bed Meetings (4 times per day and frequency increased at times of increased activity/demand)	
• Areas used to cohort patients with suspected or confirmed COVID-19 are compliant with the environmental requirements set out in the current PHE national guidance	• Additional hand washing facilities in anterooms on ward A7 • Side rooms in use for non-clinical activity converted back for clinical inpatient use • 2 single rooms on A2 • 1 single room on A7 • 4 additional single rooms: 2 between A5 and A6; and 2 between A8 and A9 • 3 single room pods built in AMU • 1 outside ACCU	• Old Estate with limited side room capacity	• Daily review of side room utilization at bed meetings	
• Patients with resistant/alert organisms are managed according to local IPC guidance,	• Isolation Policy and Alert organism policies in place • Datix completed when it has not been possible to isolate patients	• Limited number of side rooms further	• Isolation priority protocol in place based on transmission-based precautions • Daily liaison with Patient Flow Team to support risk prioritisation	

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:				
including ensuring appropriate patient placement		reduced by ward closures • Potential non-compliance of patients with shielding pre-operatively		

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

8. Secure adequate access to laboratory support as appropriate				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
	• Lateral Flow testing in place for staff with plan in place to introduce LAMP testing			
• regular monitoring and reporting of the testing turnaround times with focus on the time taken from the patient to time result is available	• Testing turn around times are monitored at Silver IPC cell			
• Regular monitoring and reporting that identified cases have been tested and reported in line with the testing protocols (correctly recorded data)	• LION BIS used to monitor testing in line with guidance and follow-up of omitted tests on admission/ day 3 /day 5/ weekly from day 5 • Documentation of IPC advice on receipt of positive results • RCA requests for cases ≥ day 8 of admission, with monitoring system in progress • Daily data validation process for Sit Rep			

8. Secure adequate access to laboratory support as appropriate				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
	signoff and external reporting			
• Screening for other potential infections takes place	• Other routine admission screening (CPE, MRSA, VRE) in place			
• that all emergency patients are tested for COVID-19 on admission	• All patients being admitted to the Trust have Covid admission tests taken in ED • POCT (Abbot ID Now) testing introduced in ED			
• that those inpatients who go on to develop symptoms of COVID-19 after admission are retested at the point symptoms arise	• Covid is considered as a differential diagnosis for inpatients developing respiratory symptoms	• A small number of RCA investigation findings identified missed testing opportunities	• Discussion took place at Medical Cabinet to advise timely testing for Covid in patients developing Hospital acquired pneumonia	
• that those emergency admissions who test negative on admission are retested on day 3 of admission, and again between 5-7	• Daily monitoring system in place to achieve full screening compliance for admission, day 3 and day 5 swabs • Weekly screening implemented	RCAs are identifying some routine samples are being missed	• Daily senior nurse oversight to ensure compliance • Electronic systems support identification of patients who have not be screened as per routine testing protocol • Additional control measures put in place to ensure compliance including reminders via daily safety brief, emails to senior staff, electronic monitoring system	

8. Secure adequate access to laboratory support as appropriate				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
days post admission				
• that sites with high nosocomial rates should consider testing COVID negative patients daily	• Community prevalence decreasing 16/04/2021 • Reduced nosocomial case numbers • Increased testing in outbreak areas as advised be the Infection Control Doctor			
• that those being discharged to a care home are being tested for COVID-19 48 hours prior to discharge (unless they have tested positive within the previous 90 days) and result is communicated to receiving organisation prior to discharge	• Discharge screening in place with results shared accordingly prior to patient discharge			
• that those being discharged to a care facility within their 14 days isolation period	• Named community facility for care of patients who require continued isolation for Covid-19			

8. Secure adequate access to laboratory support as appropriate				RAG
Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions	
should be discharged to a designated care setting, where they should complete their remaining isolation				
• that all Elective patients are tested 3 days prior to admission and are asked to self-isolate from the day of their test until the day of admission	• Elective admission screening in place with results viewed prior to admission			

9. Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections				RAG
Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions	
Systems and processes are in place to ensure that:				
• Staff are supported in adhering to all IPC policies, including those for other alert organisms	• PPE Champions in place • Clinical advice for management of patients with suspected infections continued • IPC 7 day and on call service to provide advice			

9. Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure that:				
	• PPE donning and doffing included in Induction and Mandatory training sessions			
• Any changes to the PHE national guidance on PPE are quickly identified and effectively communicated to staff	• Subscription and daily review of Gov.UK email updates. Covid-19 Policy is updated as updates are received (currently version 7). TWSB and Covid daily Bulletin used to communicate updates	Update required to include pathway guidance in line with latest guidance	• Subscription and daily review of Gov. UK email updates • Control Room inbox is monitored 7 days per week and guidance issued over the weekend- out or of hours is escalated for action • Additional posters ordered Links to PHE videos are available on the Trust Hub and distributed • Meeting held with Critical Care to review PPE levels (15/04/21)	
• All clinical waste and linen/laundry related to confirmed or suspected COVID-19 cases is handled, stored and managed in accordance with current national guidance	• Guidance included in Covid-19 Policy. Early guidance adhered to when initial classification of a HCID. Waste was quarantined and disposed of by incineration • Guidance included in the Coronavirus Policy • Used linen is processed as infected via red alginate stitched bag stream			

9. Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure that:				
• PPE stock is appropriately stored and accessible to staff who require it	• Stock control in place • In and out of hours access protocol in place • Specialist PPE equipment office with access available 7 days/week			

10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Appropriate systems and processes are in place to ensure:				
• Staff in 'at-risk' groups are identified using an appropriate risk assessment tool and managed appropriately including ensuring their physical and wellbeing is supported	• An integrated risk assessment has been produced for staff who are 'extremely vulnerable', at 'increased risk', pregnant and Black, Asian and Minority Ethnic (BAME) staff. For BAME staff, based on the number of BAME staff recorded on ESR, there is 93.5% compliance. All BAME staff risk assessments will be quality checked and a sample audit will take place in July 2020 to ensure agreed actions have been undertaken • Chief People Officer and Chief Executive Officer and Chairman attended the BAME Staff Network			

10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Appropriate systems and processes are in place to ensure:				
	Group in June 2020 to receive feedback • Individual letters have been sent to BAME members of staff, outlining support available • Named midwife contact within Maternity Department provided for pregnant staff • All staff who are considered clinically extremely vulnerable are supported by robust workforce support and the Trust are in the process of having one to one discussion to agree support and adjustments • All staff working at home have been provided with a 'working from home pack', including access to mental health support • Enhanced Occupational Health Service to 7 days per week with additional staffing both administration and clinical • An enhanced wellbeing offer has been developed, linked to learning from Wuhan, Italy and the British Psychological Society • Electronic system in place for Covid-19 Workforce risk assessment			

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

10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Appropriate systems and processes are in place to ensure:				
	• An accredited Fit2Fit company or the Department of Health virtual training provided staff training			
• All staff required to wear an FFP respirator have been fit tested for the model being used and this should be repeated each time a different model is used	• Programme of Fit Testing in place • Compliance with Fit testing is monitored. Paper submitted to QAC in February 2021			
• A record of the fit test and result is given to and kept by the trainee and centrally within the organisation	• Spreadsheet with Fit testing details included	• Data not held on ESR	• Action in place to review use of ESR for recording Fit Testing records	
• For those who fail a fit test, there is a record given to and held by trainee and centrally within the organisation of repeated testing on alternative respirators and hoods	• Spreadsheet with Fit testing details included	• Data not held on ESR	• Action in place to review use of ESR for recording Fit Testing records	
• For members of staff who fail to be adequately fit tested a discussion should be had, regarding re	• Alternative respiratory protection is offered i.e. powered hood • Staff are redeployed to green pathway areas or amber areas			

10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Appropriate systems and processes are in place to ensure:				
deployment opportunities and options commensurate with the staff members skills and experience and in line with nationally agreed algorithm	where aerosol generating procedures are not performed • Provision of specialist PPE equipment is recorded including advice on decontamination of re-usable PPE			
• A documented record of this discussion should be available for the staff member and held centrally within the organisation, as part of employment record including Occupational Health	• Provision of specialist PPE equipment is recorded	• Documented evidence of discussion and central holding of this record	• Process under review to capture this data	
• Following consideration of reasonable adjustments e.g. respiratory hoods, personal reusable FFP3, staff who are unable to pass a fit test for an FFP respirator are redeployed using the nationally agreed algorithm and a record	• Provision of specialist PPE equipment is recorded	• Documented evidence of discussion and central holding of this record	• Process under review to capture this data	

10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Appropriate systems and processes are in place to ensure:				
kept in staff members personal record and Occupational health service record				
• Boards have a system in place that demonstrates how, regarding fit testing, the organisation maintains staff safety and provides safe care across all care settings. This system should include a centrally held record of results which is regularly reviewed by the board	• Spreadsheet with Fit testing details included • Compliance with Fit testing is monitored. Paper submitted to QAC in February 2021	• Data not held on ESR	• Action in place to review use of ESR for recording Fit Testing records • Information on Fit testing figures is reported at Tactical meetings and included at Senior Executive Oversight Group Meetings • Report to QAC 02/2021	
• Consistency in staff allocation is maintained, with reductions in the movement of staff between different areas and the cross-over of care pathways between planned/elective care pathways and urgent/ emergency care	• Staffing reviews undertaken for all COVID areas • Staff movements managed by the senior nursing team at daily meetings • Senior Nurse presence 7 days per week 8am-8pm to support staffing management • Planned elective areas have designated teams, who are not moved to any other area in the Trust			

10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Appropriate systems and processes are in place to ensure:				
pathways, as per national guidance	• Where it is necessary to move staff between different areas to support patient safety, this is discussed with the Infection Control Team. This cross over has not occurred between Elective and Emergency Care pathways			
• All staff adhere to national guidance on social distancing (2 metres) wherever possible, particularly if not wearing a facemask and in non-clinical areas	• Signage in place along corridors to socially distance, keep left and walk in single file • Risk assessments of all areas to achieve Covid-19 Secure spaces • IPC Team and/or Health and Safety Team review where concerns have been raised	• Compliance in office spaces	• Non -clinical area daily action card in development	
• Health and care settings are COVID-19 secure workplaces as far as practical, that is, that any workplace risk(s) are mitigated maximally for everyone	• Risk assessment in place to reduce risk • Agile working policy includes home working			
• Staff are aware of the need to wear facemask when moving through COVID-19 secure areas	• Guidance on PPE distributed by email, PPE booklet, posters			
• Staff absence and well-being are monitored	• Managers have been supported to record absence in 'real time'. Daily			

10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Appropriate systems and processes are in place to ensure:				
and staff who are self-isolating are supported and able to access testing	and weekly absence reporting is in place • Data reported to Tactical meetings			
• Staff that test positive have adequate information and support to aid their recovery and return to work	• A COVID-19 Occupatinal Health advice line has been created, to provide a range of advice and guidance to the workforce • The OH Service has also developed the co-ordination and advice service for staff testing (for symptomatic staff) • Enhanced Occupational Health Service to 7 days per week with additional staffing both administration and clinical • Occupational Health and Wellbeing advise staff of test results and provide further wellbeing support as and when required • Retesting is in place as appropriate and is set out in Staff Testing SOP	• Test and Trace Service hours of operation	• National guidance for 16 hour per day service (cover in place for 11.5 hours per day) • Notifications from Test and Trace are received in the Control Room and forwarded to the Occupational Health and Infection Control Teams for action	

3) ACTIONS REQUIRED/RESPONSIBLE OFFICER

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

4) IMPACT ON QPS?

