Warrington and Halton Hospital NHS Foundation Trust
Board of Directors
Agenda

Wednesday 30th July 2014, 1300 - 1700hrs
Trust Conference Room, Warrington Hospital

1300	***W&HHFT/TB/14/112***	***Welcome, Apologies & Declarations of Interest***		Chairman
	W&HHFT/TB/14/113	***Presentation: Dementia Friends***	Presentation	Mr & Mrs Mason, External presenters
	W&HHFT/TB/14/114	***Minutes of the previous meeting held on 25th June 2014***	Paper	
	W&HHFT/TB/14/115	***Action Plan***	Paper	Chairman
1330	***W&HHFT/TB/14/116***	***Chairman's Report***	Verbal update	Chairman
	W&HHFT/TB/14/117	***Chief Executives Report***	Verbal update	Chief Executive

Quality

1400	***W&HHFT/TB/14/118***	***Quality Dashboard***	Paper	Director of Nursing and Organisational Development
1410	***W&HHFT/TB/14/119***	***Head of Midwifery Report 2013***	Annual Report	Director of Nursing and Organisational Development & Head of Midwifery
1430	***W&HHFT/TB/14/120***	***Safeguarding vulnerable adults (i) and Children (ii) Annual Reports 2013/14***	Annual Report	**Nicki Richardson** –Named Nurse/ Midwife – Safeguarding Children & **Dianne Goncalves** Safeguarding Adults Matron
1450	***W&HHFT/TB/14/121***	***Infection Control*** ***i. Director of Infection Control Annual Report*** ***ii. Infection Control Q1 Report 2014/15***	Annual Report/ Paper	Director of Nursing and Organisational Development & Associate Director of Nursing – Infection Control
1500	***W&HHFT/TB/14/122***	***Concerns & Complaints Q1 Report 2014/15***	Paper	Director of Nursing and Organisational Development
1510	***W&HHFT/TB/14/123***	***Q1 Governance Report 2014/15***	Paper	Director of Nursing and Organisational Development
1520	***W&HHFT/TB/14/124***	***CQC Intelligent Monitoring Q1 2014/15***	Paper	Director of Nursing and Organisational Development
1530	***10 Minute Break***			

People

1540	***W&HHFT/TB/14/125***	***i. Workforce and Educational Development Key Performance Indicators*** ***ii. Staffing Levels Monthly Report***	Paper	Director of Nursing and Organisational Development
1550	***W&HHFT/TB/14/126***	***Workforce Plan***	Paper	Director of Nursing and Organisational Development

Sustainability

1610	***W&HHFT/TB/14/128***	***Finance Report to 31 May 2014***	Paper	Director of Finance & Commercial Development
1630	***W&HHFT/TB/14/129***	***Corporate Performance Dashboard & Exception Report***	Paper	Chief Operating Officer
1645	***W&HHFT/TB/14/130***	***Corporate Risk Register***	Paper	Director of Nursing and Organisational Development
	W&HHFT/TB/14/131	***Board Assurance Framework***	Paper	Executive
1655	***W&HHFT/TB/14/132***	***Monitor Q1 Governance Report***	Paper	Director of Finance and Commercial Development
1705	***W&HHFT/TB/14/133***	***Board Committee Reports:*** ***Board Committee Verbal Update*** ***a) Quality Governance Committee held on 8 July 2014*** ***b) Finance and Sustainability Committee held on 24th July 2014*** ***c) Audit Committee held on 21st July 2014*** ***d) Charitable Funds Committee held on 21st July 2014*** ***Minutes for Noting:*** ***e) Quality Governance Committee held on 13th May 2014*** ***f) Finance and Sustainability Committee held on 17th June 2014*** ***g) Audit Committee held on 6th May and 23rd May 2014*** ***h) Charitable Funds Committee held on 6th May 2014***		Chair of each Committee
	W&HHFT/TB/14/134	***Any Other Business***		

1715 ends		***Dates of next meeting*** *1 October 2014*		

Warrington and Halton Hospitals NHS
NHS Foundation Trust

W&HHFT/TB/14/113

BOARD OF DIRECTORS

Presentation	Dementia Friends Presentation from Mr and Mrs Mason (member of the public)
Date of Meeting	25th June 2014

W&HHFT/TB/14/115

TRUST BOARD
ACTION PLAN – Current / Outstanding Actions
Meeting: Trust Board 30th July 2014

Meeting date	Minute Reference	Action	Responsibility & Target Dates	Status	
26-02-2014	TB/14/034	The Director of Nursing and Organisational Development to present to the April 2014 Board meeting the Governance Dashboard Report (see TB/14/33)	Director of Nursing and Organisational Development:	Quality Dashboard update and included under agenda item TB/14/118	Action complete

Warrington and Halton Hospitals NHS
NHS Foundation Trust

W&HHFT/TB/14/116

BOARD OF DIRECTORS

Paper Title	**Chairman's Report**
Date of Meeting	30th July 2014

W&HHFT/TB/14/117

BOARD OF DIRECTORS

Paper Title	**Chief Executive's Report**
Date of Meeting	30th July 2014


Quality

W&HHFT/TB/14/118

BOARD OF DIRECTORS

Paper Title:	Quality Dashboard (2014/2015) July 2014
Date of Meeting	30 July 2014
Director Responsible	Karen Dawber (Director of Nursing and Organisational Development)
Author(s)	Ros Harvey (Corporate Nursing Programmes Manager) Hannah Gray (Clinical Effectiveness Manager)
Purpose	To monitor performance against the KPIs within the Trust's Improving Quality: Patient Safety, Experience and Clinical Effectiveness Strategy

Paper previously considered (state Board and/or Committee and dates)	**Committee**	**Date**

Relates to which Trust objectives

	appropriate
• Ensure all our patients are safe in our care	√
• To be the employer of choice for healthcare we deliver	√
• To give our patients the best possible experience	√
• To provide sustainable local healthcare services	√

Key points arising from the Report/Paper (please include up to eight bullet points and reference page/paragraph as appropriate).

Page/Paragraph Reference

- This dashboard has been reviewed to ensure that the Board is in receipt of data relevant to current quality measures. Please see page 2 for the rationale relating to these changes.
- Please note that VTE and Dementia are extracted on the 23rd July 2014 and are therefore provisional until final submission to UNIFY on the 28th July 2014.

Recommendation(s) (include what you require the Board to do; approve/note/ratify etc.)

The Board is asked to:

- Note and approve the revised measures based on the rationale provided on page 2.
- Note progress and compliance against the revised key performance indicators
- Agree if the financial values associated with the Quality Contract and CQUIN measures should be included in this report
- Approve actions planned to mitigate areas of exception

Quality Dashboard 2014/2015 revision

The KPIs in the Quality Dashboard have been reviewed in line with the revised requirements for 2014/2015 from the:-

- CQUINs – National (Local CQUINs will be monitored by the CQUIN monitoring group and reported by exception if required).
- Quality Contract
- Quality Account - Improvement Priorities
- Quality Account – Quality Indicators
- Sign up to Safety – national patient safety topics
- Open and Honest

This is part of a wider review of Quality KPIs to align reporting with the restructuring of committees to improve the management of quality initiatives under safety; effectiveness and experience.

There are a number of measures which meet the inclusion criteria but do not lend themselves to quantitative reporting for example the local CQUINs require implementation of a system or process and establishing a baseline in quarters one and two. Other qualitative measures which cannot be translated for monitoring within the quality dashboard include:-

- In patient survey – improvement in worst performing
- Complaints – lessons learnt
- Patient experience dashboard - creation of a dashboard
- Medicines management - creation of a dashboard
- Dementia – carers' audit
- Friends and family – day case and outpatients

There are also a number of measures which meet the inclusion criteria, but further work is required to develop the KPI criteria or data flow, these include:-

- Discharge and transfer (CQUIN) / Discharge and handover (National Patient Safety Priority).
- Missed and delayed diagnoses (National Patient Safety Priority).
- Deteriorating patients (adults and children) (National Patient Safety Priority).

We have included KPIs which do not meet the above inclusion criteria but are thought to be of sufficient interest to the Trust Board namely:-

- Never events
- Prevention of future deaths reports
- MSSA

The following KPIs no longer meet the inclusion criteria so they have been removed from dashboard:-

- Clinical nursing indicators – replaced with new care indicator system
- Critical Care best practice bundles, blood stream infections and ventilator associated pneumonia
- Emergency readmissions within 30 days of discharge (elective)

1. Key Performance Indicators

	Threshold	IC	A	M	J	Q1	J	A	S	Q2	O	N	D	Q3	J	F	M	Q4	YTD
Safety																			
Mortality																			
HSMR (to end March 2014)	<=100 = G, As expected = A, Higher than expected = R	QI, IP, QC															98		
SHMI (to end Feb 2014)	<=100 = G, As expected = A, Higher than expected = R	QI, IP, QC														105			
Total deaths in hospital	Not set		98	88	76	262													262
Regulation 28 - Prevention of future deaths report	Not set		0	0	0	0													0
Incidents resulting in Major or Catastrophic harm	TBC	QC	0	1	0	1													1
Incidents of major or catastrophic harm under investigation	N/A		3	1	3	7													7
Falls																			
All falls	Not set		70	65	65	200													200
Moderate, major and catastrophic harm	<=13 per year	IP	0	2	0	2													2
Moderate, major and catastrophic harm (awaiting approval)	N/A		0	0	1	1													1
Major and catastrophic harm	<=2 per year	QC	0	0	0	0													0

	Threshold	IC	A	M	J	Q1	J	A	S	Q2	O	N	D	Q3	J	F	M	Q4	YTD
Pressure Ulcers																			
Grade 3 and 4 Hospital Acquired (Avoidable)	<=6 per year	IP	1	1	0	2													2
Grade 3 and 4 Hospital Acquired (Unavoidable)	<=10	QC	0	0	0	0													0
Grade 3 and 4 Hospital Acquired (Under review)	N/A		0	0	0	0													0
Grade 2 Hospital Acquired	<=101 per year	IP	3	7	4	14													14
Grade 2 Hospital Acquired (under review)	N/A		0	3	1	4													4
% RCA / mini investigation completed	100%	IP	100	100	100	100													100
% of patients with a pressure ulcer (Community or hospital acquired) (ST)	<=3.99% (median YTD)	C	4.92	3.99	3.73														3.73%
Health Care Acquired Infections																			
MRSA	0= green, 1-5=amber, >5 red	QC, IP	0	1	0	1													1
Clostridium difficile	<=26 per year	QC, IP	2	3	2	7													7
MSSA	Not set		1	0	1	2													2
Out of hours transfers	TBC	BK	KPI in development. Already reported in 'Night Report'																
Never Events	0 per year		0	0	0	0													0
Medicines Safety Thermometer % harm free (ST)	TBC	IP	PILOT	PILOT	PILOT														

	Threshold	IC	A	M	J	Q1	J	A	S	Q2	O	N	D	Q3	J	F	M	Q4	YTD
VTE																			
% of patients risk assessed	>=95%	QC	95.55	95.92	95.47*														
% of eligible patients having prophylaxis (ST)	100%	QC	92	99.8	93		100												
Number of patients who developed a VTE	Baseline TBC	QC	7	10															
% free from harm (ST)		OH	97.3%	99.2%	97.8%														
Catheter Acquired Urinary Tract Infections																			
CA – UTI: Number of catheterised patients who developed a UTI (ST)	<=3 per month	IP	4	2	2														
CA – UTI % of catheterised patients who developed a UTI (ST)	<=0.6% each month	IP	0.76	0.38	0.39														
Dementia																			
Dementia Assessment % (Part 1)	>=90%	C	94.55	95.69	95.43*														
Dementia Assessment % (Part 2)	>=90%	C	100	100	100*														
Dementia Assessment % (Part 3)	>=90%	C	100	100	100*														
Care Indicators																			
Falls - risk assessment % compliance	>=95%	IP	100	95	95	96.6													96.6
Waterlow - risk assessment % compliance	>=95%	IP	98	92.7	88.3	93													93

	Threshold	IC	A	M	J	Q1	J	A	S	Q2	O	N	D	Q3	J	F	M	Q4	YTD
Effectiveness																			
MUST - risk assessment measures	>=95%	IP	57.2	59.4	60	58.9													58.9
Advancing Quality % compliance																			
Acute MI (2013/14)	>=91.46%	IP, C													97.84	97.97	97.33		97.33
Hip and Knee (2013/14)	>=92.23%	IP, C													96.23	96.52	96.71		96.71
Heart failure (2013/14)	>=86.85%	IP, C													87.35	87.50	87.29		87.29
Pneumonia (2013/14)	>=75.23%	IP, C													72.95	72.25	72.53		72.53
Stroke (2013/14)	>=62.57%	IP, C													55.48	55.82	55.16		55.16
COPD (from April 2014)	>=50%	IP, C																	
Patient Reported Outcome Measures (PROMS)																			
Hip replacement April – Dec 2013 (Average health gain)	0.43 (England average)	IP,QC											0.40						
Knee replacement April – Dec 2013 (Average health gain)	0.33 (England average)	IP,QC											0.34						
Groin surgery April – Dec 2013 (Average health gain)	0.085 (England average)	IP,QC											0.09						
Patient Experience																			
Staff friends and family question (Extremely likely and likely responses from F&F quarterly staff survey)	TBC	C				66.8													
Always events (Q1&2 implementation, Q3 data collection)	TBC	IP																	
Mixed sex occurrences	0	QC	6	3	0														9

	Threshold	IC	A	M	J	Q1	J	A	S	Q2	O	N	D	Q3	J	F	M	Q4	YTD
Friends and family test																			
Friends and Family Test (Trust score, out of maximum 5)	TBC		4.54	4.5															
Friends and Family Test Inpatients NP score	>=70 (National average)	OH	76	74															
Friends and Family Test A&E NP score	>=50 (National average)	OH	42	35															
Friends and family response rate (A&E)	Q1 – >=15% Q4 - >=20%	C	23.08	18.52	20.79	20.75													20.75
Friends and family response rate (inpatients)	Q1 – >=25% Q4 - >=30% March 2015 achieve >=40%	C	27.32	26.83	34.62	29.55													29.55
Complaints and concerns																			
Number of concerns received	Not set	IP	1	5	3	9													9
Number of complaints received	2013/2014 received 422 (No threshold set)	IP	32	45	40	117													117
% of complaints resolved within the agreed timescale	>=94%	IP	94.44	95.24	100	96.51													96.51

ST = Safety Thermometer. This is a survey carried out on one day a month on all wards. The survey provides a point prevalence figure e.g. of the number of inpatients who have a hospital acquired pressure ulcer on that day. The figure is NOT the total number of incidents in the month.

Key: YTD = Year to date, ST = Safety Thermometer (monthly point prevalence survey), IC = Inclusion criteria

Inclusion criteria key: Improvement priority (IP), National Quality related CQUINs (C), Local quality related CQUINs by exception*(CE), Quality Account indicators (QI), CQC Intelligent Monitoring quality related 'Elevated risks' and 'risks'(CQC), National Patient Safety Priorities (related to Sign up to Safety campaign) (SS), Contract KPIs (Quality section only) not considered at other forums (QC), Directive from Sir Bruce Keogh (BK), Open and Honest (OH)

2. Exception reporting

Care Indicators

High Quality Care was a local CQUIN for 2013/2014. The care indicators audit was a process which was developed as part of this CQUIN to audit compliance with risk assessments for Falls, Waterlow and MUST Risk Assessments. Reports received throughout 2013/2014 showed exceptional compliance with Falls and Waterlow improved from 70% to over 90% for the last four months of the year. However whilst there was a temporary improvement with compliance to MUST to over 90% in December it dropped below 70% in the last quarter of 2013/2014. The Trust identified this as an important aspect of quality of care and thus agreed to continue monitoring as a Quality Indicator for the Quality Accounts in 2014/2015. The Patient Quality & Safety Champion has increased surveillance and feedback around risk assessments in order to improve compliance going forward.

VTE Prophylaxis

The VTE Prophylaxis data is extracted from the Safety Thermometer and is required for the Quality Contract which states 100% compliance is required. Unfortunately we did not achieve this level of compliance in Q1 and following a review determined that this was due to resource issues to support data cleansing. This was undertaken for July and compliance has now reached 100%. We will continue to undertake rigorous data monitoring to ensure that we maintain full compliance.

Advancing Quality – Stroke and Pneumonia

AQ Stroke (monitored via CQUIN Group)
In order to achieve this target, the 4 hour target for direct admission needs to improve. Compliance with patients reaching the stroke unit within 4 hours of admission is one of seven factors measured for this indicator. Cumulative performance – 55.16 and latest available data for March 2014 discharges is 48.48%. The measures are as follows:-

- Stroke Unit admission 14/28
- Swallow screening 17/20
- Received Aspirin 15/16
- Weighed 28/29

Agreement reached to ring fence four beds for 4 hour stroke admission however this is not always assured as such the Trust may not achieve target of 62.57%

AQ Pneumonia (monitored via CQUIN Group)
There are a number of requirements that are required to achieve compliance with AQ for each patient however non-compliance does not appear to be based on one specific requirement so the team select individual issues to improve compliance. They are currently focussing attention on the issue of antibiotics being received with 6 hours of arrival as well as putting action plans are in place to ensure all doctors are trained in the requirements. Cumulative performance – 72.53% and latest available data for March 2014 discharges shows is 74.14%. The measures are as follows:-

- Initial antibiotic selection for CAP in immune-competent patients 24/29
- Initial antibiotic received within 6 hours of arrival 37/44
- Smoking cessation / counselling 8/10
- CURB65 Score 27/33

Two key issues are giving antibiotics and smoking cessation. Processes have been revised to improve compliance.

PROMS

Patient Reported Outcome Measures (PROMs) assess the quality of care delivered to NHS patients from the patient perspective. Currently covering four clinical procedures, PROMs calculate the average health gains after surgical treatment using pre- and post-operative surveys.
The four procedures are:

- hip replacements
- knee replacements
- groin hernia
- varicose veins

PROMs have been collected by all providers of NHS-funded care since April 2009.
PROMs measure a patient's health status or health-related quality of life at a single point in time, and are collected through short, self-completed questionnaires. This health status information is collected before and after a procedure and provides an indication of the outcomes or quality of care delivered to NHS patients.
The Health and Social Care Information Centre is responsible for scoring and publishing of PROMs data as well as linking it to other data sets such as Hospital Episodes Statistics. The Trust is required to report annual PROMS data in the Quality Report and has also selected this as a Quality Indicator for the Quality Report. The QDB shows the average health gain by procedure against the average results for England which indicates that the outcomes for hip replacement require improvement. Going forward this work will be managed within the remit of the Clinical Effectiveness Group.

Complaints and concerns

Some patients prefer to raise a concern rather than a formal complaint. Due to the way the Patient Experience Team now works, Patient Experience Officers provide cover for the PALS Officer. This has seen some "blurring" of PALS and concerns and lower numbers of concerns are reported. The team is establishing specific working definitions to ensure that concerns, complaints and PALS contacts are appropriately categorised and answered. From April 2014, any withdrawn complaints will be re-categorised as concerns. This is an improvement priority for the Trust.

Warrington and Halton Hospitals NHS
NHS Foundation Trust

W&HHFT/TB/14/119

BOARD OF DIRECTORS

Paper Title	Head of Midwifery Report 2013
Date of Meeting	30 July 2014
Director Responsible	Director of Nursing and Organisational Development
Author(s)	Melanie Hudson Associate Director of Nursing, WC&CSS / Head of Midwifery
Purpose	To inform the Board of the of the activities of midwives and Midwifery Services during 2013

Paper previously considered (state Board and/or Committee and dates)	**Committee**	**Date**

Relates to which Trust objectives	√ **appropriate**
• Ensure all our patients are safe in our care	
• To be the employer of choice for healthcare we deliver	
• To give our patients the best possible experience	
• To provide sustainable local healthcare services	

Key points arising from the Report/Paper (please include up to eight bullet points and reference page/paragraph as appropriate).

		Page/Paragraph Reference

Recommendation(s) (include what you require the Board to do; approve/note/ratify etc.)

The Board is asked to note the Head of Midwifery Report 2012

Warrington and Halton Hospitals NHS
NHS Foundation Trust

WOMEN'S, CHILDREN'S AND CLINICAL SUPPORT SERVICES

MIDWIFERY

ANNUAL REPORT

2013

Melanie Hudson
Associate Director of Nursing, WC&CSS / Head of Midwifery
July 2014

CONTENTS

1. Introduction

The Midwifery Annual Report informs the Trust Board of the activities of midwives and midwifery services during 2013.

The Maternity Service is located on the Warrington site working in an integrated service across primary and secondary care. A consultant led antenatal clinic has been held on the Halton site since 8th February 2012. Bridgewater community services provided Community Midwifery Services within Halton and Widnes and the community midwives were employed by Bridgewater Community Services.

During 2013 the Trust employed: 105.12 WTE (this includes the Head of Midwifery and the Matrons) midwives plus 18.33 WTE support carers / support assistants.

This report will serve to outline midwifery practice and midwifery services within Warrington and Halton Hospitals NHS Foundation Trust for 2013.

The start of 2013 was filled with optimism as the maternity service was successful in securing £450K to refurbish the Delivery Suite. The bid had to fulfil certain criteria which was improvement of the facilities for women and their families. The bids had to include facilities for partners to stay; improvement of bereavement facilities; promotion of normality and provision of birthing pools. The Trust bid incorporated all of the above. The Delivery Suite moved temporarily to Daresbury Wing for a period of three months, whilst the refurbishment took place. In June 2013, the Delivery Suite returned to the Croft Wing. Midwifery staff embraced the benefits the refurbishment brought for the women and their families.