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

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

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

5) MEASUREMENTS/EVALUATIONS

- Incident reporting
- IPC BAF Action plan monitoring
- Environmental Action Plan monitoring

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

Warrington and Halton Teaching Hospitals NHS Foundation Trust

APPENDIX ACTION PLAN for IPC BAF

Ref No	Action required	Target 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	Audit compliance with infection risk assessment completion in Lorenzo	May 21			ADIPC	IT		
2	Audit non-clinical area compliance with mitigation identified in risk assessments. Develop daily action card for non-clinical areas to be developed	May 21			ADIPC			
3	Improve compliance with level 2 IPC training.	May 21		Three additional training sessions per week are being provided	IPCN	ACNs Planned & Unplanned Care	Currently less than 80% compliance	
4	Update Signage aligned to Every Action Count resources	May 21		Agreement for roll out with DIPC and Communications Team	DIPC Interim Communications Lead	ADIPC		
5	Revision to Trust Covid-19 Policy – updated national guidance 16/04/21	May 21			ADIPC	CMMs		
Criterion 2 Provide and maintain a clean and appropriate environment								
6	Training of core group of staff to use the HPV decontamination machines	May 21		Provision of training by the supplier	ADE	DCN IPCNs DCN	Training provided to Warrington site task team members	
Criterion 3 Ensure appropriate antimicrobial use to optimise patient outcomes – Nil actions identified								
Criterion 4 Provide suitable and accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/medical care in a timely fashion– Nil actions identified								

Ref No	Action required	Target 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								
7	Confirmation that Triage in ED includes questions on travel to countries with variant SARS-CoV-2 strains	May 21		Draft triage template provided for implementation	AC/ SR/ SFD	CMM	SOP updated by IPC Team, Awaiting evidence of triage documentation from ED Team	
8	Template to be implemented and shared with all appropriate staff	May 21		Education of all staff on the revised Covid-19 triage process	AC/ SR/ SFD	CMM	Example template shared with ED	
9	SOP to support decision making in relation to provision of treatment where patients are unable or refuse to wear a face mask	May 21			ADG	ADIPC	Decision taken at individual department level Datix completed when patients refuse to wear a mask	
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								
10	Education on Covid-19 PPE for staff returning to work, including after pregnancy, clinically extremely vulnerable or long-term sick leave	May 21		Awaiting Occupational Health guidance. Clinical areas not classed as Covid secure.	ADIPC	ACNs Unplanned & Planned Care Groups	Clinically extremely vulnerable staff are currently excluded from the workplace	
Criterion 7 Provide or secure adequate isolation facilities – Nil actions identified								
Criterion 8 Secure adequate access to laboratory support as appropriate								
11	Daily swabbing compliance review to ensure compliance with Day of admission, Day 3 and Day 5 and weekly Covid screening	May 21			ADIPC	IPC Admin	Work in progress to align data on outstanding swabs on the BI LION report and E-outcome	
Criterion 9 Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections – Nil Concerns								
Criterion 10 Have a system in place to manage the occupational health needs and obligations of staff in relation to infection								

Ref No	Action required	Target date	Date met	Supporting action	Lead	Supported by	Evidence/ Current position	RAG status
12	Centralised records of FFP3 Fit Testing	May 21		Add records to ESR	DCN Patient Safety	DCPO	Spreadsheet includes all staff records	
13	Documented (centrally held records) process for supporting staff who fail fit testing including redeployment options. Records should be held centrally of discussions with employees	May 21			DCPO		Alternative respiratory protection (powered hoods). Redeployment Hub established for vulnerable staff	

RAG Legend	
Action not commenced	
Action in progress	
Action completed	

Key Personnel

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

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/21/05/81**	
SUBJECT:	**Infection Prevention and Control**	
DATE OF MEETING:	26 May 2021	
AUTHOR(S):	Lesley McKay, Associate Chief Nurse, Infection Prevention + Control	
EXECUTIVE DIRECTOR SPONSOR:	Kimberley Salmon-Jamieson, Chief Nurse + Deputy Chief Executive	
LINK TO STRATEGIC OBJECTIVE:	SO1 We will.. Always put our patients first through high quality, safe care and an excellent patient experience.	√
	SO2 We will.. Be the best place to work with a diverse, engaged workforce that is fit for the future.	√
	SO3 We will.. Work in partnership to design and provide high quality, financially sustainable services.	√
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): **(*Please DELETE as appropriate)***	#1124 Failure to provide adequate PPE caused by failures within the national supply chain and distribution routes resulting in lack of PPE for staff. #1134 Failure to provide adequate staffing caused by absence relating to COVID-19 resulting in resource challenges and an increase within the temporary staffing domain. #125 Failure to maintain an old estate caused by restriction, reduction or unavailability of resources resulting in staff and patient safety issues, increased estates costs and unsuitable accommodation.	
EXECUTIVE SUMMARY (KEY ISSUES):	This report provides a summary of infection prevention and control activity for Quarter 4 (Q4) of the 2020/21 financial year and highlights the Trust's progress against infection prevention and control key performance indicators. National healthcare associated infection reduction targets were not set for 2020/21. In Q4 the Trust reported: - • 9 Clostridium difficile cases • Nil MRSA bacteraemia cases • 2 MSSA bacteraemia cases • 9 E. coli bacteraemia cases • 5 Klebsiella spp. cases • 4 P. aeruginosa cases Covid-19 cases were detected: - • 732 (0-2 days) • 63 (3-7 days) • 73 (8-14 days – probable healthcare associated) • 59 (15+ days – definite healthcare associated) 8 Covid-19 outbreaks occurred: - • 2 patient outbreaks • 6 combined staff/patient outbreaks Outbreak Control Groups were established to manage the Covid-19 outbreaks and learning has been shared Trust wide.	

PURPOSE: (please select as appropriate)	Information	Approval	To note √	Decision
RECOMMENDATION:	The Board is asked to note the contents of the report.			
PREVIOUSLY CONSIDERED BY:	**Committee**		Quality Assurance Committee	
	Agenda Ref.		QAC/21/05/131	
	Date of meeting		4 May 2021	
	Summary of Outcome		Noted	
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None			

SUBJECT	Infection Prevention and Control Q2 report 2020/21	Agenda Ref:	BM/21/05/81

1. BACKGROUND/CONTEXT

This report provides an overview of infection prevention and control activity for Quarter 4 (Q4) of the 2020/21 financial year (FY). The report highlights the Trust's progress against Healthcare Associated Infection (HCAI) reduction targets and the response to the Covid-19 Pandemic.

NHSE/I use Clostridium difficile infection rates as one of a number of metrics to assess Trust performance. Both avoidable and unavoidable cases are taken into account for regulatory purposes. The Trust is assessed for breaches of the Clostridium difficile objective using a cumulative year to date (YTD) trajectory.

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

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

From the start of Q2 apportionment of bacteraemia cases (Gram positive and Gram negative) changed to include community onset healthcare associated cases (patients discharged within 28 days of positive sample being taken). Data from Q2 (onwards) has been amended to include these cases.

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

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

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

2. KEY ELEMENTS

HCAI data

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

Table 1: HCAI data by month

Indicator	Target	Position	A	M	J	J	A	S	O	N	D	J	F	M	Total
C. difficile	Local ≤44	Over trajectory	5	4	2	6	5	4	6	2	2	3	2	4	45
MRSA bacteraemia	Zero tolerance	Over trajectory	0	0	0	0	0	1	0	0	0	0	0	0	1
MSSA bacteraemia	No target	No target	1	2	0	6	1	2	2	3	3	2	0	2	24
E. coli bacteraemia	Key priority	Denominator change	2	2	5	1	7	6	4	4	5	0	3	6	45
Klebsiella spp. bacteraemia	Key priority	Denominator change	0	0	1	2	2	1	2	2	1	1	1	3	16
P. aeruginosa bacteraemia	Key priority	Denominator change	0	0	1	0	0	0	1	1	0	0	3	1	7

HCAI data for Q4

Clostridium difficile

- 9 hospital onset/ healthcare associated cases reported
- 45 cases reported for the FY – 1 case over the locally set threshold
- All hospital apportioned cases undergo post infection review
- RCA review meetings have commenced in Q4
- Ribotyping of all hospital onset/healthcare associated and community onset/ healthcare associated cases has not identified any links between the toxin positive cases

Bacteraemia Cases

From the start of Q2 apportionment of bacteraemia cases changed to include community onset/healthcare associated cases (patients with a prior hospital admission and positive sample taken within 28 days). This change in denominator makes comparison against previous performance difficult and increases the challenge for acute Trusts to meet the national reduction target.

Gram positive bacteraemia

Meticillin resistant Staphylococcus aureus (MRSA) bacteraemia

- Nil cases reported in Q4
- 1 case reported for the FY

Meticillin sensitive Staphylococcus aureus MSSA bacteraemia

- 4 cases reported in Q4
    - 3 hospital onset/healthcare associated
    - 1 Community onset/healthcare associated
- 24 cases reported for the FY

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

- 7 unknown
- 6 skin and soft tissue infection
- 4 pneumonia
- 3 peripheral cannula associated
- 2 urinary tract infection
- 2 septic arthritis

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

Gram negative bacteraemia (GNBSI)

E coli bacteraemia

- 9 cases reported in Q4
    - 6 hospital onset/healthcare associated
    - 3 Community onset/healthcare associated
- 45 cases reported for the FY

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

- 3 Gastrointestinal collection
- 2 genital system
- 11 hepatobiliary
- 4 lower respiratory tract infections
- 16 lower urinary tract infections
- 8 unknown sources
- 1 upper urinary tract infection

Klebsiella Spp.

- 5 cases reported in Q4
    - 3 hospital onset/healthcare associated
    - 2 Community onset/healthcare associated
- 16 cases reported for the FY

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

- 1 Gastrointestinal collection
- 1 hepatobiliary
- 3 intravascular devices
- 1 lower respiratory tract infections
- 6 lower urinary tract infections
- 3 unknown sources
- 1 upper urinary tract infection

Pseudomonas aeruginosa

- 4 cases reported in Q4
    - 3 hospital onset/healthcare associated
    - 1 Community onset/healthcare associated
- 7 cases reported for the FY

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

- 1 hepatobiliary
- 2 lower respiratory tract infections
- 2 lower urinary tract infections
- 1 unknown source
- 1 upper urinary tract infection

The GNBSI Prevention Group meetings are scheduled to meet in April 2021. Supported by the Quality Academy work will recommence to reduce the incidence of these infections using the breakthrough series collaborative model.

Comparative data on HCAI cases and rates across the Northwest is included in appendix 2. Appropriate comparison with similar organisations shows:

- Slightly higher case numbers compared to Local Delivery System (LDS) partners for Clostridium difficile
- Publication of comparative data by PHE is awaited for all bacteraemia cases in Q4

Outbreaks/Incidents

Scabies

In February a patient on ward B3 Halton site was diagnosed with Norwegian scabies by a Dermatologist. The patient was admitted from a Residential Home. Two members of staff reported rashes and were reviewed by their GPs who reported scabies unlikely. Outbreak meetings were held and due to the highly infectious nature of Norwegian Scabies, a decision taken to carryout mass treatment of all staff and patients on the ward. All patients on the ward and staff are being closely monitored for development of rash illness for a six-week period from detection of the index scabies case.

Pseudomonas

From January 2021 an increase in *Pseudomonas aeruginosa* cases was detected in Critical Care. Typing has identified 2 distinct clusters: -

- 3 patients with isolates from sputum samples with the same typing result
- 1 patient with the same typing result as a water outlet (but distinct from the 3 cases above)

The outbreak has been notified to Public Health England and investigations are in progress to identify potential sources. Repeat water sampling of all water outlets has been arranged and auditing of transmission risk related activity has commenced.

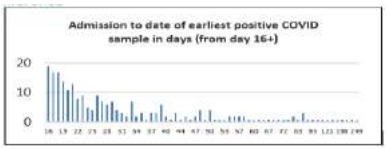
Covid-19

An increase in the local incidence of Covid-19 was observed from mid-January. Cases detected in Q4 were identified as detailed below: -

- 732 (0-2 days)
- 63 (3-7 days)
- 73 (8-14 days – probable healthcare associated)
- 59 (15+ days – definite healthcare associated)

Cases from April 2020 are shown in Appendix 3. All cases detected ≥ day 8 of admission undergo root cause analysis (RCA). Learning from the review of RCA reports identified several themes as identified in the table below.