Unfortunately 2013 has not been without its challenges with four serious untoward events and a whistleblowing incident whilst in Daresbury, all of which are detailed in the main body of the report.

2. Professional Regulation and Statutory Supervision of Midwives

Supervision of midwives is a statutory mechanism, its function is separate to the Trust and is overseen by the North West Local Supervisory Authority (LSSA). Its aim is to ensure the safety of the mother and baby and it has an important role to play in the management of risk for midwifery staff.

Supervision supports the risk management process by assisting in the recognition of poor midwifery practices and by identifying the education and training needs that support professional development.

Supervisors of Midwives have specific responsibilities:

- Undertake incident investigations.
- Provide professional advice to mothers and midwives on a 24 hour basis.
- Inform the Head of Midwifery of any serious midwifery practice or performance issues.

2.1 Supervisors of Midwives

During 2013 there were 13 supervisors of midwives (SOM). Together they supervised 142 midwives including two midwives working in the Neonatal Unit and six midwives working independently of Warrington and Halton Hospitals NHS Foundation Trust.

The recommended supervisor: midwife caseload ratio is 1:12. The average ratio for 2013 was 1:13 with varying fluctuations.

2.2 Selection of Prospective Supervisors of Midwives

Becoming a supervisor of midwives is discussed with all midwives within their annual review. Midwives who express an interest in becoming a SOM are encouraged to discuss their application with a supervisor to ensure their suitability. Selection is via a ballot system within the profession.

2.3 Resignation of Supervisors of Midwives

- No Supervisors were deselected during 2013.
- One supervisor took a break from supervision during 2013.
- One Supervisor resigned during 2013.
- One complaint was made against supervision by a member of staff.

2.4 Protected Time for Supervisors of Midwives

Protected time for supervision activities was supported by the Associate Director of Nursing, WC&CSS / Head of Midwifery. Time was required to plan and attend meetings, both at local and regional level; peer review; information dissemination and midwives annual review meetings. During 2013 and continuing into 2014 time was difficult to take. The LSA (Local Supervisory Authority) recommends two days per month for each supervisor of midwives, currently one day where possible is taken.

During 2013 difficulties were experienced by supervisors having opportunity to undertake supervision activities using the previously allocated one day per month for supervisors and two days per month for the contact supervisor, as the competing requirements of clinical commitments impacted on this. Administrative support was provided as recommended by the LSA. NHS England contacted the Director of Nursing requesting support the allocation of two days per month for the supervisors of midwives.

2.5 Access to a Supervisor of Midwives

Posters informing the public of the role of the SOM and how to contact them were displayed in all public areas. Women received an information leaflet on the role of the supervisor of midwives and telephone numbers to contact a SOM were printed in the hand held records. A 24 hour supervision on call rota allowed midwives and mothers to make contact with a supervisor at any time if they required information, support or advice.

During 2013 a Supervisors of Midwives Clinic was established, to answer any issues / areas of concern raised by individuals. This Clinic has proved very popular and there are plans to extend the Clinic to two sessions in 2014.

3. Supervision Activities

3.1 Changes in practice

SOMs worked to incorporate the recommendations from government enquiries and national guidelines into improving the midwifery care available to women.

3.2 Communication

Supervisors were represented on all the overarching groups within the Maternity Unit. In particular SOMs were represented on the Guideline Review Group; Incident reporting Group; Maternity Risk Management Group; Labour Ward Forum and the Maternity Services Liaison Committee. This provided SOMs the opportunity to promote normality within a multidisciplinary team and to meet with user representatives.

3.3 Developing trends affecting Midwifery Practice

Within the year the Maternity Unit closed on ten occasions due to either an increase in capacity or a shortfall in staffing levels. On each occasion a supervisor of midwives was notified. There were no poor outcomes for women or babies or complaints as a result of the Maternity Unit closures.

3.4 Supervisory Investigations

Six supervisory investigations were carried out in 2013 resulting in the midwives involved in the incidents being investigated and undertaking action plans to support their learning.

In conclusion 2013 continued to present challenges to both supervisors of midwives and midwives with the emphasis on working collaboratively with mothers, their families and other healthcare professionals, to provide services that were cost effective and which met the individual healthcare needs of the local population. Supervisors of midwives will continue to support midwives to deliver care in an environment of change where staff are required to adopt flexible approaches to their work.

The year culminated in a very positive LSA Audit a copy of which is attached.


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Warrington & Halton Hospitals NHS Founda

4. Risk Management / Clinical Governance

During 2013, there were 3,053 births with the maternity service providing both consultant and midwifery led care pathways. 697 incidents and near misses were reported via the electronic incident reporting system (Datix) during this time.

The following information will summarise events which have occurred within the Women's Health Department, between 1st January 2013 and 31st December 2013.

4.1 Background

The major focus for the Maternity Unit is to provide services for women who are well but who may need unscheduled care as their pregnancy and birth progresses. For most women the plan of care is straightforward, however, for others the care is more complex requiring services in the community setting, neonatal care and for a few mothers intensive care provision.

Delivering maternity care in this way presents challenges relating to planning and capacity where the birth rate rises and falls unpredictably and the health professionals are specialists who work autonomously.

The maternity service cannot completely eradicate risk and where complications arise during pregnancy and birth the consequences may have a long term effect on the individual or family concerned. To support implementation of safe care there is a risk management structure in place with identified roles and responsibilities in relation to the management of risk. During 2014 risk management links with the Corporate Governance team have been strengthened to support the maternity service to develop clinical governance reporting arrangements which will ensure key issues are effectively flagged up in corporate systems.

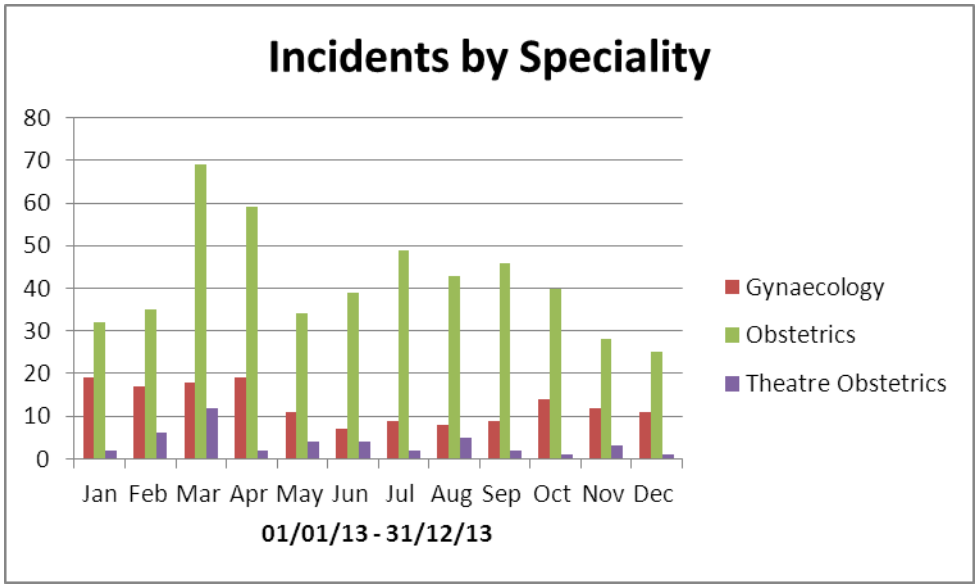
Incident Reporting
During 2013 a robust risk reporting culture continued within the maternity service as staff were encouraged to complete clinical incident reports. As a result of lessons learned staff were able to change practice.

Clinical incidents and near miss events remained a standing agenda item at the following meetings:

- Maternity Risk Management Group / Labour Ward Forum.
- Incident Reporting Group.
- Ward Manager Meetings.
- Divisional Integrated Governance Group Meetings.

Communication on the outcomes of clinical incidents to all midwifery staff was delivered via the weekly Ward Managers meeting to ward managers / team leaders and matrons who in turn further disseminated the information at a local level via safety briefings.

Incidents reported by speciality:



Breakdown of incident numbers reported per quarter - January 2013 to December 2013

01/01/13–31/12/13	Q1	Q2	Q3	Q4	Total
Women's Health	**210**	**179**	**173**	**135**	**697**
Gynaecology	54	47	26	37	154
Obstetrics	136	132	138	93	499
Theatre Obstetrics	20	10	9	5	44

Levels of reporting have remained consistent for each quarter within the speciality.

Breakdown of incidents by location within Women's Health - January 2013 to December 2013

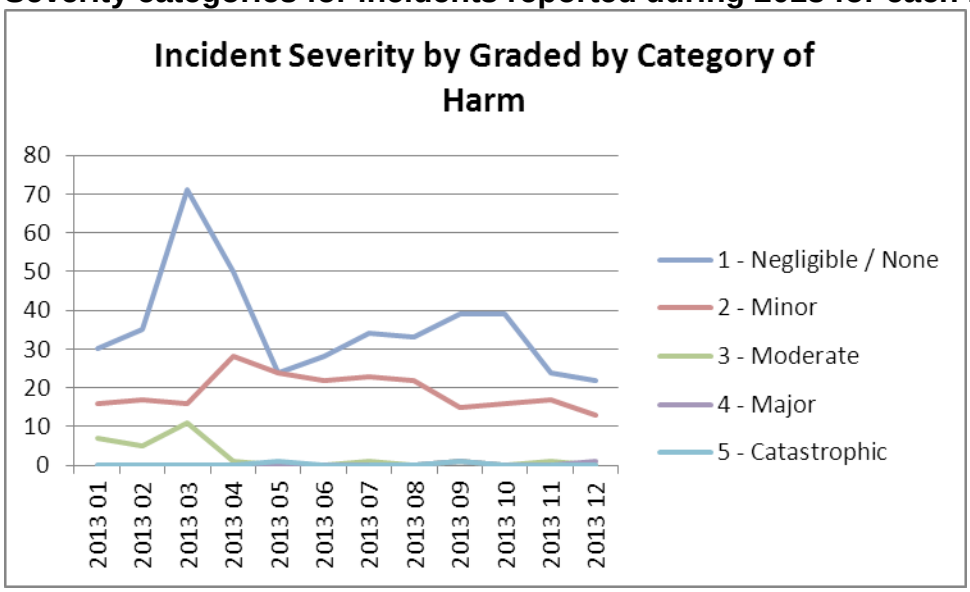
Incidents by Location	
01/01/13 - 31/12/13	**Total**
Antenatal Clinic	23
Antenatal Day Unit	23
C20	97
C23	119
Colposcopy Clinic	7
Corridor/Lift	5
Office/corridor	1
Croft Wing	49
Community Setting	35
Delivery Suite	197
Gynaecology Outpatients Warrington	5
Hysterscope Clinic	5
Maternity Theatre	70
Medical Secretaries	3
Rapid Access Pregnancy Assessment Clinic	6
UroGynae	2
Totals:	647

The most frequent location for incidents within Women's Health was the Labour Ward. This was to be expected as the majority of reported incidents were related to events occurring during labour and delivery.

Incident Severity

Within the Women's Health Department 47% of incidents occurred on the Labour Ward of which 42%% were graded as low / negligible harm. Maternity services report incidents relating to complications of pregnancy and birth to track trends in clinical practice and monitor clinical outcome. These included a significant number of incidents which do not necessarily have an adverse outcome or were near miss events.

Severity categories for incidents reported during 2013 for each month



The incidents were graded as follows:

- 429, (62%) negligible / no harm.
- 229, (33%) minimum harm.
- 27, (4%) moderate harm.
- 2, (0.3%) major harm.
- 2, (0.3%) catastrophic harm.

From February 2013 to May 2013 the Labour Ward was relocated to Daresbury Wing as part of a Labour Ward refurbishment programme. An increased number of negligible / no harm incidents, including an increased number of staffing incidents, were reported during this time as staff experienced difficulties with the location of the Ward away from the Maternity Unit.

- Four incidents were StEIS reportable and root cause analysis investigations were completed. Action plans were developed in response to lessons learned. The Maternity Risk Management Group was responsible for monitoring and completion of action plans, in addition they were monitored by the Clinical Commissioning Group Serious Incident Committee.
- No incidents were reported as Never Events.

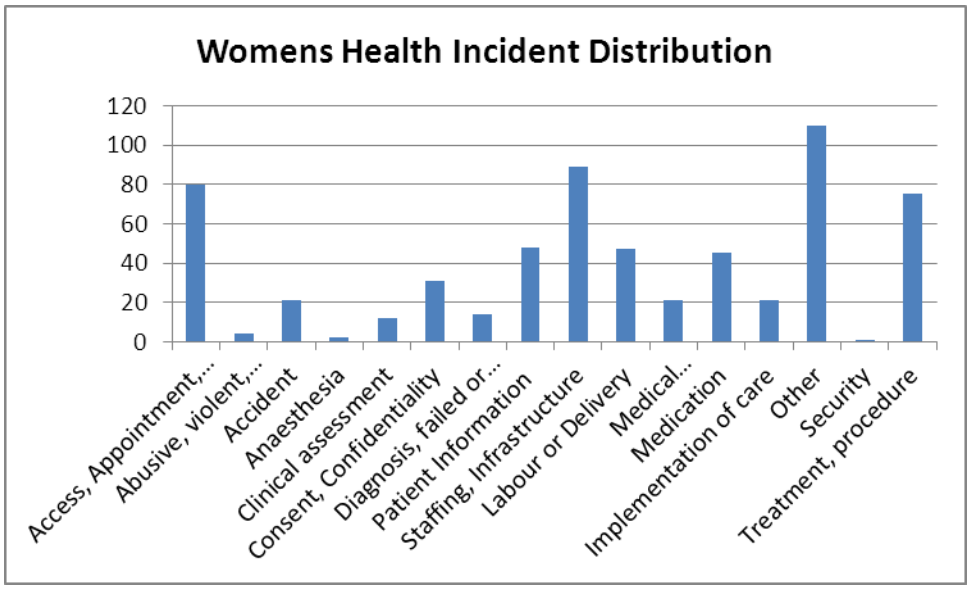
People affected by incidents within Women's Health

01/01/13 - 31/12/13	**Total**
Incidents affecting patients	622
Incidents affecting Staff	46
Incidents affecting contractors and visitors	4
Incidents affecting the trust. eg. premises, site, equipment, infrastructure, reputation	30
Totals:	702

The majority of incidents relating to staff were reported when staffing levels were reduced within Women's Health. A reduction in staffing levels was also reported under infrastructure incidents.

The maternity service reported one incident under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR), when a staff member slipped on a wet floor and sustained an injury. Increased signage was introduced in the area to prevent similar incidents recurring.

Distribution of incidents by reported group, January – December 2013



Distribution of incidents associated with pregnancy and birth which did not necessarily have an adverse outcome, January – December 2013

Top 10 Incidents Associated With Labour and Delivery	
Other not included in pick list	45
3rd and 4th degree tear	20
Shoulder dystocia	18
Postpartum haemorrhage > 2000mls	9
Interuterine Death	7
Deviation from recognised protocol	7
Postpartum haemorrhage > 1000ml or maternal compromised	6
Postnatal re-admission mother	5
Unexpected transfer to NNU	4
Admission to Neonatal Unit >37 weeks gestation	4
Totals:	125

Clinical incidents relating to pregnancy and birth may not necessarily have an adverse outcome but are reported as a way of tracking trends and to allow review of incidents to assure the maternity service that guidelines are followed and care is managed appropriately.

Third and fourth degree perineal trauma; shoulder dystocia and haemorrhage were frequently reported incidents which formed part of the departmental clinical audit programme during 2013.

Incidents of intrauterine death were reported when women presented on admission with an intrauterine death diagnosed prior to the onset of labour. All Intrauterine death incidents were reviewed individually and presented at the departmental Perinatal Meeting for multidisciplinary discussion and to share any lessons learned. Three intrapartum stillbirths were reported to commissioners and the Coroner and Serious Untoward Incident (SUI) investigations were completed.

Maternal and Perinatal Morbidity

Maternal deaths are rare events and their consequences are devastating for all involved. A maternal death is defined as the death of a woman while pregnant or within 42 days of the end of pregnancy from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes.

The maternity service participates in MBRRACE a national reporting system which collates all data relating to maternal deaths and perinatal statistics in order to drive improvements in maternal and child health.

In March 2013 the maternity service reported a maternal death to MBRRACE following a report that a mother had been admitted to a specialist heart and chest hospital two weeks post-delivery following an elective caesarean section at Warrington and Halton Hospitals NHS Foundation Trust.

The maternal death review provided an opportunity for the maternity service to review the care given and learn from a rare and tragic event. The review concluded that the maternal death was not the result of deficiencies in care.

Perinatal mortality is defined as the death of a fetus or newborn in the perinatal period that commences at 24 completed weeks' gestation and ends before seven completed days after birth. Stillbirth is defined as; a baby delivered without signs of life after 23+6 weeks of pregnancy.

	Incidence of Fetal Demise 01/01/13 – 31/12/13					
	No.of deliveries	**No. of Terminations of Pregnancy**	**No. of babies born at <22wks gestation**	**No. of late fetal losses 22-28wks gestation**	**No. of still births >28wks gestation**	**SUI investigation**
Jan	256	2	0	0	0	
Feb	255	0	0	0	0	
March	246	0	0	0	1	
April	253	0	1	0	2	
May	251	1	0	0	1	1
June	234	2	0	0	0	
July	271	0	0	0	0	
Aug	290	0	1	0	1	
Sept	275	0	0	0	2	2
Oct	265	0	2	0	0	
Nov	243	2	0	1	0	
Dec	249	0	0	1	1	1
Total	**3088**	**7**	**4**	**2**	**8**	**4**

Unexplained and unanticipated stillbirths were reviewed using the National Patient Safety Agency NPSA Intrapartum Tool V3 to gather information and identify causal factors. In each case clinical management was assessed and benchmarked against current local and national guidance. The Intrapartum Tool gathered information on socio demographic factors, maternal health and pregnancy history as well as any admissions and events occurring during pregnancy. Understanding the way in which a number of factors could combine to impact on maternal and fetal wellbeing allowed midwives and obstetricians opportunities for improvement in care planning to be made.

Serious Untoward Incident Reporting

During 2013, four Serious Untoward Incidents were reported to the Clinical Commissioning Group. All of the incidents were related to unanticipated fetal demise in utero with three of the incidents occurring during the intrapartum period.

During this challenging time Warrington and Halton Hospitals NHS Foundation Trust initiated independent reviews into the root cause of the incidents. Experts from Liverpool Women's Hospital and Leeds General Hospital were asked to carry out unbiased independent reviews of the cases to determine whether the investigation process was robust and to identify any further learning and improvement points that could be implemented and shared with staff. The teams reviewed clinical care, governance and risk management arrangements and also conducted interviews with staff involved in the incidents. The findings from the reviews were received within the Department and action plans are being developed in response to the recommendations made.

Following a local review of the maternity service governance processes there are on-going discussions with the acute governance team around the level of resource and support that is required to support governance arrangements within the Department.

Lessons Learned
Weekly meetings between the Clinical Risk Midwife; ward managers and team leaders continued during 2013. Safety alerts and safety briefings at handover supported staff to improve practice following lessons learned from incident reviews.

Serious Incident Case Review meetings took place in a multidisciplinary forum to enable shared learning and review of clinical practice to identify changes required to ensure safe and effective delivery of care.

Changes to practice included:

- Increasing the duration of pharmacological thromboprophylaxis for all women undergoing a caesarean birth to seven days, in order to reduce the risk of venous thromboembolism.

- Standardising how staff measure and document fundal height assessments in the antenatal period.

- Introduction of a mandatory perineal suturing training session for all midwives.

- Implementation of the Perinatal Institute national notes to improve communication with cross boundary organisations and improve documentation of routine practices and procedures within the service.

4.2 Maternity Services Governance and Risk Management Meetings

The Maternity Risk Management Group Committee (MRMG) has agreed terms of reference and is chaired jointly by the Associate Director of Nursing, WC&CSS / Head of Midwifery and the Obstetric Governance Lead. Specialist groups such as the Incident reporting Group and the Guideline Review Group report their activities to the Maternity Risk Management Group.

During 2013 all maternity related risk management issues were discussed at the MRMG and escalated through the divisional governance reporting process. Topics reviewed by the MRMG include approval of incident investigation reports; monitoring of action plans; approval of local guidelines and policies; implementation of changes in clinical practice and review of the Maternity Risk Register.

4.3 Clinical Negligence Scheme for Trusts (CNST) Maternity Clinical Risk Management Standards

The National Health Service Litigation Authority (NHSLA) reviewed their CNST standards for maternity services in January 2013. No substantive changes were made to the standards although the NHSLA announced they would disband the CNST assessment process after March 2014. The maternity service completed a previous successful Level 2 assessment in June 2012 and was working towards an October 2014 assessment. When the changes were announced the maternity service worked hard against a tight deadline to prepare for the Level 3 assessment.

Following assessment in March 2014 the maternity service was successful in achieving Level 3 of the CNST Maternity Clinical Risk Management Standards. During the assessment the assessors examined how the unit monitored implementation of maternity guidelines and policies in relation to the 50 CNST

criteria. Audit reports; meeting minutes and action plans were used to evidence implementation and monitoring by the maternity service with the findings verified by spot checks of health records. The maternity service received a score of 43 out of 50 criteria.

Examples of Initiatives and good practice
During 2013 the maternity service implemented a number of new initiatives to improve the care and safety of mothers and babies who use the maternity service.