Table 2 Themes from RCA Investigations

Contributory factors	Context	Action to address	RAG
Length of stay and multiple ward moves	 • medically fit patients awaiting social input • complex care requirements e.g. critical care • patient moves to create operational capacity	• Patient Flow Oversight Group established to review patient pathways • Length of stay group working with the QI Team on discharges	

Contributory factors	Context	Action to address	RAG
Missed swabbing opportunity	• Patients developing symptoms of hospital acquired pneumonia/Covid-19 specific symptoms	• Infection Control Doctor has tabled this for discussion at Medical Cabinet to highlight consideration to test any patient developing respiratory symptoms for Covid. Medical Leads to be agreed to take this forward	
Missed screening samples day 3 and day 5	• National guidance to screen on admission, day 3 and then between day 5 -7. Trust standard set to screen on admission, day 3 and day 5 • Admission screen missed (19) • Day 3 screen missed (66) • Day 5 screen missed (187) • Day of admission is taken as day 1 (as per national guidance) and this has caused confusion with due date of swabs. Some swabs taken on day 4 and day 6 or 7 and some swabs omitted • Unidentified cases in a shared bay risks exposing other patients to Covid-19 infection	• Senior nursing oversight daily to review all inpatients to ensure required swabs are taken according to agreed timescales • IT solutions implemented using E-outcome and the BI reporting system • NHSE/I contacted to obtain comparative data on nosocomial cases. Verbal reports at Northwest network meetings have highlighted some Trusts count day of admission as day 0 (not day 1 as per advised reporting standard), which will impact figures • A paper will be submitted to the Executive team outlining these issues	
Occasional PPE non-compliance	• Audit programme in place for both aerosol and non-aerosol generation procedures • Issues reported mainly relate to face mask not covering the nose and mouth	• Peer support to adjust PPE for their own safety in addition to that of others • New Communications campaign using the NHSE/I every action counts toolkit • Infection Control will be a key priority in the Nursing and Midwifery Strategy 2021/23 	
Decrease in nursing cleaning scores	• Cleaning audits show common items requiring cleaning including the Resuscitation PPE storage box and observation machines	• Cleaning of the PPE storage box added to my kit check list • Cleaning campaign for high touch items refreshed • Housekeepers accompany auditors to timely action cleaning audit findings • Reintroduce Infection Control Audit schedule • Restart of Ward Accreditation Scheme • Clinical Area Action Cards introduced for daily check	

Learning from Trust Outbreaks

Outbreak Control Groups are set up to investigate clusters of Covid-19 cases.

During Q4, 8 Covid-19 outbreaks were reported: -

- 2 outbreaks affecting patients
- 6 outbreaks affecting both staff and patient

Themes emerging from investigation of outbreaks include: -

- Possible missed opportunity to test – hospital acquired pneumonia (HAP)
- Multiple ward moves
- Having positive and negative patients on the same ward
- Missed day 3 and day 5 swab
- Occasional concerns with compliance with PPE
- Length of stay
- Covid-19 exposure in a bay

Next steps include: -

- Increase uptake of Lateral Flow Testing/LAMP for staff
- Continue to provide and reinforce updates on Covid-19 IPC precautions
- Continue review and thematic analysis of RCAs from nosocomial cases
- Staff vaccination programme completion

The additional hydrogen peroxide vapour machines for environmental decontamination have been put in to use to ensure appropriate levels of decontamination are achieved.

The Infection Prevention and Control Team members continued to provide education and road shows where staff raised concerns about PPE guidance. The programme of Fit Testing of FFP3 respirators has continued.

The risk assessment to support the re-introduction of visiting has been recirculated in preparation for lockdown restrictions being lifted. Compassionate visiting arrangements remain in place and visitors are supported with training on use of PPE.

The procurement team continue to provide an extended service and have maintained availability of personal protective equipment throughout the pandemic. PPE stock levels remains under constant review. Mutual aid from other Trust is in place. Scrub Suits continue to be offered as an alternative to home laundering of uniforms. A national managed inventory has been implemented to ensure Trusts have a 7 - 14 days supply (dependant on storage capacity). Additional steps with quality control have been taken at national level.

The Environmental Action Plan produced jointly with Infection Prevention and Control, the Associate Director of Estates and Facilities and the Deputy Chief Nurse for Patient Safety has been updated. This action plan incorporates a number of other actions including: reduction of entrances/exits, signage promoting social distancing, Perspex barriers at reception desks, ensuring high standards of cleanliness and risk assessments to create Covid secure areas for staff. A risk assessment tool has been implemented across the Trust.

NHSE/I have published an update to the Board Assurance Framework (version 1.5) linked to the Code of Practice on prevention of Healthcare Associated Infections. The Trust compliance has been reassessed and a detailed paper submitted to the Quality Assurance Committee and Trust Board. An action plan has been developed to support minor gaps in assurance.

Infection Prevention and Control Training

Overall compliance with Mandatory training was 85% in March 2021.

Table 3 Infection Control Training compliance

Infection Control Training	A	M	J	J	A	S	O	N	D	J	F	M
Overall % of staff trained	-	84%	-	-	85%	-	-	-	84%		82%	85%

Level 2 (clinical training) is 78% in March 2021. Face to Face mandatory infection control training was halted due to the pandemic and will recommence as part of the recovery schedule. All Clinical Business Units have been requested to set an improvement trajectory. The Infection Prevention and Control Nurses are providing 3 additional virtual training sessions per week to drive improved compliance.

Infection Prevention and Control Audits

The IPCN audits were halted due to the Covid-19 pandemic and will recommence as part of the recovery schedule. Auditing of hand hygiene and Personal Protective Equipment (PPE) compliance for both aerosol generating and non-aerosol generating procedures is in place across the Trust with nil significant issues highlighted.

Environmental Hygiene

The frequency of cleanliness monitoring has been increased in areas where outbreaks of Covid-19 have been reported. Activity in place pre pandemic to implement the recommendations of the draft National Standards of Healthcare Cleanliness document will recommence as part of the recovery schedule. Hydrogen peroxide vapour has been used to support terminal cleaning and increased following the purchase of additional equipment.

Antibiotic Point Prevalence Audit

The point prevalence prescribing audit carried out in February. Summary findings include:

- 88% compliance with the Trust Formulary (below the internal compliance standard of 90%)
- 11 wards were 100% compliant with the formulary
- 26 patients were prescribed antibiotics non-compliant with the formulary
- 4 patients did not have indication for antimicrobials documented

Several concerns/areas for improvement were identified including: -

- CURB score not documented
- Co-amoxiclav use in elderly patients and Clostridium difficile risk
- Duration of antibiotics for Urinary Tract Infections (UTI)
- Increase in prescribing UTI prophylaxis
- Dual antibiotic cover e.g. Metronidazole prescribed with Tazocin
- Covid-19 Group not documented

Next steps include: -

- Promotion of antimicrobial review standards
- Desktop location of the antibiotic formulary to be highlighted to all locum medical staff
- Antibiotic Ward Round activity focus on areas with high prescribing and or low compliance
- Escalation of prescribing concerns from ward Pharmacists to the Lead Pharmacist in Antimicrobial Stewardship
- Feedback of audit findings to Medical Cabinet and CBU Governance Meetings in addition to individual prescribers

Awareness raising events

The Infection Prevention and Control Team have focussed awareness raising activity throughout Q4 on Covid-19.

3. ACTIONS REQUIRED/RESPONSIBLE OFFICER

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

4. IMPACT ON QPS

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

5. MEASUREMENTS/EVALUATIONS

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

6. TRAJECTORIES/OBJECTIVES AGREED

- The Clostridium difficile threshold for 2020/2021 has been set locally at ≤ 44 cases
- There is a national GNBSI target of 25% reduction by 2021/2022 and the full 50% reduction by 2024. A 25% GNBSI reduction target has been set as a priority within the Quality Strategy for 2021/22
- The zero tolerance to avoidable MRSA bacteraemia cases remains in place