The maternity service commenced the Perinatal Institute Gestation Related Optimal Weight Chart (GROW), a customised antenatal chart used for plotting fundal height and estimated fetal weight which is used to define each pregnancy's growth potential. Customised assessment of birth weight and fetal growth has been recommended by the RCOG since 2002 and their use has been re-emphasised in the 2013 Green Top guideline *Small-for-Gestational-Age Fetus, Investigation and Management*

The Delivery Suite was refurbished resulting in a pleasant environment for women in labour. The rooms are of a good size with en-suite facilities. Low technology delivery rooms were developed with access to two birthing pools. The refurbishment has been well received by service users and their families.

Induction of labour (IOL) is indicated when the maternal and / or fetal risks of ongoing pregnancy outweigh the risks of induction of labour and birth and is a relatively common procedure. The creation of an induction of labour bay has improved facilities for women who wish to have a birthing partner present during the early stages of the induction of labour process. The IOL bay also reduced the number of delayed procedures caused by capacity issues when women were admitted to a combined antenatal / postnatal ward.

The maternity services provided influenza vaccination clinics for pregnant women to support NHS England strategies for 'flu pandemic planning.

4.2 Complaints, PALS referrals and Clinical Claims

There were 11 referrals to the Patient Advocate and Liaison Service and the Complaints Department during January 2013 to December 2013 in relation to Maternity services.

These included:

- 8 Formal Complaints.
- 3 Informal concerns.

Of these complaints one was upheld; five were partially upheld; four were not upheld and one was withdrawn.

Claims are broken down into financial years. In 2012/13 there were 12 claims and in 2013/14 there were ten claims.

The complaints received related to communication and care delivery issues. Communication was perceived to be poor between mothers and the midwifery / medical teams.

5 Guideline Development

The Guideline Development Group continued to meet throughout 2013 giving priority to review and update of guidelines in preparation for the successful Level 3 CNST assessment. The focus of the group is to address guidelines that are currently in use as part of the rolling programme of review and update. Local guidelines have now been incorporated onto the Trust Hub archiving system, with a focus on improving the availability and retrieval of guideline and policy documents to staff in all clinical areas.

6. Prevention of infection

The Infection control team have continued to support clinical areas within the department to prevent incidents of hospital acquired infection. There were no reported cases of MRSA bacteraemia and no cases of *Clostridium difficile* during 2013 within maternity.

7. National Reports and Recommendations

The Confidential Enquiry into Maternal and Child Health (CEMACH) which undertook mortality and morbidity reviews within the maternity service and published recommendations for improving maternal and child health, based on its findings has now been dissolved and superseded by MMBRACE which is governed by the National Perinatal Epidemiology Unit who will continue to collate all data relating to maternal deaths and perinatal statistics in order to drive improvements in maternal and child health. This is a triennial report, however, there have been significant issues which may impact on MMBRACE's ability to produce its first report. Given the standing of the National Perinatal Epidemiology Unit the issues will be resolved and an excellent report will be produced to which the maternity service will be proactive in its response.

At Warrington and Halton Hospitals NHS Foundation Trust, the Maternity Unit has a designated senior midwife who co-ordinated the statistics and analytical information which was included in the enquiry.

Recommendations from other bodies, such as the National Institute for Clinical Excellence (NICE); Royal College of Obstetricians and Gynaecologists (RCOG) and Royal College of Midwives (RCM) were discussed at Maternity Unit meetings which included the Maternity Risk Management Group; the Labour Ward Forum and the Maternity Services Liaison Committee. Practice within the Maternity Unit was examined and benchmarked against recommendations and any changes implemented as appropriate. This is also escalated through the Divisional Governance structure.

8. Clinical Policies & Guidelines

The major midwifery policies & guidelines were formulated in line with Royal College of Midwives; Royal College of Obstetricians and Gynaecologists and National

Institute of Clinical Excellence recommendations. All policies and guidelines were research / evidence based and regularly updated by the relevant personnel then taken through the Maternity Services Liaison Committee for information and the Maternity Guideline Review Group for ratification; prior to this they were circulated to the supervisors of midwives; obstetric consultants and the Divisional Head of Nursing, WC&CSS / Head of Midwifery. If a policy involved cross department working it was circulated to the relevant personnel for comments and was disseminated via the Trust Clinical Governance meeting.

9. Audit and Research

The Maternity Service, as previously stated, has a robust audit programme which is driven by the Obstetric Audit Lead and the Audit Midwife. Numerous audits were undertaken during 2013, many of which were relevant for NHSLA accreditation. All audits were formally presented on a monthly basis to the multidisciplinary team and any recommendations implemented.

Warrington and Halton Hospital NHS Foundation Trust's Maternity Service continues to be involved in numerous research projects and is the leading Trust in the North West for research into women's health issues. The INFANT Study, which was a major research project, closed in October 2013. Research is supported by two Band 6 midwives and Lead Obstetrician, Dr. Rita Arya.

During 2013 the following research studies were undertaken:

- BUMPES – A study of position during the late stages of labour in women with an epidural.

- EMPIRE – Anti-epileptic drug monitoring in pregnancy: An evaluation of effectiveness, cost effectiveness and acceptability of dose adjustment strategies.

- SAFE / RAPID – New methods of detecting problems in pregnancy involving all women having amniocentesis.

- PREP – Development and validation of a prediction model for risk of complications in early onset pre eclampsia.

- TABLET – A randomised controlled trial of the efficacy and mechanism of levothyroxine treatment on pregnancy and neonatal outcomes in women with thyroid antibodies.

- DAPPA – Spot protein creatinine ration (SPCr) and spot albumin creatinine ratio (SACr) in the assessment of pre-eclampsia.

- INFANT – A multi-centre randomised controlled trial (RCT) of an intelligent system to support decision making in the management of labour using TG.

10. Midwifery Staffing Review

Please see attached report.

Midwifery Staffing Review July 2014.doc

11. Recruitment and Retention

All newly recruited midwives to the Trust underwent an enhanced CRB disclosure prior to commencing employment, and their registration details were confirmed with the Nursing and Midwifery Council. All new midwives to the Trust underwent a Trust Induction and where appropriate preceptorship.

12. Improving Working Lives

The Maternity Unit continued to be proactive in improving working lives, accommodating job share; term time working and other flexible working options supported by the Human Resources Department.

13. Training

13.1 Continuing Professional Development (CPD)

Maternity Services - specialised training
The maternity services expectations in relation to staff training were identified in the Training Needs Analysis (TNA) within the maternity services training policy.

The TNA was supported by a training programme, which was informed and reviewed by the Practice Development Midwife (PDM). It detailed a schedule of maternity specialist mandatory training required by each staff group within the maternity service and reflected recommendations from the National Confidential Enquiries; the NHS Litigation Authority; the Royal Colleges; Advanced Life Support in Obstetrics; National Institute for Clinical Excellence and other relevant information sources. The PDM in association with the Maternity Risk Management Group (MRMG) reviewed training to address the results from audit; incidents; complaints and claims and other information sources. Amendments to training programmes were made as appropriate, to ensure that lessons were learned thus supporting the maternity services governance framework.

13.2 CPD- Internal Courses

Midwifery Skills Drill Update Days
Training supported the requirements of the CNST Maternity Standards portfolio; Trust Mandatory Training and Maternity Services TNA. Sessions were also provided to promote staff development and CPD requirements. Training was provided over a four day programme on an annual basis.

Skills Drills Training Day 1

Time	Topic	Trainer
08.00-08.15	Registration & Introduction	
08.15-09.00	The Systematic approach to the Severely ill pregnant woman/Deteriorating Patient MEOWS. Care following operative vaginal delivery.	Jeanette Carter
09.00-12.30	Skills Theory/Practical Drills APH/PPH Eclampsia Coffee break Shoulder Dystocia Cord Prolapse Breech	Jeanette Carter Dr R Arya Dr El-Housseiny Band 7 Midwives
12.30-13.15	Lunch	
13.15-14.00	Mental Health Training- Maternal mental health disorders, risk assessment records and referral routes	Anne Anderson
14.00-15.30	Neonatal Resuscitation Coffee break	Claire Evans
15.30-16.30	Continuous Electronic Fetal Monitoring Close and Evaluation	Jeanette Carter

Dates

9/1/13	6/2/13	6/3/13	4/4/13	1/5/13
16/1/13	13/2/13	13/3/13	11/4/13	8/5/13
22/1/13	19/2/13	27/3/13	17/4/13	14/5/13
31/1/13	28/2/13		25/4/13	22/5/13

Skills Drills Training Day 2

Time	Topic	Trainer
0815-08.30	Registration	
08.30-12.00	Conflict Resolution Training	Phil Sloan Sean O'Brien
12.00-12.30	Lunch	
12.30-14.00	Pain relief –in Labour Options and management Non-pharmacological and pharmacological choices	Dr El-Housseiny
14.00-16.30	Clinical application of customised Growth charts. Standardising fundal height Documentation and record keeping	Jeanette Carter Ann Goodwin

11/1/13- Friday	24/4/13- Wednesday
23/1/13- Wednesday	9/5/13- Thursday
7/2/13- Thursday	17/5/13- Friday
22/2/13- Friday	24/5/13- Friday
7/3/13- Thursday	6/6/13- Thursday
15/3/13- Friday	13/6/13- Thursday
19/4/13- Friday	27/6/13- Thursday

Skills Drills Training Day 3

Time	Topic	Trainer
09.00-10-00 10.00-11.00 11.00-11.15 11.15-12.15 12.15-13.00	Fire Information Governance Break Infection Control Lunch	Trust Trainers Lecture Theatre Education Centre Warrington
13.00- 14.15	Child Protection	Safeguarding Team
14.15- 15.15	Local Blood Transfusion Training	Julie Yates
15.15- 16.45	Assessors update Including Coffee	Gill Hughes Rachel Crone
16.45-17.00	Close of day and evaluations	

Skills Drills Training Day 4

09.00- 13.00	Adult Resuscitation	Clinical Training Ward A4 Halton
13.00- 13.30	Lunch	
13.30-17.00	Self directed study time – training to be completed within 2 weeks of attendance • e-learning opportunity • National screening committee • K2	

Maternal AIMS
Maternal AIMS training was planned throughout 2013. Maternal AIMS is a Midwifery specific course and it was introduced to the Trust by the PDM in 2012. Documentation is provided by the Critical Care Network and the course requires a 3 yearly recertification.

'Live Skills Drills'
Live drills continued throughout 2013. These occurred in all departments and six were planned on an ad hoc basis throughout the year in different clinical areas.

Perineal Repair
Perineal repair updates were provided as part of the Day 2 Programme. The sessions were a theoretical, evidence based update which included the observation of a DVD showing the continuous perineal repair technique; Subcuticular suturing to the skin and Aberdeen knot to complete the repair. All midwives on Labour Ward and new starters were competency assessed as per the local policy.

13.3 CPD- External Courses

Newborn Life Support Training- NLS (External Training for Band 7, Labour Ward Midwives)

This training was provided externally to the Trust. Four Band 7 midwives are due their 4 yearly update this year. These sessions are booked and planned.

Advanced Life Support in Obstetric Course - ALSO
The Department successfully hosted the ALSO within the Trust and secured a number of free places for midwives to attend.

CPD Apply modules and training
Midwives were supported to access CPD modules. The Departmental Education Strategy Group (ESG) identified that supporting midwives to complete the Examination of the Newborn module should be a priority throughout 2013/14. Midwives were asked to express their interest in attending the Examination of the Newborn (EONB) module. Community midwives were identified as a key staff group enabling them to support a holistic homebirth service. Staff groups who wished to access any other modules, (apart from the mentorship module when support maybe negotiated) via CPD Apply were required to identify their own time / funding streams. Attendance at CPD modules was discussed and approved at ward manager meetings.

13.4 Additional departmental activity

Preceptorship
The Preceptorship programme throughout 2013 evolved and developed to support preceptors and to guide them through the preceptorship period. Preceptors were given a preceptorship pack on commencement to the Trust. The preceptorship programme has adapted to support the service but also the preceptors development. During 2013 there were 13 midwives on the preceptorship programme.

IV Cannulation
The services' aim is that all midwives allocated to the Labour Ward are able to perform IV cannulation therefore providing a holistic care pathway.
The Trust lead for IV cannulation training has supported local development by providing sessions for midwives incorporating the IV Cannulation and drug calculation sessions. Nine midwives have successfully completed the training since its inception and further training is planned.

GROW Training
This was incorporated into Day 2 training in 2013. External training was provided to address a service need. This training was delivered by the Perinatal Institute.

Complementary Therapies
The successful delivery of this service required qualified practitioners to facilitate the sessions. Midwives applied for training via CPD application. The services provided / to be provided were / are:

- Hypnobirthing
- Yoga: pregnancy and postnatal
- Aquanatal
- Moxibustion
- Placental encapsulation
- Acupuncture

Resource Room
The resource room was available to facilitate multidisciplinary training within the department; the PDM managed bookings it was used to support:

- Medical staff training
- Safeguarding meetings
- Infant feeding update sessions
- Suturing workshops
- Drills/ Mandatory Training
- Aromatherapy workshops
- Promoting Normality Study Days
- Medical devices training
- Infant resuscitation sessions
- Manual Handling updates

The room also provided access to a PC terminal and resources for example, information boards and files; access to local and national guidelines.

14. Clinical Practice Facilitator

At Warrington and Halton Hospitals NHS Foundation Trust's Maternity Unit we aim to ensure all students are provided with an environment which is conducive to their learning experience. This is achieved through the Clinical Practice Facilitator.

The main role of the Clinical Practice Facilitator is to act as a practitioner enhancing and improving the clinical competency of pre-registration students, ensuring 'fitness

for practice'. This function is achieved with liaison between students; assessors and HEI's.

This role is continually expanding to meet the varying needs of students; assessors; HEI's and the Trust, however, the main aims are to:

- Liaise with HEI's to maintain sufficient numbers and quality of assessors in practice (regular updates).
- Provide support and advice to mentors and students.
- Develop and implement a system to respond to issues arising from clinical placement areas (students and assessors).
- Work alongside students in the clinical area at the request of the mentor and in particular students are having difficulties or are unable to achieve the required learning outcomes.
- Evaluate the student's experiences.
- Evaluate the assessor's experiences.
- Provide student learning resources (information packs; links with specialist roles).
- Involvement with clinical audit and reviews.
- Leads and supports volunteers.

15. Return to Practice 2013

In 2013 the maternity unit supported three return to practice midwives.

16. Examination of the Newborn

The maternity service currently has a cohort of midwives who have successfully completed the Examination of the Newborn course.

The acquisition of this course enabled midwives to extend their autonomous practice into the care of the normal neonate and complemented their autonomous care of low risk women in the antenatal; intra partum and postnatal periods. In the case of home deliveries, midwives who hold this qualification went out to the community and performed an examination of a normal neonate. This was appreciated by the new mothers and further enhanced the midwives role as an autonomous practitioner.

During 2013 Examination of the Newborn Clinics continued to enhance the service given to women and their babies. This fulfilled NIPE recommendations.

17. Public Health

The maternity service continued to be proactive in delivering the public health agenda. With the dissolution of Primary Care Trusts public health has moved to local authorities in the New Year, whilst no decision in relation to funding of public health roles within the maternity service has been decided. The key roles in relation to infant feeding; smoking cessation and drugs and alcohol have continued to be funded.

18. Specialist Midwives

18.1 Infant Feeding Co-ordinator (Funded by Warrington and Halton Hospitals NHS Foundation Trust) 28 hours per week 0.8 WTE

The Infant Feeding Co-ordinator and the Infant Feeding Team of midwives provided the following support to their colleagues and breastfeeding mothers and their babies:

- Telephone support to breastfeeding mothers in the early days and where and when necessary visiting mothers.
- Liaised with community staff regarding mothers who may require more support / assistance with breastfeeding issues.
- Visited mothers on the postnatal and neonatal wards and provided breastfeeding support and promoting the benefits of skin to skin.
- With regard to tongue tie the Infant Feeding Co-ordinator regularly referred babies to other hospitals when necessary. The Infant Feeding Co-ordinator is currently trying to develop an in-house service.
- The Infant Feeding team of midwives were available for individual support in the antenatal period to discuss the benefits of breastfeeding and skin to skin.
- Continued provision of information for breastfeeding mothers in discharge packs.
- Liaised with other areas e.g. Irlam and Halton and provided information to women who deliver at Warrington and Halton Hospitals NHS Foundation Trust but live out of area ensuring that women knew how to access their local breastfeeding support services.
- Attended events e.g. ‘Bru’ café coffee mornings promoting breastfeeding support.
- Attended college events recruiting Bosom Buddy volunteers and highlighting the benefits of breastfeeding to students.
- Held regular meetings with staff on the neonatal ward and liaised closely with the Breastfeeding Link Nurse and discussed future developments for neonates in line with UNICEF Baby Friendly.
- Provided support to the Breastfeeding Project Officer in continuing to develop the Infant Feeding website and provided advice when appropriate.

- Provided breastfeeding support and management advice to Peer Support Co-ordinators and staff.

- Assisted in identifying women in Quintile One areas by postcodes on Ward and offered further support.

Antenatal Project
The Infant Feeding Co-ordinator attended the Folly Lane Antenatal Project once / twice per month and supported the midwife providing infant feeding information to antenatal women in Quintile One areas.

Bosom Buddy Support Groups
With regard to Bosom Buddy Support Groups:

- The Infant Feeding Co-ordinator attended the fortnightly Bosom Buddy support group in community ensuring midwifery input and supporting breastfeeding mothers.

- Audited attendance and supplied information to the Infant Feeding Co-ordinator Community Lead.

Statistics
With regard to infant feeding statistics the Infant Feeding Co-ordinator undertook the following:

- Developed a process for improving data collection in conjunction with the IT and Information Departments.

- Reported initiation and discharge figures on a monthly basis.

UNICEF Baby Friendly Initiative
The UNICEF Baby Friendly Initiative is a world wide programme of the World Health Organisation and UNICEF. The Baby Friendly Initiative works with the health care system to ensure a high standard of care for pregnant women and breastfeeding mothers and babies. UNICEF provide support for implementing best practice and have an assessment and accreditation process that recognises when the desired standards have been achieved.

As part of Warrington and Halton Hospitals NHS Foundation Trust BFI Accreditation the Infant Feeding Co-ordinator concentrated on the following points:

- Reviewed and updated UNICEF adapted Midwives Breastfeeding Management Training Programme and amended materials.

- Trained staff in UNICEF Breastfeeding Management with 85% of staff trained.

- Redesigned breastfeeding training for paediatric staff (UNICEF based).

- Undertook practical skill reviews undertaken on a one to one basis with midwives and health care support workers.

- Updated staff with new developments from UNICEF at handovers.

- Developed an Infant Feeding Guideline and Hypoglycaemia Guideline and amended as per UNICEF requirements.

- Drafted a Bed Sharing Policy.

- Worked towards Stage Three UNICEF accreditation. This was assessed in November 2013 and areas to address were highlighted therefore an action plan was developed.

- With assistance from the Breastfeeding Project Officer arranged two day training sessions for staff with regard to UNICEF Breastfeeding Management.

- Provided breastfeeding training including practical skills for staff.

- Audited care of women at antenatal and postnatal stages as part of the UNICEF Stage Three Process.

- Introduced supplementation audits and devised a reminder for staff on policies and procedures of supplementation as required by UNICEF.

- With support from the Matron, GUM; Rheumatology and Outpatient Services implemented regular breastfeeding manager meetings which informed and supported Ward Managers and Team Leaders with UNICEF Stage Three requirements.

CNST
The following ongoing developments to comply with CNST were undertaken:

- A robust process for referrals of babies less than 28 days with feeding problems was developed.

- Breastfeeding support offered and care plans developed for mothers of babies with feeding problems who have been readmitted to the Children's Ward within 28 days.

- Referral information flowchart developed for staff.

- Involvement in Level 1 investigations of babies readmitted to the Children's Ward with weight loss.

Meetings attended
The Infant Feeding Co-ordinator attended the following meetings during 2013:

- Maternity Services Liaison Committee

- Invest in Breast

- Breastfeeding Strategy

- Band 7 Quality Review Group

- Breastfeeding Meetings with Team Leaders / Managers at Warrington Hospital
- Specialist Midwives
- AQuA
- Champs
- Operational Breastfeeding

The Infant Feeding Co-ordinator managed the Peer Support Co-ordinators / Breastfeeding Project Officer.

18.2 Smoking Cessation Midwife (Funded by the Primary Care Trust)
15 hours per week Band 7 midwife
7 hours per week Band 6 midwife

During 2013 the smoking cessation service maintained an opt out service with no waiting time for appointments. The smoking cessation service continued to work with and promote the 7 Steps Programme. The smoking cessation service also continued to work towards achieving the SATOD targets.

Future plans for the smoking cessation service are to offer support for women who have achieved and maintained a quit status and support in the postnatal period to enable a smoke free environment for children.

18.3 Teenage Pregnancy Midwife 2014
15 hours per week 0.5 wte

Many teenage mothers suffer social and economic deprivation and the impact of teenage pregnancy on the health of mothers and their babies is well documented. Babies born to mothers under the age of 18 are at an increased risk of prematurity and are 25 % more likely than average to have a low birth weight. There is a 60% higher than average infant mortality rate in babies born to mothers who are under age 18yrs of age.

"Early intervention and prevention are at the heart of what the Children's Partnership is seeking to achieve for children, young people and families in Warrington.

The number of patients delivered in Warrington Hospital in 2013 and who lived in the Warrington area aged 18 and under at delivery was 46, with the previous year being 59.

The teenage pregnancy three year rolling average figure continued to suggest we were making progress as it showed a gradual decline over that time period.