Work streams will continue to:-

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

- Implement a recovery plan to review overdue policies

7. MONITORING/REPORTING ROUTES

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

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

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

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

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

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

Daily monitoring by the Senior Executive Oversight Group during the pandemic

8. TIMELINES

- 2020/21 FY

9. ASSURANCE COMMITTEE

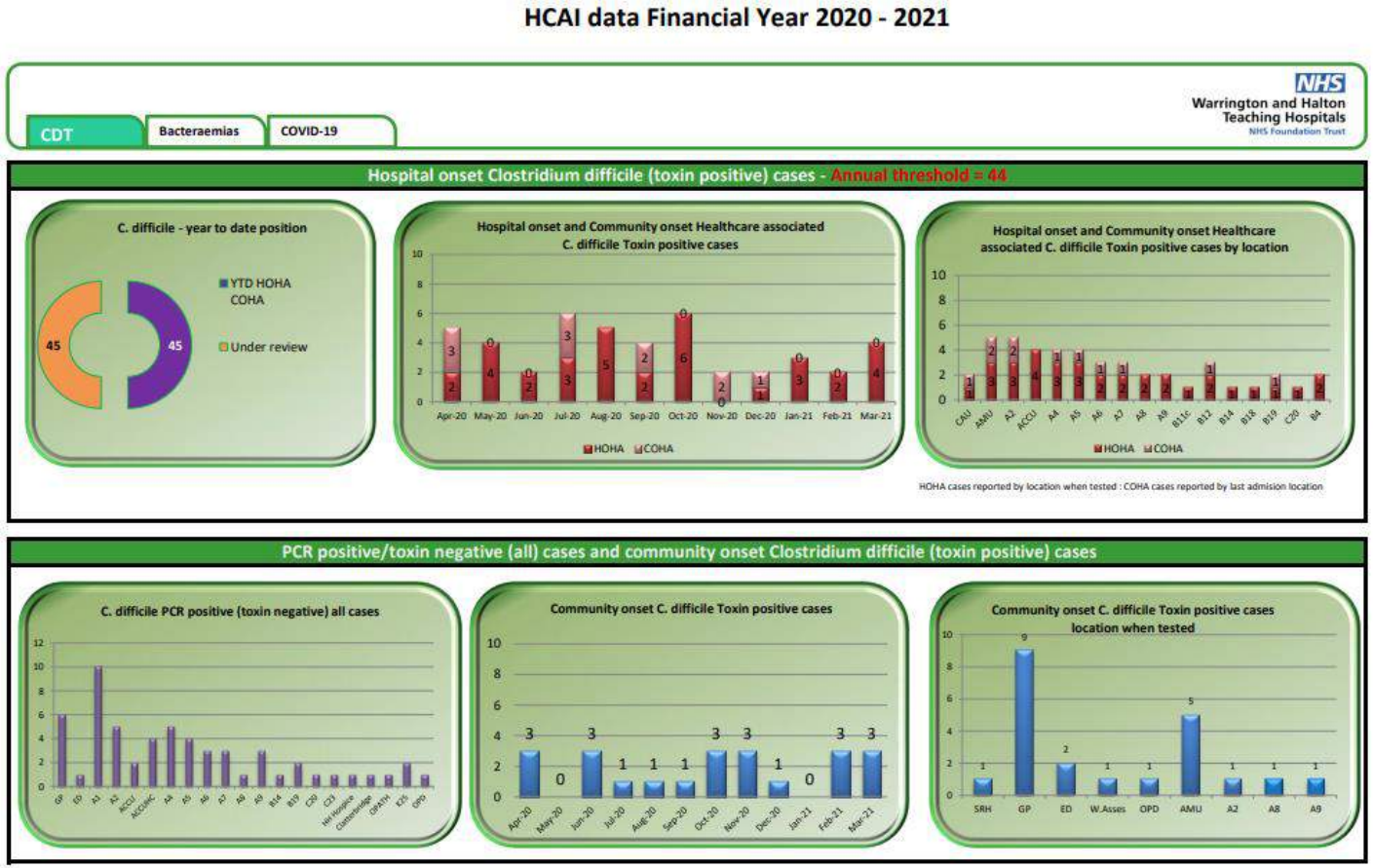
- Infection Control Sub-Committee

10. RECOMMENDATIONS

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

APPENDIX 1 Healthcare Associated Infection Data April 2020 - March 2021

Clostridium difficile Cases

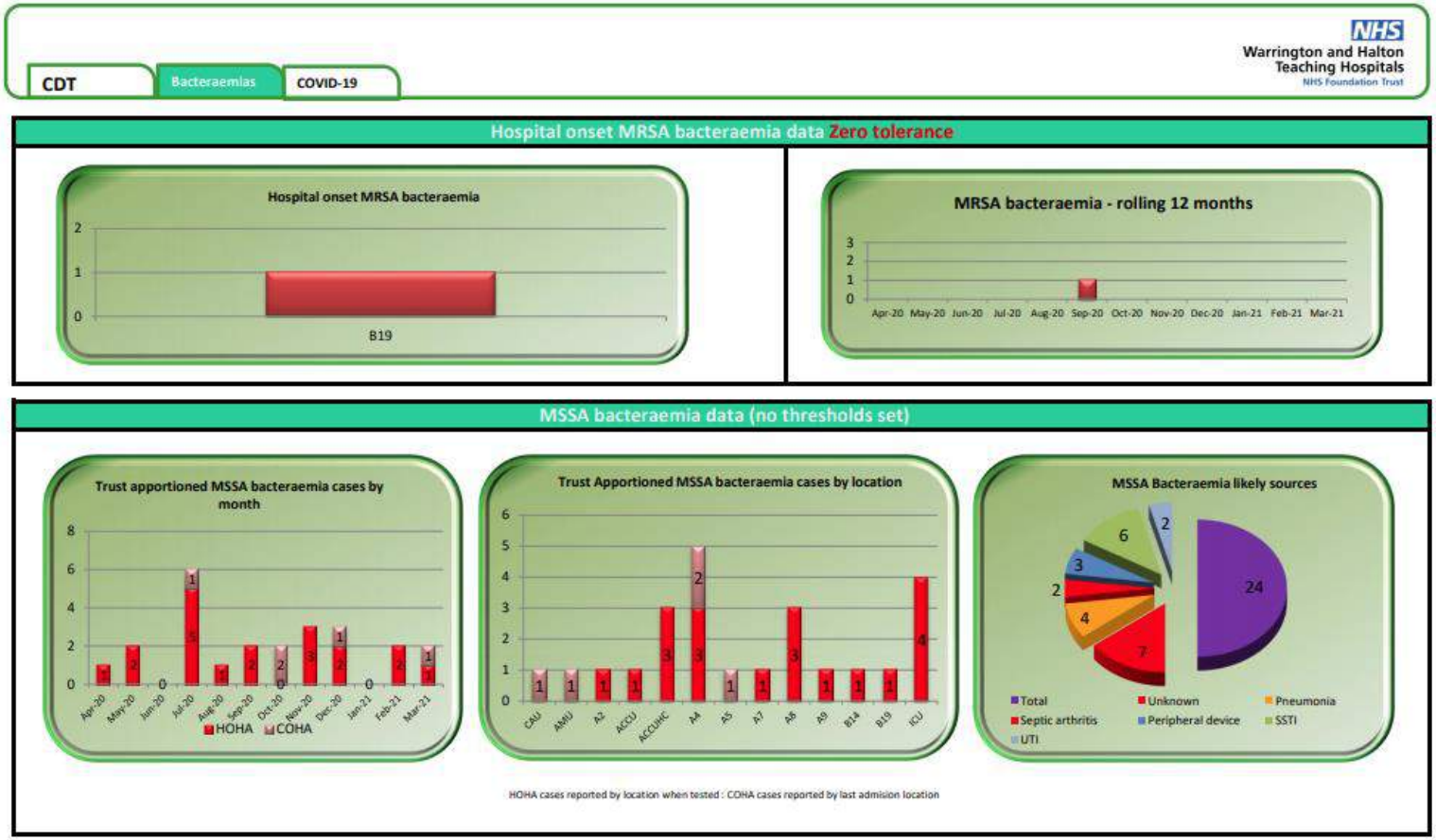


Hospital onset/Healthcare associated = HOHA
Community onset/Healthcare assocaiated = COHA
Community onset/Healthcare associated cases are linked to the ward the patient was most recently discharged from

Apr 2020 - Mar 2021

Gram Positive Bacteraemia Cases

HCAI data Financial Year 2020 - 2021



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Community onset/Healthcare associated cases are linked to the ward the patient was most recently discharged from

April 2020 - March 2021

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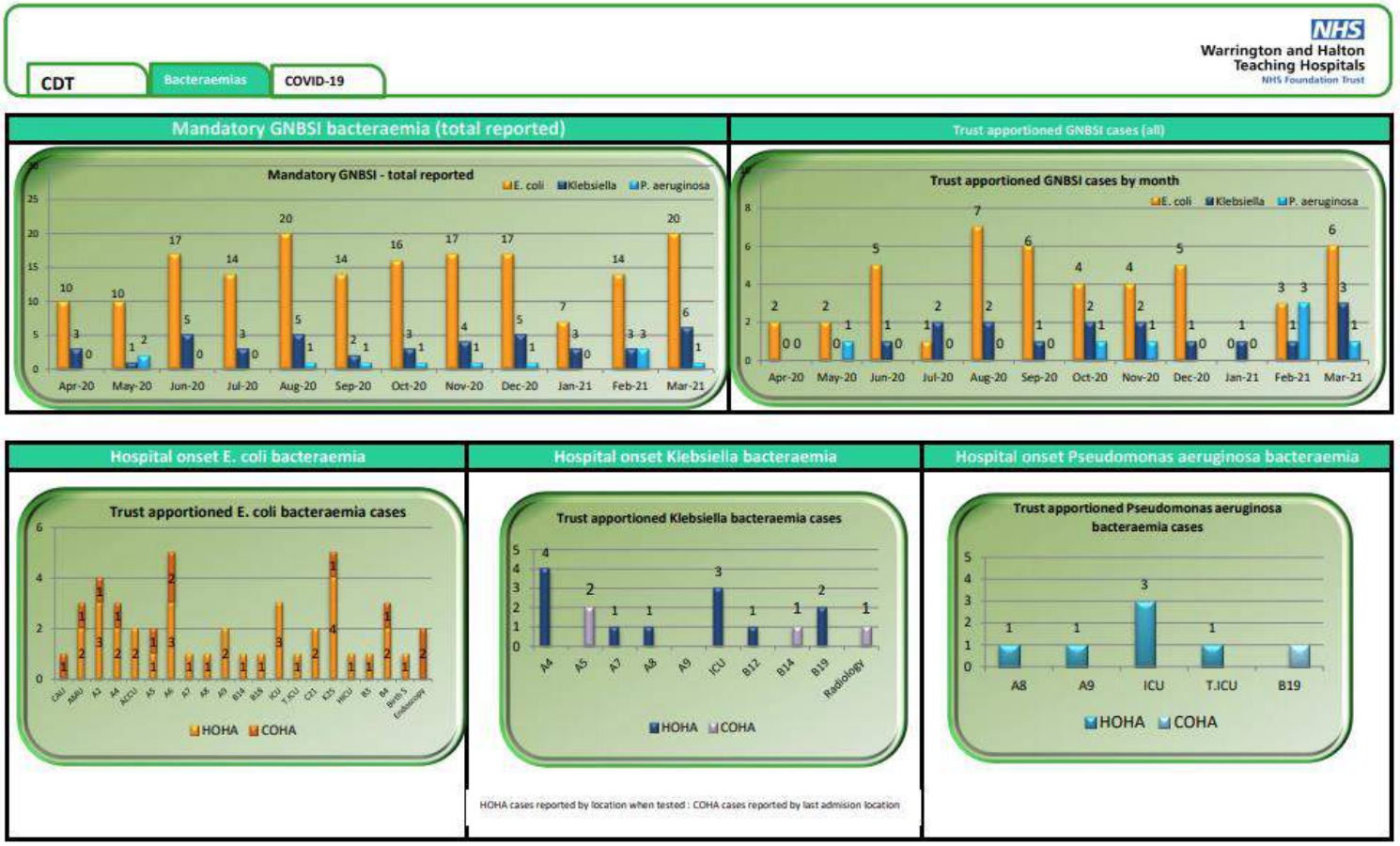
Gram Negative Bacteraemia Cases

HCAI data Financial Year 2020 - 2021



Hospital onset/Healthcare associated = HOHA
Community onset/Healthcare assocaiated = COHA
Community onset/Healthcare associated cases are linked to the ward the patient was most recently discharged from

April 2020 - March 2021

APPENDIX 2 COMPARISION OF HEALTHCARE ASSOCIATED INFECTION DATA ACROSS THE NORTHWEST

Clostridium difficile (March 2020 to February 2021)

Public Health England

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

Organisation Name	March 2020 to February 2021	Rate per 100,000 bed days	Significance
ALDER HEY CHILDREN'S NHS FOUNDATION TRUST	4	7.8	Low (0.001)
BLACKPOOL TEACHING HOSPITALS NHS FOUNDATION TRUST	91	46.2	High (0.001)
BOLTON NHS FOUNDATION TRUST	53	28.3	
COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST	41	26.4	
EAST CHESHIRE NHS TRUST	8	8.8	Low (0.001)
EAST LANCASHIRE HOSPITALS NHS TRUST	72	27.8	
LANCASHIRE TEACHING HOSPITALS NHS FOUNDATION TRUST	104	46.6	High (0.001)
LIVERPOOL HEART AND CHEST HOSPITAL NHS FOUNDATION TRUST	4	11.7	Low (0.025)
LIVERPOOL WOMEN'S NHS FOUNDATION TRUST	0	0.0	
LIVERPOOL UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	110	24.6	
MANCHESTER UNIVERSITY NHS FOUNDATION TRUST	169	32.4	
MID CHESHIRE HOSPITALS NHS FOUNDATION TRUST	22	13.9	Low (0.001)
NORTH CUMBRIA INTEGRATED CARE NHS FOUNDATION TRUST	72	42.8	High (0.025)
PENNINE ACUTE HOSPITALS NHS TRUST	89	26.8	
SALFORD ROYAL NHS FOUNDATION TRUST	45	20.1	Low (0.025)
SOUTHPORT AND ORMSKIRK HOSPITAL NHS TRUST	37	31.4	
ST HELENS AND KNOWSLEY TEACHING HOSPITALS NHS TRUST	42	19.2	Low (0.025)
STOCKPORT NHS FOUNDATION TRUST	26	15.3	Low (0.001)
TAMESIDE AND GLOSSOP INTEGRATED CARE NHS FOUNDATION TRUST	30	26.6	
THE CHRISTIE NHS FOUNDATION TRUST	35	77.6	High (0.001)
THE CLATTERBRIDGE CANCER CENTRE NHS FOUNDATION TRUST	5	27.3	
THE WALTON CENTRE NHS FOUNDATION TRUST	3	8.2	Low (0.001)
UNIVERSITY HOSPITALS OF MORECAMBE BAY NHS FOUNDATION TRUST	61	31.3	
WARRINGTON AND HALTON TEACHING HOSPITALS NHS FOUNDATION TRUST	47	29.5	
WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FOUNDATION TRUST	59	29.3	
WRIGHTINGTON, WIGAN AND LEIGH NHS FOUNDATION TRUST	40	29.1	
North West	1269	28.3	

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MRSA – Annual rolling rate (October – December 2020)

MSSA – Annual rolling rate (October – December 2020)

Public Health England

MRSA quarterly tables: Trust cases & rates

Organisation Name	October to December 2020	Rate per 100,000 bed days	Significance
ALDER HEY CHILDREN'S NHS FOUNDATION TRUST	0	0.0	
BLACKPOOL TEACHING HOSPITALS NHS FOUNDATION TRUST	0	0.0	
BOLTON NHS FOUNDATION TRUST	0	0.0	
COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST	0	0.0	
EAST CHESHIRE NHS TRUST	0	0.0	
EAST LANCASHIRE HOSPITALS NHS TRUST	2	2.9	
LANCASHIRE TEACHING HOSPITALS NHS FOUNDATION TRUST	0	0.0	
LIVERPOOL HEART AND CHEST HOSPITAL NHS FOUNDATION TRUST	0	0.0	
LIVERPOOL WOMEN'S NHS FOUNDATION TRUST	1	17.0	
LIVERPOOL UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	0	0.0	
MANCHESTER UNIVERSITY NHS FOUNDATION TRUST	6	4.5	
MID CHESHIRE HOSPITALS NHS FOUNDATION TRUST	0	0.0	
NORTH CUMBRIA UNIVERSITY HOSPITALS NHS TRUST	0	0.0	
PENNINE ACUTE HOSPITALS NHS TRUST	0	0.0	
SALFORD ROYAL NHS FOUNDATION TRUST	2	3.1	
SOUTHPORT AND ORMSKIRK HOSPITAL NHS TRUST	0	0.0	
ST HELENS AND KNOWSLEY TEACHING HOSPITALS NHS TRUST	1	1.7	
STOCKPORT NHS FOUNDATION TRUST	0	0.0	
TAMESIDE AND GLOSSOP INTEGRATED CARE NHS FOUNDATION TRUST	0	0.0	
THE CHRISTIE NHS FOUNDATION TRUST	0	0.0	
THE CLATTERBRIDGE CANCER CENTRE NHS FOUNDATION TRUST	0	0.0	
THE WALTON CENTRE NHS FOUNDATION TRUST	0	0.0	
UNIVERSITY HOSPITALS OF MORECAMBE BAY NHS FOUNDATION TRUST	1	1.9	
WARRINGTON AND HALTON TEACHING HOSPITALS NHS FOUNDATION TRUST	0	0.0	
WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FOUNDATION TRUST	0	0.0	
WRIGHTINGTON, WIGAN AND LEIGH NHS FOUNDATION TRUST	1	2.8	
North West	14	1.2	

Public Health England

MSSA quarterly tables: Trust cases & rates

Organisation Name	October to December 2020	Rate per 100,000 bed days	Significance
ALDER HEY CHILDREN'S NHS FOUNDATION TRUST	4	30.4	
BLACKPOOL TEACHING HOSPITALS NHS FOUNDATION TRUST	7	13.0	
BOLTON NHS FOUNDATION TRUST	5	11.0	
COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST	4	9.9	
EAST CHESHIRE NHS TRUST	3	12.9	
EAST LANCASHIRE HOSPITALS NHS TRUST	20	29.3	
LANCASHIRE TEACHING HOSPITALS NHS FOUNDATION TRUST	7	12.8	
LIVERPOOL HEART AND CHEST HOSPITAL NHS FOUNDATION TRUST	7	83.6	
LIVERPOOL WOMEN'S NHS FOUNDATION TRUST	0	0.0	
LIVERPOOL UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	16	13.7	
MANCHESTER UNIVERSITY NHS FOUNDATION TRUST	30	22.4	
MID CHESHIRE HOSPITALS NHS FOUNDATION TRUST	4	9.7	
NORTH CUMBRIA INTEGRATED CARE NHS FOUNDATION TRUST	8	19.2	
PENNINE ACUTE HOSPITALS NHS TRUST	14	16.6	
SALFORD ROYAL NHS FOUNDATION TRUST	12	18.6	
SOUTHPORT AND ORMSKIRK HOSPITAL NHS TRUST	3	10.1	
ST HELENS AND KNOWSLEY TEACHING HOSPITALS NHS TRUST	8	13.8	
STOCKPORT NHS FOUNDATION TRUST	1	2.3	Low (0.001)
TAMESIDE AND GLOSSOP INTEGRATED CARE NHS FOUNDATION TRUST	3	10.7	
THE CHRISTIE NHS FOUNDATION TRUST	3	26.9	
THE CLATTERBRIDGE CANCER CENTRE NHS FOUNDATION TRUST	2	48.3	
THE WALTON CENTRE NHS FOUNDATION TRUST	5	56.0	
UNIVERSITY HOSPITALS OF MORECAMBE BAY NHS FOUNDATION TRUST	6	11.4	
WARRINGTON AND HALTON TEACHING HOSPITALS NHS FOUNDATION TRUST	8	18.7	
WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FOUNDATION TRUST	9	16.8	
WRIGHTINGTON, WIGAN AND LEIGH NHS FOUNDATION TRUST	5	13.8	
North West	194	16.7	

E. coli bacteraemia – Quarterly data (October – December 2020)

Public Health England

E. coli quarterly tables: Trust cases & rates

Organisation Name	October to December 2020	Rate per 100,000 bed days	Significance
ALDER HEY CHILDREN'S NHS FOUNDATION TRUST	1	7.6	Low (0.025)
BLACKPOOL TEACHING HOSPITALS NHS FOUNDATION TRUST	29	54.0	
BOLTON NHS FOUNDATION TRUST	9	19.8	Low (0.025)
COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST	18	44.5	
EAST CHESHIRE NHS TRUST	6	25.8	
EAST LANCASHIRE HOSPITALS NHS TRUST	30	44.0	
LANCASHIRE TEACHING HOSPITALS NHS FOUNDATION TRUST	21	38.4	
LIVERPOOL HEART AND CHEST HOSPITAL NHS FOUNDATION TRUST	4	47.8	
LIVERPOOL WOMEN'S NHS FOUNDATION TRUST	1	17.0	
LIVERPOOL UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	37	31.8	
MANCHESTER UNIVERSITY NHS FOUNDATION TRUST	52	38.8	
MID CHESHIRE HOSPITALS NHS FOUNDATION TRUST	8	19.3	Low (0.025)
NORTH CUMBRIA INTEGRATED CARE NHS FOUNDATION TRUST	26	62.4	
PENNINE ACUTE HOSPITALS NHS TRUST	33	39.0	
SALFORD ROYAL NHS FOUNDATION TRUST	16	24.7	
SOUTHPORT AND ORMSKIRK HOSPITAL NHS TRUST	16	54.0	
ST HELENS AND KNOWSLEY TEACHING HOSPITALS NHS TRUST	22	37.9	
STOCKPORT NHS FOUNDATION TRUST	16	36.5	
TAMESIDE AND GLOSSOP INTEGRATED CARE NHS FOUNDATION TRUST	9	32.0	
THE CHRISTIE NHS FOUNDATION TRUST	11	98.8	High (0.025)
THE CLATTERBRIDGE CANCER CENTRE NHS FOUNDATION TRUST	3	72.5	
THE WALTON CENTRE NHS FOUNDATION TRUST	2	22.4	
UNIVERSITY HOSPITALS OF MORECAMBE BAY NHS FOUNDATION TRUST	26	49.5	
WARRINGTON AND HALTON TEACHING HOSPITALS NHS FOUNDATION TRUST	13	30.3	
WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FOUNDATION TRUST	20	37.4	
WRIGHTINGTON, WIGAN AND LEIGH NHS FOUNDATION TRUST	12	33.1	
North West	441	37.9	

We are WHH & We are PROUD

NHS Warrington and Halton Teaching Hospitals NHS Foundation Trust

Klebsiella bacteraemia - Annual rolling rate (October – December 2020)

Pseudomonas aeruginosa - Annual rolling rate (October – December 2020)

Public Health England

Klebsiella quarterly tables: Trust cases & rates

Organisation Name	October to December 2020	Rate per 100,000 bed days	Significance
ALDER HEY CHILDREN'S NHS FOUNDATION TRUST	2	15.2	
BLACKPOOL TEACHING HOSPITALS NHS FOUNDATION TRUST	9	16.8	
BOLTON NHS FOUNDATION TRUST	4	8.8	
COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST	2	4.9	Low (0.025)
EAST CHESHIRE NHS TRUST	3	12.9	
EAST LANCASHIRE HOSPITALS NHS TRUST	9	13.2	
LANCASHIRE TEACHING HOSPITALS NHS FOUNDATION TRUST	8	14.6	
LIVERPOOL HEART AND CHEST HOSPITAL NHS FOUNDATION TRUST	0	0.0	
LIVERPOOL WOMEN'S NHS FOUNDATION TRUST	1	17.0	
LIVERPOOL UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	13	11.2	
MANCHESTER UNIVERSITY NHS FOUNDATION TRUST	36	26.9	High (0.025)
MID CHESHIRE HOSPITALS NHS FOUNDATION TRUST	3	7.2	
NORTH CUMBRIA INTEGRATED CARE NHS FOUNDATION TRUST	8	19.2	
PENNINE ACUTE HOSPITALS NHS TRUST	11	13.0	
SALFORD ROYAL NHS FOUNDATION TRUST	12	18.6	
SOUTHPORT AND ORMSKIRK HOSPITAL NHS TRUST	4	13.5	
ST HELENS AND KNOWSLEY TEACHING HOSPITALS NHS TRUST	11	18.9	
STOCKPORT NHS FOUNDATION TRUST	6	13.7	
TAMESIDE AND GLOSSOP INTEGRATED CARE NHS FOUNDATION TRUST	7	24.9	
THE CHRISTIE NHS FOUNDATION TRUST	5	44.9	
THE CLATTERBRIDGE CANCER CENTRE NHS FOUNDATION TRUST	3	72.5	
THE WALTON CENTRE NHS FOUNDATION TRUST	2	22.4	
UNIVERSITY HOSPITALS OF MORECAMBE BAY NHS FOUNDATION TRUST	8	15.2	
WARRINGTON AND HALTON TEACHING HOSPITALS NHS FOUNDATION TRUST	5	11.7	
WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FOUNDATION TRUST	7	13.1	
WRIGHTINGTON, WIGAN AND LEIGH NHS FOUNDATION TRUST	3	8.3	
North West	182	15.6	

Public Health England

Pseudomonas aeruginosa quarterly tables: Trust cases & rates

Organisation Name	October to December 2020	Rate per 100,000 bed days	Significance
ALDER HEY CHILDREN'S NHS FOUNDATION TRUST	3	22.8	
BLACKPOOL TEACHING HOSPITALS NHS FOUNDATION TRUST	3	5.6	
BOLTON NHS FOUNDATION TRUST	2	4.4	
COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST	0	0.0	
EAST CHESHIRE NHS TRUST	1	4.3	
EAST LANCASHIRE HOSPITALS NHS TRUST	4	5.9	
LANCASHIRE TEACHING HOSPITALS NHS FOUNDATION TRUST	1	1.8	
LIVERPOOL HEART AND CHEST HOSPITAL NHS FOUNDATION TRUST	2	23.9	
LIVERPOOL WOMEN'S NHS FOUNDATION TRUST	0	0.0	
LIVERPOOL UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	5	4.3	
MANCHESTER UNIVERSITY NHS FOUNDATION TRUST	9	6.7	
MID CHESHIRE HOSPITALS NHS FOUNDATION TRUST	2	4.8	
NORTH CUMBRIA INTEGRATED CARE NHS FOUNDATION TRUST	2	4.8	
PENNINE ACUTE HOSPITALS NHS TRUST	4	4.7	
SALFORD ROYAL NHS FOUNDATION TRUST	3	4.6	
SOUTHPORT AND ORMSKIRK HOSPITAL NHS TRUST	1	3.4	
ST HELENS AND KNOWSLEY TEACHING HOSPITALS NHS TRUST	6	10.3	
STOCKPORT NHS FOUNDATION TRUST	1	2.3	
TAMESIDE AND GLOSSOP INTEGRATED CARE NHS FOUNDATION TRUST	2	7.1	
THE CHRISTIE NHS FOUNDATION TRUST	5	44.9	
THE CLATTERBRIDGE CANCER CENTRE NHS FOUNDATION TRUST	1	24.2	
THE WALTON CENTRE NHS FOUNDATION TRUST	0	0.0	
UNIVERSITY HOSPITALS OF MORECAMBE BAY NHS FOUNDATION TRUST	5	9.5	
WARRINGTON AND HALTON TEACHING HOSPITALS NHS FOUNDATION TRUST	2	4.7	
WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FOUNDATION TRUST	4	7.5	
WRIGHTINGTON, WIGAN AND LEIGH NHS FOUNDATION TRUST	6	16.6	
North West	74	6.4	