The Teenage Pregnancy Midwife attended the Young Parents Support Group which was held at Jubilee Park. This group is for antenatal and postnatal young parents. The group involves joint agency working with the specialist health visitor and the nursery nurse responsible for young parents. The Teenage Pregnancy Midwife concentrated on the antenatal parents in the group in order to prepare them for

labour; delivery and the postnatal period. The Teenage Pregnancy Midwife advised the early postnatal parents to access contraceptive services early, in order to prevent unwanted pregnancies. The pregnancy support midwives attended the group to promote breastfeeding and to identify the young girls who wanted to breastfeed and offered them early support within the hospital environment. The attendance at the group varied in numbers and we are looking at re-locating to the town centre if premises can be found, as historically the attendances have been better in this location.

The Teenage Pregnancy Midwife booked all pregnant young girls aged 18 and under. The booking visit usually took place within the home where a good social assessment could be carried out.

The Teenage Pregnancy Midwife performed numerous CAFs; arranged Family Support Meetings if it appeared that a co-ordinated action plan was needed or would refer to single agencies if required.

The Teenage Pregnancy Midwife continued to chair the Teenage Parents Group held every two months. This is a multi-agency group attended by a health visitor; nursery nurse; careers advisor; college welfare; housing support and a family support worker. This was an arena to share concerns regarding provisions or individual problems.

At present we are working together to create an antenatal and postnatal pathway to support young girls who are going back into education to allow this process to be as smooth as possible as some of these young girls do not receive parental support with this process.

The Teenage Pregnancy Midwife attended the Warrington Better Prevention Group and worked with the Health Improvement Manager from Warrington Public Health in providing data regarding conceptions and deliveries and this allowed them to be proactive in hotspot areas.

The Teenage Pregnancy Midwife attended meetings within the school if the child was of school age this allowed a multi-agency approach to offering support and also supported the school's risk assessment and encouraged young girls to remain in education for as long as possible.

The Teenage Pregnancy Midwife was invited to schools within the Warrington area to give support to students with up to date antenatal information. Schools wanted to know about antenatal screening tests and antenatal care. This was a great way to engage with the community and created links between education and health.

The Teenage Pregnancy Midwife attended numerous case conferences; Child in Need meetings; core groups or Leaving Care review meetings. The change in the last year for these meetings was the reports that have to be completed and submitted to Children's Social care prior to, or at the meeting. Following the meetings a report had to be completed with the outcome and filed in the hospital notes so that all areas of maternity were aware of the action plan

The Teenage Pregnancy Midwife continued as a CAF trainer working within the CAF team and delivered CAF training to all agencies across Warrington. Support and

encouragement was given to ensure that all midwives and carers accessed training and felt confident in completing CAF'S.

The Teenage Pregnancy Midwife also worked within the Hospital Safeguarding Team. The Teenage Pregnancy Midwife attended the monthly multi-agency meeting or supported the general management of the safe guarding office with peer support; audit and information sharing.

The Teenage Pregnancy Midwife attended the Specialist Midwife Meetings; Monthly Quality Control meetings; Women's Health Audit meetings and Ward Managers Meetings.

18.4 Drug Liaison Midwife
15 hours per week 0.4 wte

The Antenatal Clinic also known as the Pregnant Substance User Clinic [PSUC] continued to be held weekly on a Monday morning at CRI Pathways to Recovery Adult Drug Centre, 14 -16 Bold Street Warrington, with adapted parentcraft classes for the needs of the substance users following the Antenatal Clinic, this included a tour of the Maternity and Neonatal Units at Warrington Hospital. This venue was more suitable for our pregnant women as it is based in Warrington town centre and very few patients did not attend their appointment.

The Pregnancy Group is a multi-agency group of professionals who offered specialised and holistic care to these vulnerable women which could include attending core group meetings and / or case conferences for which a report on the progress of the woman and her pregnancy was presented. Each week following the Antenatal Clinic the team updated on the patients' plan of care and drug / reduction therapy. New pregnant women were introduced to the service. Multi-agency assessment involved forward planning and decision making by all agencies to ensure a healthy pregnancy and birth and the correct safe environment for the baby to live once it was born, this offered advice and support to keep families together wherever possible.

Leaflet and Poster
The service is currently not advertised in GP surgeries and children's centres. It is necessary to link with these places to explain the service and how to refer any women using illicit drugs. A leaflet and poster has been ratified and printed. CRI have arranged distribution of the poster to all GP surgeries in Warrington and will provide some to display in Warrington Hospital's Antenatal Clinic and Antenatal Day Unit.

Antenatal Bookings
To continue the 'one stop shop' approach to the service pregnant women could have their antenatal booking appointment at the Pregnancy Substance User Clinic [PSUC].

PUP Course [Parents under Pressure]
Since 2011 the Pregnancy Substance User Antenatal Clinic linked in with the NSPCC and the Parents Under Pressure course. The course criteria was any patient who has drug or alcohol issues and has an infant under one year old. The PUP Team liaised with the pregnancy team for referral and monthly meetings were

held prior to the Antenatal Clinic for update and new patients. The PUP team visited the women in the postnatal period weekly for 20 weeks to work on parenting skills and adaption to life with a new baby and if reduction in / stopping substance misuse. This gave the women support and could result in these women not being referred to Children's Social Care [CSC] where they may well have been in the past. This service continues and has shown to be beneficial.

Alcohol Midwife
There is a gap in the service which has identified the need for a specialised alcohol midwife. The drug team have now joined with the alcohol team and share the same premises. They attend the same groups and work alongside the same care pathways but the drug using women have a specialised Antenatal Clinic. The Drug Liaison Midwife has asked the team for numbers to present to management. More hours would be required if the role is to expand.

There is a need for greater education with regard to alcohol consumption in pregnancy and concerted effort is required to improve the identification and advice for women regarding risky alcohol consumption pre and during pregnancy. Alcohol and Pregnancy is part of the Public Health Agenda. The Drug Liaison Midwife feels these issues could be addressed locally considering the overall number of women in Warrington drinking is 31.9% - National average is 22.7%.

Summary
Since 2005 the numbers of pregnant women who are substance misusers has steadily increased as awareness of the service becomes apparent and the stigma reduces.

Attendance at the Antenatal Clinic has improved and pregnancy outcomes are healthier. The style of substance use has changed, cocaine and cannabis are deemed 'recreational' drugs in society and hence patients may not view themselves as substance users resulting in midwives not knowing they are. If problems do occur in the antenatal period midwives may need to be aware that it may be the result of undisclosed substance use and ask questions accordingly to gain more information. The Drug Liaison Midwife liaised and linked in with Specialist Midwives and Drug Key Workers in out of area clinics and drug centres regarding information; home environments; involvements from other services and drug history and treatment of the pregnant women who live outside the Warrington area but are having their baby at Warrington Hospital.

The Drug Liaison Midwife updated the patient's records and reported to safeguarding and midwives where appropriate.

The Drug Liaison Midwife attended the monthly safeguarding liaison meetings for information sharing and update.

18.5 Screening Midwife
37.5 hours per week
The National Screening Committee continued to focus on Quality Assurance within their standards.

New standards were introduced for Newborn Screening in August 2013. The pilot programme to identify a further five metabolic disorders has been completed in March 2014 and commencing either September 2014 or January 2015 there will be a

further 4 tests added to the current programme, Homocystinuria (HCU), Maple Syrup Urine Disease, Glutaricaciduria-Type 1,and Isovalericacidaemia. Details of the start date will be confirmed later in 2014.

Key performance indicators for antenatal screening were based on Hepatitis B; HIV; Downs screening; Sickle Cell and Thalassaemia and Newborn Bloodspot Screening, the Screening Midwife was responsible for these programmes. Quarterly reports were reported to the regional screening team and ultimately the Department of Health.

Collaboration between the Data Quality team; the Screening Midwife and the Payment by Results Midwife resulted in the implementation of a new data collection system that provided accurate KPI data.

The implementation of Payment by Results was pivotal in the requirement of accurate data collection.

The annual screening report is due in August 2014 and the improvement in data collection will make this process easier to collate.

Newborn hearing screening was also part of the screening programme but the screening midwife was not responsible for this and statistics were collated by the programme co-ordinator Deborah Grogan.

The NIPE programme completed the pilot stage and is now integrated into the screening programme here in Warrington. Across the country other areas are to become part of a national rollout. The Screening Midwife is not the lead for this programme but works closely with the NIPE lead.

19. Infection Control

Infection control for Women's Health was monitored via the Divisional Infection Control Team and the Trust's Infection Control Committee, both of which met on a monthly basis. The Matron for Women's Health produced a monthly report, which was fed into both these groups. This monthly report was also disseminated to the ward managers for them to print a copy for their staff to access, this ensured that staff were kept up to date with the audit results and also any new or updated infection control policies.

Monthly audits on the Matron's report included: hand hygiene; VIP's; work wear and uniform; commodes and High Impact Interventions. Cleaning audits were carried out in all the areas by the Trust's monitoring team, the frequency of these audits was dependent on the area. The Labour Ward was monitored on a weekly basis, whilst the outpatient areas were monitored quarterly.

All staff were expected to attend their annual mandatory infection control training and infection control was a standing agenda item at the weekly ward manager meetings.

20. Child Protection / Safeguarding

The Maternity Unit was charged with implementing and embedding a safeguarding clinical supervision system following an Ofsted inspection report in February 2013. To enable this the following actions were undertaken:

- A standard operating procedure was developed and the policy updated.
- Group supervision for community midwives (case holders) was established in December 2013. This was supported by the two Community Team Leaders.

- Reactive supervision was recorded regularly.

Safeguarding Level 3 training was increased from 15% to 78% compliant across the Trust.

A safeguarding preceptor pack and information folders for midwives was developed.

Social care moved to a combined assessment process. This called on the expertise of all partners to contribute to the assessment process of children and young people when they were being assessed by social workers. The greatest impact of this was on midwifery staff who needed to produce reports with 'opinions' of what it was like for the child or the baby of the women and or their families. These reports could form part of court proceedings and they required fresh eyes; quality control and oversight prior to submission. A patient may have numerous reports during their pregnancy and midwives had to attend all related meetings.

NHS England and Warrington Safeguarding Children Board increasingly requested that midwives demonstrated that they offered early help for families who were identified as being below the threshold for the services of social care. Midwives were the major contributors to CAF (common assessment framework) assessments. Maternity increased CAF levels by 21% in the calendar year. These generated additional work including co-ordination; fresh eyes; action planning and the arrangement of Family Support meetings.

There was an increase locally and regionally in women who had babies that were not discharged with their mothers. This was partly due to the Monroe report and new public law changes that looked at quicker decision making for babies placed in foster care / adoption. Research demonstrated that there was significant impact on children who were neglected or emotionally abused at an early age. The quicker the removal and securing of a stable placement, the lesser the developmental or emotional effects. These cases usually involved families where the mother was pregnant and care proceedings had not concluded on other children These had a significant on both the community midwife and hospital midwives working with women and preparing them not to be discharged with their baby. This also impacted on the length of stay postnatally. If parents did not agree to Section 20 (voluntary accommodation of bay, a court order needed to be sought and there was usually a two to five day length of stay of mothers in postnatal beds waiting to go to court.