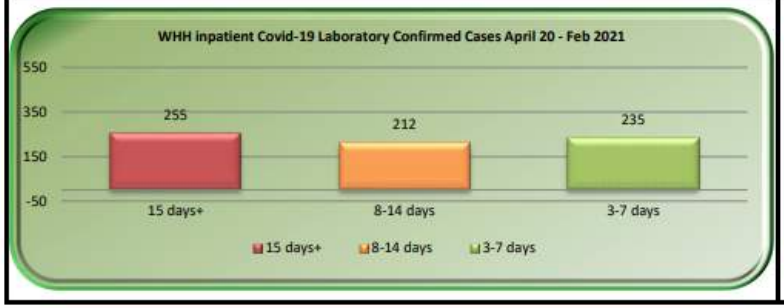
APPENDIX 3 COVID-19 Cases

HCAI data Financial Year 2020 - 2021

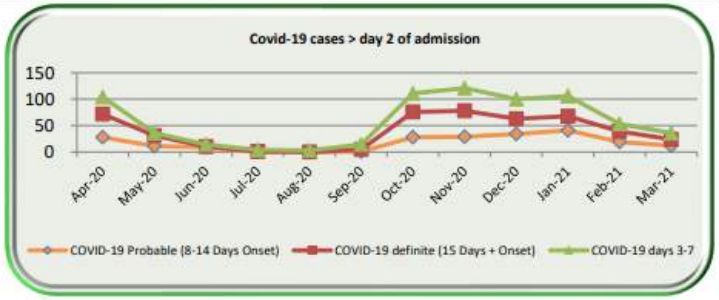
CDT | Bacteraemias | COVID-19

NHS Warrington and Halton Teaching Hospitals NHS Foundation Trust

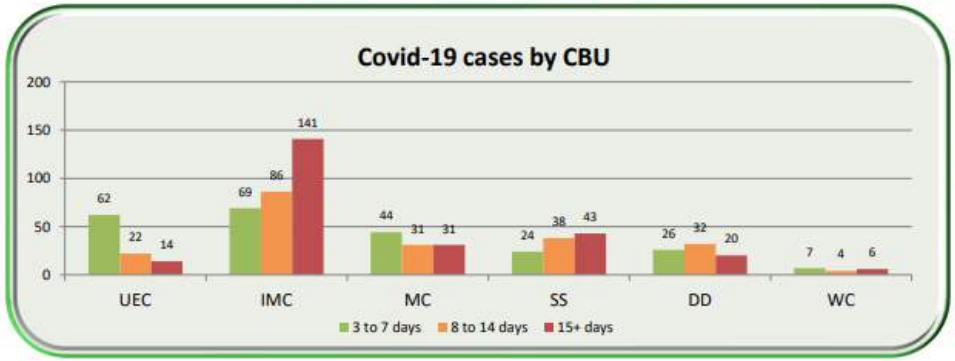
COVID-19 - Total inpatient cases from April 2020 February 2021



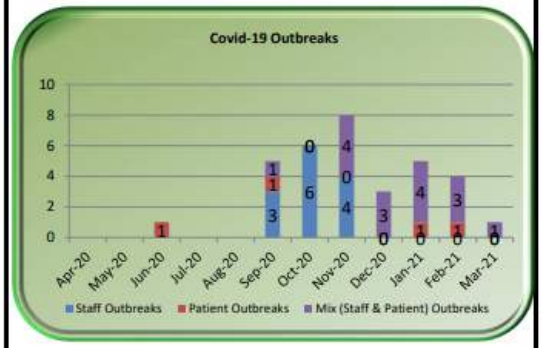
Covid-19 Cases by Month



Day 8-14 and 15+ combined from April - December



Outbreaks



April 2020 - March 2021

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/21/05/82**				
SUBJECT:	**Quality Strategy Annual Update**				
DATE OF MEETING:	26 May 2021				
AUTHOR(S):	Layla Alani, Deputy Director Governance				
EXECUTIVE DIRECTOR SPONSOR:	Kimberley Salmon-Jamieson, Chief Nurse & Deputy Chief Executive				
LINK TO STRATEGIC OBJECTIVE: (*Please select as appropriate*)	SO1 We will.. Always put our patients first through high quality, safe care and an excellent patient experience.	x			
	SO2 We will.. Be the best place to work with a diverse, engaged workforce that is fit for the future.	x			
	SO3 We will ..Work in partnership to design and provide high quality, financially sustainable services.	x			
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF):					
EXECUTIVE SUMMARY ***(KEY ISSUES):***	The purpose of this paper is to provide a summary of the following: • Progress made in relation to the Trust Quality Strategy and the Quality Pledges detailed within the strategy. • Proposals for reviewing the Quality Strategy to ensure that it is still aligned to the Trust's current priorities.				
PURPOSE: ***(please select as appropriate)***	Information	Approval	To note x	Decision	
RECOMMENDATION:	The Board of Directors is asked to note the report.				
PREVIOUSLY CONSIDERED BY:	**Committee**	Quality Assurance Committee			
	Agenda Ref.	QAC/21/04/95			
	Date of meeting	4 May 2021			
	Summary of Outcome	The Quality Assurance Committee were asked to note the report			
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full				
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	Choose an item.				

1. BACKGROUND/CONTEXT

Our aim is to be a learning organisation that consistently transforms practice by continuous learning in order to provide the best possible health care.

The Quality strategy was developed to ensure patients are safe in our care; secondly, to provide patients with the best possible clinical outcomes for their individual circumstances; and thirdly, to deliver an experience of hospital care which is as good as it possibly can be. With the above care model in mind we use the following three priority domains: Patient safety, Clinical effectiveness and Patient experience.

For each priority domain we have a series of Quality Priorities; the progress of each priority is reported on a quarterly basis to the Trust's Quality Assurance Committee. This report describes the progress made with the quality priorities over the past 12 months.

2. KEY ELEMENTS

2.1 Measurements of success and priority domains

The Quality Strategy uses the following measures of success;

- ✓ We will ensure that we minimise harm for patients
- ✓ We will have safe systems of work in place
- ✓ Every patient should have the opportunity to feedback about their experience and we promise to use this to improve care and services
- ✓ We will ensure partnership working and needs based care. We will simplify patient focused processes.
- ✓ We will communicate in line with our values
- ✓ We will ensure that we are providing care that is evidence based
- ✓ We will ensure that we are focused on outcomes for patients and that we are benchmarking/peer reviewing ourselves against the 'best in class'
- ✓ We will ensure that we foster a culture of Quality Improvement

The priority domains are outlined below:

Priority 1 - Patient Safety; the Trust is committed to developing and enhancing its patient safety and learning culture where quality and safety is everyone's top priority

Priority 2 - Clinical Effectiveness; ensuring practice is based on evidence so that we do 'the right things the right way to achieve the right outcomes' for our patients

Priority 3 - Patient Experience; by focussing on patient experience we want to place the quality of patient experience at the heart of all we do, where "seeing the person in the patient" is the norm

2.2 Assurance and Priorities progress

The table below contains updates on each priority pledged for 2020/2021.

Gram Negative Bloodstream Infections - A 5% reduction in Gram Negative Bloodstream Infections (GNBSI)

Progress to date:

Reduced focus on GNBSI reduction due to increase in Covid activity and the infection prevention team supporting other urgent workstreams. There has been progress made in relation to;

- A team of staff have revised the national Urinary catheter passport, and this has been adapted as the passport of choice across Cheshire and Merseyside.
- Work has been undertaken with the Patient Safety Nurses to redesign patient Fluid Balance Charts and patient hydration.
- Weekly emails circulated with up-to-date information on cases by location & monthly dashboard.

Work will recommence on:

- The GNBSI Action meetings in April 2021.
- Gram Negative Collaborative driver diagram and action plan have been developed with the Quality Academy with agreed tests of change and will be launched from April.
- The Focus of activity will include:-
  - Aim to reduce use of urinary catheters – daily challenge in place;
  - Improvements to care of urinary catheters – review of all urinary catheter policies required and introduction of competency assessments;
  - Patient Hand Hygiene Strategy;
  - Hydration Strategy;
  - Report to Medical Cabinet;
  - Grand Round Presentation.

Partial Compliance: due to impact of covid -19 plans for improvement remained in their infancy. This priority will be repeated for 2021/ 2022 with the support of the Quality Improvement team.

Pledge: A 10% reduction in the overall number of inpatient Serious Harm Falls.

Progress to date:

8 moderate harm falls compared to 14 from the previous year – 10% achieved

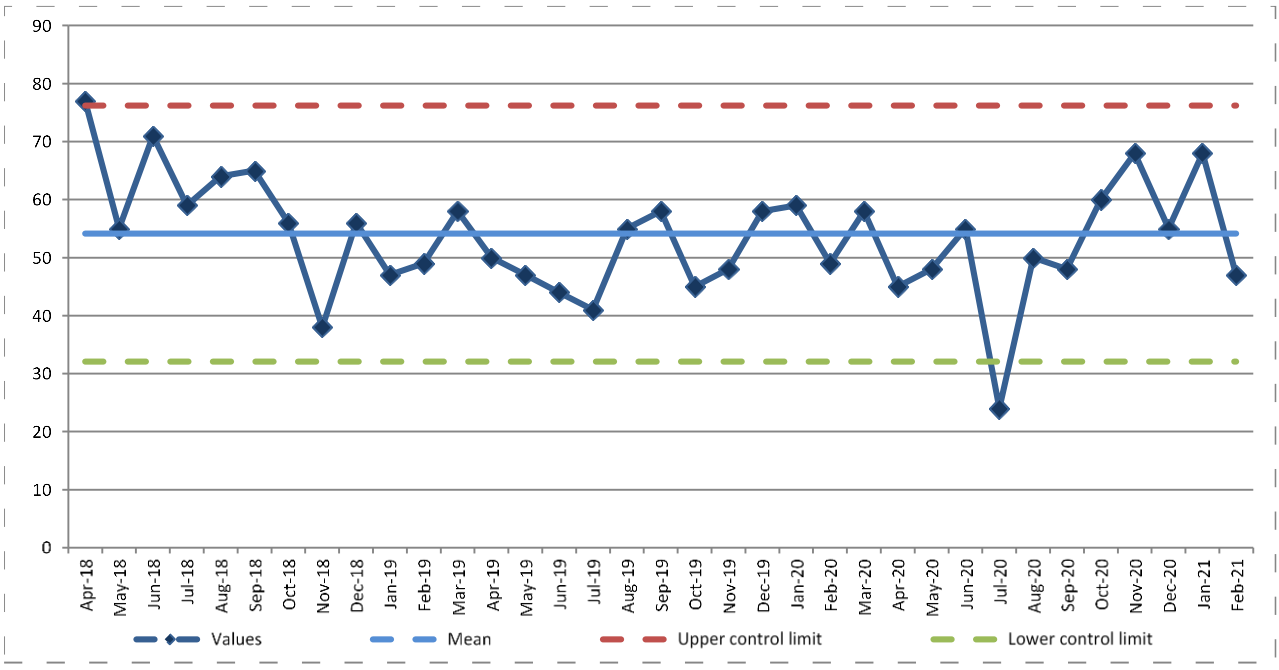
The COVID-19 crisis has had a significant impact on quality improvement work for falls. Despite this the number of falls has reduced (as per SPC chart below) as has the severity of falls. In 2018 – 2019 the Trust reported 14 harm falls and 2019 -2020 only 8 harm falls have been reported. Whilst this achieves the 10% indicated in the priority pledge it is recognised that this has likely been impacted by activity in the Trust during the pandemic.

To ensure continual support and education in caring for patients at risk of falls weekly meetings have continued to ensure the sharing of key themes and learning across the Trust. In addition, the safety brief

includes a section around falls each day.

There has been additional investment in the Quality Improvement Team and the falls collaborative is due to restart in April 2021 with a baseline completed by the end of March 2021. This will include a plan of ward sustainability, a buddy system and an additional implementation plan for new wards. By March 2022, all wards will have undergone falls QI collaborative.

Inpatient Falls – SPC Chart



Fully compliant

Pledge: Deteriorating Patient - Recording of NEWS2 score, escalation time and response time for unplanned critical care admissions.

Progress to date:

Weekly monitoring of NEWS2 compliance by ward managers and matrons has continued for all areas.

The Deteriorating Patient Group was established and NEWS2 compliance data is reviewed in this meeting. Deficits in compliance are addressed with targeted training at ward and individual level.

The electronic observations system has now been rolled out to all appropriate wards and departments. Initial spot checks indicate improved compliance. A full audit is being completed in March 2021 with a report/action plan to follow. This work will continue at ward level.

Partial Compliance

Pledge: Clinical Effectiveness - We will improve outcomes, based on evidence and deliver care in the right place, first time, and every time.

Progress to date:

The Chief Medical Examiner, Medical Examiner and Medical Examiner Officer have been appointed. The Medical Examiner Office is successfully overseeing bereavement services, ensuring thorough scrutiny of all non-coronial deaths and offer a point of contact for bereaved families to raise concerns about the care provided prior to the death of a loved one. The ME service has successfully started to review deaths and is reviewing around 50-60% of all deaths with an aim to review 100% by end of April 2021.

The ME service has been approached to lead a pilot for community roll out in May 2021.

Fully Compliant

Pledge: We will do the right thing for patients by ensuring decisions about health care are based on the best available, current, valid and reliable evidence

Progress to date:

The COVID-19 crisis has had a significant impact on the GIRFT Regional Implementation Teams due to redeployment and subsequent redesign. As a result of these operational challenges most GIRFT activity by the regional teams was paused. During this time the national GIRFT programme continued to analyse data and provide GIRFT national speciality reports.

In August 2020 GIRFT stated its intention to recommence the GIRFT programme utilising virtual platforms. In addition, GIRFT have provided webinars and workshops to share best practice and promote continued improvement and provided GIRFT post Covid recovery guidance and recommendations for different speciality and organisational areas.

GIRFT's model of analysing data to uncover best practice supports the identification of ideal service pathways and provides case studies for trusts to adapt to their own needs. GIRFT has continued to help specialties refocus within the constraints of COVID, adopting changes that did not seem possible before the pandemic. In October 2020, the Trust was notified that the majority of the GIRFT team had been redeployed during the pandemic and since September 2020 there had been a reconfiguration within GIRFT; meaning the implementation managers are now aligned to STP/ICS geographies rather than specialty focused. There are two implementation managers for Cheshire and Merseyside.

GIRFT had planned to roll out a web platform to provide accessibility to view and update actions for specialities and condition specific GIRFT areas, for example VTE. This was therefore delayed with update of information starting to become available.

Overall, there are 182 actions across all specialties, 48 of these are breached and have been risk rated as follows:

Risk	Number of actions
Low	33
Medium	12
High	3

Actions in the high-risk category, have been escalated to clinicians and an update requested, this will be followed in prioritised succession of action risk ratings and monitored on a regular basis with support from the Associate Medical Director of Clinical Effectiveness.

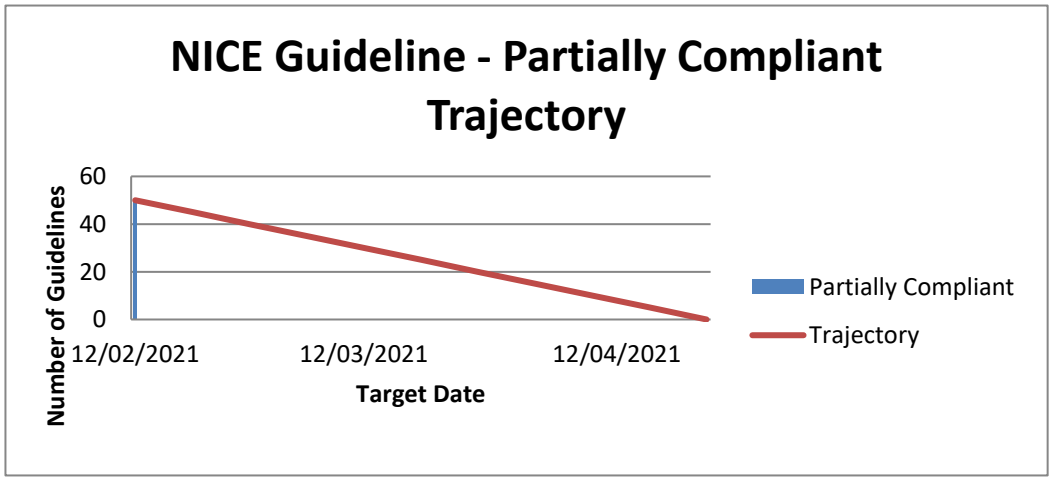
NICE update:

90% of the overall baseline have been completed- meeting the Trust Target.

	Number compliant	Number applicable but not yet fully compliant	Number outstanding *including those in date*	Compliance
Clinical Support Services	196	2	14	**92.5%**
Digestive Diseases	43	3	0	**93.5%**
Integrated Medicine & Community	14	7	0	**66.7%**
Medical Care	45	7	2	**83.3%**
Surgery Specialties	38	2	1	**92.7%**
Urgent & Emergency Care	19	5	0	**79.2%**
W&C Health	74	6	0	**92.5%**

A baseline toolkit has been created to support staff with filling out baseline assessments.

A partially compliant trajectory has been developed to monitor performance with those that have partial evidence attached.



Partial compliance GIRFT

NICE target of 90% - Fully compliant

Pledge: CBU Governance - to be strengthened, to ensure that CBU Governance is embedded and consistently and effectively applied across all areas

Progress to date:

MIAA audit has been completed and key recommendations have been aligned into a robust action plan.

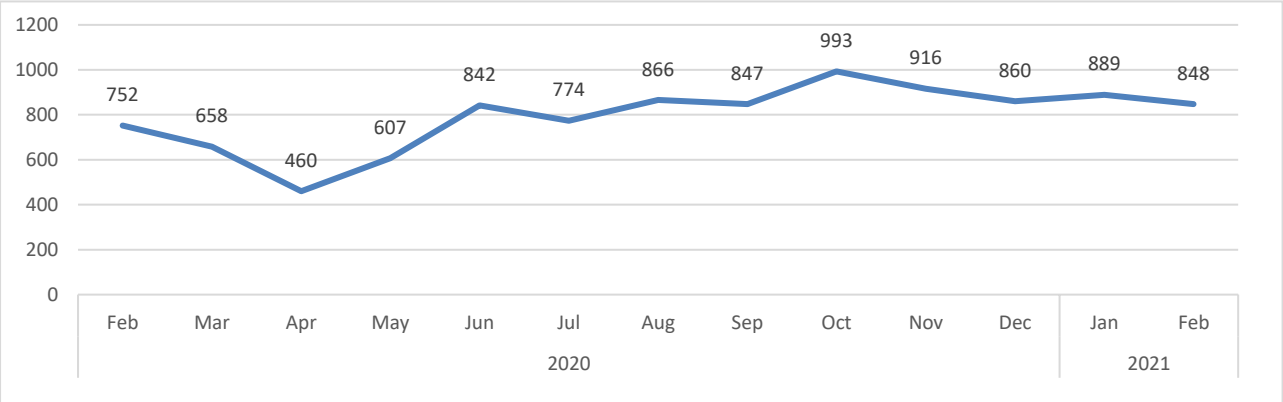
The incident policy has been redefined is currently under ratification and will be live by end of March 2021.

Complaints have seen an increase in responses responded to within timeframe from 95% to 100%.

Incident investigations with action plans are actively reviewed by the Patient Safety Manager to ensure that action plans are appropriate and reflective of incident findings. An audit is undertaken and fed back for areas that require improvement. The latest audit for quarter 3 found a steady decline during the pandemic for actions completed from 86% to 66%. This is monitored on a weekly basis and is now monitored by the newly appointed Head of Clinical effectiveness. Investigation training has also been sought and is planned to take place by May 2021.

Incident reporting levels are monitored by the Senior Governance Manager. During the height of the pandemic incident reporting was lower than expected in March and April 2020 (see chart below). However, this has now returned to expected (1000-800 incidents reported per month) reporting levels.

Incident Reporting – Run Chart



Duty of Candour (DOC) has been maintained at 100% across the Trust.

Partial compliance: Whilst improvement has been made there is further work required to strengthen SMART action plans and adopt a more timely and proactive approach to the closure of incidents with evidence. This requires close working with CBU teams and has been affected by the pandemic. This priority will be repeated in 2021/ 2022.

Pledge: End of Life – Serious Illness Programme; Better Communication, Better Care.

Progress to date:

The Serious Illness Care Programme is a system level intervention designed to improve the lives of people

with a serious illness by optimising the timing, frequency and quality of serious illness conversations. Comprising clinical tools, training support and systems innovations the Programme empowers patients to actively participate in thinking and planning for the future with their illness.

WHHFT is leading and supporting implementation at four Trusts across the UK:

- ✓ Warrington and Halton Teaching Hospitals NHS Foundation Trust (WHHFT)
- ✓ North West ***London*** University *Healthcare NHS Trust (NWL**)***
- ✓ Liverpool University Hospitals NHS Foundation Trust (LUH)
- ✓ North East Academy Partnership (encompasses Gateshead Newcastle and Northumbria.) The Partnership joined in November 2020

WHHFT is currently in the Implementation Phase. Cardiology and Gastroenterology are the two pilot sites. Gastroenterology will focus on patients with advanced liver disease and Cardiology will focus on patients with advanced cardiac failure. Clinical Leads have been identified and both specialties are now exploring workflow, screening and patient identification. Gastroenterology have commenced a focused baseline evaluation with support from IM trainees.

Work has been focused on systems change and customising workflow. The training programme has been developed to facilitate virtual delivery including the experiential skills section. This was scheduled to take place for Warrington clinicians in November and then December 2020. Both were delayed because of the pandemic and will need to be rescheduled for April/May 2021

Programme implementation will be underpinned by research using a mixed methods approach. Data will be collected over a 12 month implementation period, to illustrate the impact of the conversation on the care provided to patients. This data will enhance the UK evidence base and provide important information to support future roll out. IRAS and HRA approval has now been secured.

The Royal College of Physicians are keen to support dissemination of the Programme and joint educational initiatives are planned for 2021 including delivery via the RCP Player and a joint national Foundation workshop.

Key identified risks are:-

- Failure to secure additional participating sites for 2021/2022 and loss of funding
- Managing capacity and demand
- Further delays in implementation due to the third wave of COVID-19
- Failure to secure transfer of trademark from The Clatterbridge Cancer Centre to WHHFT
- Training and implementation coinciding with winter pressures and post COVID operational pressures reducing capacity of clinicians across all sites to complete training and commence serious illness conversations

The Serious Illness care programme produces a quarterly Progress Report for all sites with full details of progress for the four sites benchmarked against the Programme Roadmap.

Partial Compliance: This will form part of 2021 / 2022 priorities to further drive the standard of care for end

of life patients recognising the potential to expand this piece of work across healthcare sectors.

Pledge: Deconditioning / PJ Paralysis

Progress to date:

During the Covid 19 Pandemic, the implementation plan development was halted prior to commencing implementation. De conditioning/ End PJ paralysis priority will form part of the falls and pressure ulcer collaboratives moving forward with the support of quality improvement.

Compliance: Not achieved

Pledge: Learning Disabilities – Development and implementation of the Trust Learning Disability Strategy which will help to improve our understanding of the needs of people with learning disabilities and autism, and work together to improve their health and wellbeing

Progress to date:

The learning disability strategy has been completed and ratified. The LD steering group membership and terms of reference has been completed and the first meeting will be held in March in March 2021.

The learning disability action plan and work plan has been updated with key milestones achieved.

This implementation of the strategy Trustwide will be a quality priority for 2021/22.

Fully compliant

3. IMPACT ON QPS?

The Quality strategy was developed to ensure patients are safe in our care; secondly, to provide patients with the best possible clinical outcomes for their individual circumstances; and thirdly, to deliver an experience of hospital care which is as good as it possibly can be.

4. ASSURANCE COMMITTEE

Progress in relation to the Quality Strategy is reported to both the Patient Safety and Clinical Effectiveness Sub-Committee and the Quality Assurance Committee. A new 3 year strategy is being devised.

5. RECOMMENDATIONS

The Board of Directors is asked to note this report.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/20/05/84**	
SUBJECT:	**Mortality Review Q4**	
DATE OF MEETING:	26 May 2021	
AUTHOR(S):	Layla Alani, Deputy Director Governance	
EXECUTIVE DIRECTOR SPONSOR:	Alex Crowe, Executive Medical Director	
LINK TO STRATEGIC OBJECTIVE:	SO1 We will.. Always put our patients first through high quality, safe care and an excellent patient experience.	x x x
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF):		
EXECUTIVE SUMMARY *(KEY ISSUES):*	This paper represents the scheduled 'Learning from Deaths' report in compliance with National Guidance requirements. The Q4 report for 2020/2021 provides a report for awareness and scrutiny in line with National Guidance and the required National Reporting Criteria; and details learning following reviews. **Key points to note are;** • During Q4 2020/21 373 deaths have occurred within the Trust. • 78 have met the criteria to be subject to a structured judgement review (SJR) and 40 of those were reviewed, which is a 51.3% of deaths have been reviewed. In order to ensure that the number of SJRS reviewed is increased each SJR reviewer will now review a minimum of 5 SJRS. In addition, the newly appointed lead for mortality has recruited to a new deputy who will also undertake SJRs. • 2 were to subject to investigation using root cause analysis (RCA) methodology. • HMSR is as expected at 103.20 and is a reduction from last reporting period and is not an outlier. • SHMI is expected at 105.90 and is a reduction from the last reporting period and is not an outlier. • Attached as appendices are the MRG themes of the month for noting.	

	• Attached as appendices is the latest Healthcare Evaluation Data report for information.			
PURPOSE: ***(please select as appropriate)***	Information	Approval	To note x	Decision
RECOMMENDATION:	The Board of Directors is asked to note the report.			
PREVIOUSLY CONSIDERED BY:	**Committee**	Quality Assurance Committee		
	Agenda Ref.	QAC/21/05/130		
	Date of meeting	4 May 2021		
	Summary of Outcome	Noted		
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	Choose an item.			

1. BACKGROUND/CONTEXT

Guidance states that all Trusts are required to review their processes and to implement systems to review, understand and learn from deaths that occurred. National Guidance set the requirements of this:

- 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 patient's care, with a clear process for completing mortality reviews. Learning identified during mortality reviews allows specialities to review and improve their processes, with collated learning providing corporate themes for larger quality improvement projects. The Trust is committed to systematically investigating, reporting and learning from deaths.

The content of this report provides an overview of the process and systems that are in place to ensure that deaths are reviewed appropriately, and that learning has occurred

2. KEY ELEMENTS

The Trust use the HED (Healthcare Evaluation Data) system to asses our overall mortality data, highlighting any themes or trends that support the requirement for focused reviews. This also enables benchmarking against other Trusts.

Using both the HED and the Datix Risk Management system to obtain data, this report will include;

- 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.

3. MEASUREMENTS/EVALUATIONS

3.1 Total number of deaths and investigation levels.

During Q4;

Month	Number of Deaths	Number of those which met SI *
January 2021	158	1
February 2021	119	1
March 2021	96	0

3.2 Investigations of deaths

Structured Judgement Reviews of deaths - Structured Judgement Reviews are presented to the Mortality Review Group (MRG), an assessment of problems in care is made and any actions or lessons to be learned are sent to the appropriate forum. Particular groups of patients are reviewed at the MRG:

- All deaths of patients subject to care interventions with elective procedures. These are identified using the electronic patient record which provides a daily update as to patients that have died.
- Patients undergoing an emergency laparotomy.
- SHMI/HSMR outliers identified using the HED system.
- Deaths where learning will inform existing or planned improvement work, for example if work is planned on improving sepsis care, relevant deaths should be reviewed, as determined by the Trust;
- Death of a patient with mental health needs (this covers Inpatients who are detained under the Mental Health Act) identified via the Trust Patient Safety Manager. If the death may have been due to, or partly due, to problems in care including suspected self-inflicted death it will be investigated as a serious incident.
- Trauma deaths will be reviewed and presented at MRG on a quarterly basis.
- Patients who have died aged between 18 and 55 years.
- Patients who have died with no DNACPR in place.
- Once a quarter, a further sample of other deaths will be selected that do not fit the above identified categories, to ensure we take an overview of where learning and improvement is needed most overall.
- All Coroners' reports received post-inquest will be triangulated with the SJR to enhance the learning.
- Any concern that a member of staff may have in relation to a patient death will be reviewed through the mortality process.
- At the request of the Medical Director or Chief Nurse.

3.3 SJR reviewed

During Quarter 4, 40 Structured Judgement Reviews were completed by members of the MRG out of 78.

Table 1 below details their overall care rating;

Q4	Overall Assessment Care Rating Following SJR					Total
	1: Very Poor	2: Poor	3: Adequate	4: Good	5: Excellent	
	0	**2**	31	6	1	40

*2 were presented at MRG and determined to be a concise RCAs (Root Cause Analysis investigations) and the learning from these reports will be available for the next reporting period (datix ID 5835 and 5540).

Cases rated as *1:* ***Very Poor*** or *2:* ***Poor*** are reviewed by MRG and then referred to the Governance Department for further discussion and possible further investigation. Consideration is also given to external reporting via StEIS where appropriate.

Cases rated as *3:* ***Adequate*** are referred to MRG for further discussion and cases rated as *4:* ***Good*** and *5:* ***Excellent*** are disseminated for learning through the Mortality & Morbidity Meetings.

3.4 Snapshot of learning identified in MRG:

There were a number of cases discussed at MRG where improvements could be made in terms of the decision to engage palliative care and what to treat when a patient is palliative. The identified learning was included in the 'themes of the month' newsletter and circulated to the Clinical Speciality meetings and the Medical Cabinet meeting (see appendix 1).

In order to ensure learning is meaningful a quality improvement lead now attends the MRG to review how learning is captured and shared.

M8122 - This 87-year-old patient with advanced dementia and a working diagnosis of a likely urinary tract infection. Her main carer was her husband however this was supplemented by carers three times a day. On day 5-8 capacity appears to be assessor dependent one saying, 'patient has capacity', another, 'patient has dementia but complying with treatment', another 'consents to care provided' and lastly 'does not have capacity - question need for MCA DoLS'. On day 9 active treatment was stopped and patient commenced on IPOC. The patient sadly on day 25.

Learning: There were missed opportunities for capacity assessments to be completed and DoLS applications to be made even though the possibility was mentioned. There had been an application on previous admissions and there should have been one on this occasion also. At MRG safeguarding confirmed that this patient had a need for referral as they were admitted with care support needs and had not passed urine for some time. Nursing notes

did mention capacity however this could have been clearer. The MRG group determined that whilst there were some learning points the overall care was adequate.

Action taken to address: The ward where the patient had been treated were asked to review this case and reflect on the capacity assessment and why there may have been discrepancies with this and complete a reflective piece.

M5533 – This 70-year-old patient was admitted with a working diagnosis of Covid-19 pneumonia. The patient was noted to have learning difficulties and had carers at home. It was assessed that the patient lacked capacity to decide about care and discharge and a DoLS was put in place. A DNAR was put in place after a conversation with the patient's sister. However, it seems that there had been some communication issues and whilst this did not impact the care of the patient, it was not best practice. Patient died on day 6 of admission.

Learning – There was no adequate documentation of what learning difficulties this patient had and the extent to which this affected the patient or her performance status. In this case there was no evidence that the DNAR decision was taken in view of the learning disability the patient had but rather on general frailty, however, it can be difficult to assess this if there is no information regarding the LD. Learning difficulties have a broad scale and when taking notes we need to be more curious so that the level of care can be specified and more appropriately tailored to an individual patient which would also provide support and reassurance to their family.

Action – Check whether there is a standard assessment for people with learning difficulties that could be used by the care team to enable a more thorough evaluation of a patients care needs and feedback at the next MRG.

Snapshot of learning from SI/Concise reports:

In addition to SJRS there are two root cause analysis reports which are underway, where a patient has sadly died. Below details a snapshot of the learning from these incidents (these incidents have come via datix system and are not deaths that have been discussed at the MRG).

WEB112097 - Patient activated the major haemorrhage protocol. There was a delay in receiving the bloods by 3 hours.

Learning – There was no named person at the time taking ownership for tracking the bloods.

Action taken:

- Debrief undertaken with all staff involved;
- Lesson learning shared via safety huddle,

**The RCA is still underway and a more detailed action plan will be available for the next reporting period.*

WEB110740 - Patient sadly died suddenly after discharge from hospital.

Learning – Final observations were not taken just before discharge. Sadly the patient died of an unrelated episode as per findings on Post Mortem by the Coroner that could not have been foreseen.

Action taken:

- Learning discussed with all staff at safety huddle and a reminder circulated regarding final observations;
- Learning from the completed root cause analysis shared with staff involved.

4. TRAJECTORIES

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

- SHMI is expected at 105.90 and is a reduction from the last reporting period and is not an outlier.

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

- HMSR is as expected at 103.20 and is a reduction from last reporting period and is not an outlier.

It is noted on the latest HED report that the following are showing as a higher number of deaths based on expected;

- Other endocrine disorders, Thyroid disorders;
- Acute posthemorrhagic anaemia, deficiency and other anaemia;
- Cardiac dysrhythmias;

- Urinary tract infections.

A review panel was convened for the last reporting period for Decardiac dysrhyhimias and findings shared in the last mortality paper.

A review panel is currently underway to look at the learning from the deaths in the those patients with Acute posthemorrhagic anaemia, deficiency and other anaemia and the feedback from that review by the MRG will be available for the next reporting period.

There are plans in place to undertake review panels for all those deaths noted above on the HED report.

5. MONITORING/REPORTING ROUTES

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

6. IMPACT ON QPS?

The learning from deaths helps us to make changes that will ensure high quality, safe care and an excellent patient experience.

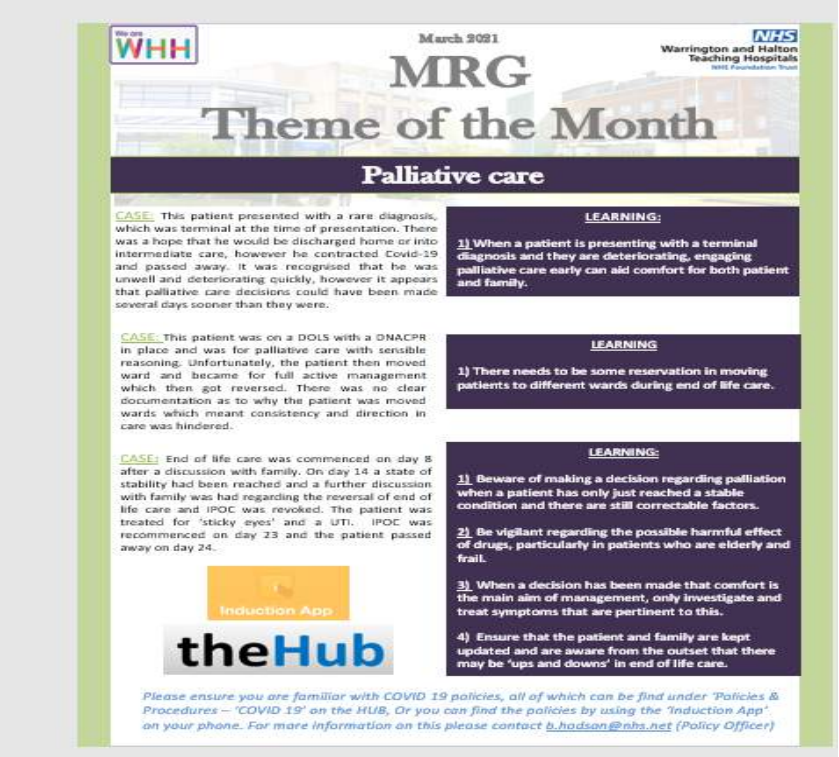
7. TIMELINES

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

8. RECOMMENDATIONS

The Board of Directors are asked to note this report.

Appendix A



March 2021

MRG Theme of the Month

Palliative care

CASE: This patient presented with a rare diagnosis, which was terminal at the time of presentation. There was a hope that he would be discharged home or into intermediate care, however he contracted Covid-19 and passed away. It was recognised that he was unwell and deteriorating quickly, however it appears that palliative care decisions could have been made several days sooner than they were.

LEARNING:

1) When a patient is presenting with a terminal diagnosis and they are deteriorating, engaging palliative care early can aid comfort for both patient and family.

CASE: This patient was on a DOLS with a DNACPR in place and was for palliative care with sensible reasoning. Unfortunately, the patient then moved ward and became for full active management which then got reversed. There was no clear documentation as to why the patient was moved wards which meant consistency and direction in care was hindered.

LEARNING

1) There needs to be some reservation in moving patients to different wards during end of life care.

CASE: End of life care was commenced on day 8 after a discussion with family. On day 14 a state of stability had been reached and a further discussion with family was had regarding the reversal of end of life care and IPOC was revoked. The patient was treated for 'sticky eyes' and a UTI. IPOC was recommenced on day 23 and the patient passed away on day 24.

LEARNING:

1) Beware of making a decision regarding palliation when a patient has only just reached a stable condition and there are still correctable factors.

2) Be vigilant regarding the possible harmful effect of drugs, particularly in patients who are elderly and frail.

3) When a decision has been made that comfort is the main aim of management, only investigate and treat symptoms that are pertinent to this.

4) Ensure that the patient and family are kept updated and are aware from the outset that there may be 'ups and downs' in end of life care.

Induction App

theHub

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

Appendix B

mortality_report.pdf