21. Community Midwifery

21.1 Home Birth

The maternity unit continued to promote normality and encouraged home birth for all eligible women. During 2013 we had an increase in home births with 21 women

achieving a home birth; five women had to come into hospital for induction of labour and five women were transferred in due to complications in labour. All the women who chose to labour and birth at home had an excellent experience and outcome for themselves and their babies. Those women who had to come into hospital for induction of labour and those women who had to be transferred into the hospital during labour also had a good outcome for themselves and their babies.

21.2 Early Bird Clinics

The Early Bird Clinics provided women with information prior to booking allowing them to consider their options for antenatal screening at an early stage of pregnancy and enabling midwives to tailor booking appointments to the individual needs of women

21.3 Rolling Programme

The rolling programme continued throughout 2013. Women found this programme to be of benefit and very enjoyable.

22. Sudden Untoward Incidents 2013

Please find attached the final reports of the Sudden Untoward Incidents which took place in maternity in 2013:


Investigation Report 2013-15101 Amendm


2013-27007 Investigation Report


2013-28427-Level 2 investigation report F

23. Achievements and Challenges 2013

23.1 Successes for 2013 include the following:

- Achievement of NHSLA CNST Level 3.
- Continued development of the Aromatherapy Service.
- Introduction of hypnobirthing service.
- Introduction of pregnancy yoga classes.
- Development of Aquanatal classes.
- Successful Band 5 preceptorship midwife programme and increased confidence in the newly qualified midwives.
- Two midwives have successfully achieved the Examination of the Newborn module.
- Refurbishment of Maternity Unit

23.2 The main challenges for 2013 were:

- Preparation work for the NHSLA CNST Level 3 Assessment. Staff and the team led by Eshita Hasan, Audit and Governance Lead and Anne Goodwin, Clinical Risk Midwife worked tirelessly and were rewarded with NHSLA CNST Level 3.

- Staffing during 2013 due to sickness absence proved to be problematic. This was supported by the midwifery management team and supervisors of midwives to ensure the safe care of women and their babies.

- Vacant midwifery posts.

- Cancellation of training due to staff shortages.

- In March 2013, a whistleblowing incident to the CQC occurred. A copy of the report to the CQC is attached.

Final RESPONSE IN RELATION TO THE AI

- Four serious untoward incidents.

- During December 2013, following a Sudden Untoward Incident, interim measures regarding fetal surveillance in labour for all women regardless of risk status was introduced. This led to low morale and confidence amongst midwifery staff.

24. References

DOH 2001 *Making a difference*: The nursing, midwifery and health visitors contribution: The Midwifery Action Plan. HMSO London
DOH 2000. *An Organisation with a memory*. HMSO London
Drazek et al 2004 *: Guidance for Supervisors of Midwives.*: North West LSA.
CEMACH 2007 "*Saving Mothers' Lives*" RCOG Press. London
DOH 2000 *NHS Plan.* HMSO London
NSF DOH 2004 HMSO London
NICE Guidelines 2003 London
NHSLA / CNST December 2009 NHSLA
DOH 2007 Maternity Matters
Hidden Harm 2004

Warrington and Halton Hospitals NHS
NHS Foundation Trust

W&HHFT/TB/14/120(i)

BOARD OF DIRECTORS

Paper Title	Safeguarding Vulnerable Adults – Annual report 2013/2014
Date of Meeting	30Th July 2014
Director Responsible	Corporate
Author(s)	Dianne Goncalves – Safeguarding Matron
Purpose	This paper seeks approval of the content of the Safeguarding Vulnerable Adults Annual Report

Paper previously considered (state Board and/or Committee and dates)	**Committee**	**Date**
	Members of Safeguarding Steering group	11th July 2014

Relates to which Trust objectives	√ **appropriate**
• Ensure all our patients are safe in our care	√
• To be the employer of choice for healthcare we deliver	√
• To give our patients the best possible experience	√
• To provide sustainable local healthcare services	√

Key points arising from the Report/Paper (please include up to eight bullet points and reference page/paragraph as appropriate).

		Page/Paragraph Reference
1	Change in definition to Vulnerable adults	**P2**
2	Impact on recent House of Lords Select committee on the impact of Mental capacity Act	**Exec summary p3 & p15**
3	Implications of Dep of Health Prevent Agenda and impact on the Trust	**Exec summary p5 & p10**
4	The challenges the Trusts faces by the resent supreme court decision on application of DOLS to patients in our care	**P16**
5	Trust Training figures	**Exec summary p5 & p11**
6	Improvements to lessons learnt and safeguarding referrals	**Exec summary P6 7 p12**

Recommendation(s) (include what you require the Board to do; approve/note/ratify etc.)

Board is asked to approve the Safeguarding Vulnerable Adults – Annual report 2013/2014

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Safeguarding Vulnerable Adults

Annual Report 2013/2014

Contents

Safeguarding Adults Annual Report 2013/2014

1 Introduction

We are proud to present the 4th Annual report on safeguarding vulnerable adults for Warrington and Halton Hospitals NHS Foundation Trust. Safety from harm and exploitation is one of our most basic needs and everyone has a right to be safe. As adults, we constantly weigh up the balance of risks and benefits in what we do and the choices we make. 'Safeguarding' is a range of activity aimed at upholding the fundamental right to be safe, at the same time as respecting people's right to make choices. Safeguarding involves empowerment, protection and justice. This annual report and audit of compliance describes the systems, processes, training and accountability arrangements for Safeguarding Adults at the Trust.

Definition of Vulnerable Adult

Changes to the Term Vulnerable Adult
The term ***'adult at risk'*** has been used to replace the term ***'vulnerable adult'***. This is because 'vulnerable adult' may wrongly imply that some of the fault for the abuse lies with the adult being abused. Therefore 'adult at risk' is used as an exact replacement for 'vulnerable adult'. An adult at risk is a person aged 18 years or over who is or may be in need of community care services by reason of mental health, age or illness, and who is or may be unable to take care of themselves, or protect themselves against significant harm or exploitation (Law Commission, 2011). ***(Department of Health – No Secrets 2000)***

The Statement of Government Policy on Adult Safeguarding' (May 2013) and the Social Care Institute for Excellence 'Safeguarding adults at risk of harm: A legal guide for practitioners' (2011), outline the key principles in safeguarding adults as:-.

- **Empowerment-**The presumption of person led decisions and informed consent. Adults should be in charge of their care. Self-determination can involve risk and making sure that such risk is recognised and understood by all concerned, and minimised whenever possible.
- **Protection**- Patients should be offered the support necessary for them to protect themselves.
- **Prevention**-prevention of harm or abuse is the primary goal
- **Proportionality-** Safeguarding responses should be proportional to the nature and seriousness of the concern
- **Partnership-** Safeguarding adults is most effective where individuals professionals and communities work together to prevent ,detect and respond to harm and abuse
- **Accountability**-That there is accountability and transparency in delivering safeguarding, with agencies recognising that it may be necessary to share confidential information, but that any disclosure should be compliant with relevant legislation.

2. National Context

Whilst there is currently no specific statutory provision for safeguarding adults in England and Wales, the legal framework for intervening in safeguarding incidents is provided through a combination of common law, local authority guidance and general statute law.

The ***White Paper Caring for our future: reforming care and support and the Care Bill (2013),*** confirms the intention to place Adult Safeguarding on a statutory footing, through legislating for Safeguarding Adults Board and empowering local authorities to make safeguarding enquiries.

The Department of Health has made clear its expectation that existing Safeguarding Boards and multi-agency partnerships should use current resources to deliver clear and effective local

safeguarding arrangements and that local authorities, in partnership with police, NHS organisations, housing bodies and others, should be working to improve the safety of those in vulnerable situations. In advance of the legislation, Safeguarding Adults Boards should take action to make sure everyone involved in local adult safeguarding is clear about their role and accountability.

The important link between safeguarding and mental capacity assessments were further embedded when in March 2014, a ***House of Lords Select Committee published a report into the impact of the Mental Capacity Act 2005 (MCA).*** The committee's overall finding was that while the MCA is a 'visionary piece of legislation', the Act has 'suffered from a lack of awareness and a lack of understanding'. In total, the report made 39 recommendations. The two key recommendations were: an independent oversight body; and the replacement of the Deprivation of Liberty Safeguards (DoLS). The government is expected to release a response in June /July 2014. The implications of this report was further reinforced with the a recent judgement from the Supreme Court decision on the application and assessment of DOLS within an acute hospital setting which may have far reaching implications for all acute trusts

The safeguarding process has this year also been included in the government's national counter terrorism strategy in aiming to reduce the risk to the United Kingdom from international terrorism. They have developed and published recommendation known locally as 'Prevent.'***. Prevent is a Government strategy and is led by the Home office***. (ref:DoH Cm8092, 2011). Prevent focuses on working with individuals and communities who may be vulnerable to the threat of violent extremism and terrorism. Supporting vulnerable individuals and reducing the threat from violent extremism in local communities is a priority for the health service and its partners. The overall aim of the Prevent Strategy is to prevent people from becoming terrorists or being involved in supporting violent extremism. The Department of Health instructed the health sector to engage fully in this programme and to develop their own strategy on how this will be achieved. In 2013/14 NHS contracts have been amended to include Prevent for providers of service

3 Executive Summary

The Trust's dedication to safeguarding is evidenced through our frontline staff's work with other agencies to protect vulnerable people from abuse and our Safeguarding Team's multi-agency working to improve processes that protect people and improve early help and identification for those at risk. Safeguarding is truly everyone's business across the Trust. The importance of ensuring that safeguarding is at the heart of our organisation has been brought into spotlight over the past year with national reports published on Jimmy Savile "Giving Victims a Voice" and Mid Staffordshire NHS Trust's Public Inquiry. The following page summaries some of the key changes, reviews and improvements undertaken in the previous year by the Trust to achieve the aim of ensuring patients are safe in our care.

3.1 Changes to the Warrington Adults Safeguarding Board. (WASB)

The WASB has seen some significant changes this year with the appointment of an independent chair that is also the independent chair for the children board. This has allowed for closer accountability and closer scrutiny of the work jointly undertaken by both boards. A memorandum of agreement has been drawn up in relation to the roles and responsibilities of memebers organisation who sit on the board. Although this has still to be finalised a copy of the draft agreement can be found in **appendix 1**

3.2 Warrington Clinical Commissioning Group (CCG)

Each year the Trust is tasked with undertaking a self assessment for safeguarding covering both Adults and Children. Within this assessment there are 50 standards that are monitored on a quarterly basis by the CCG. To achieve compliance with each standard the Trust supplies documentary evidence including completed audits. By year end the Trust achieved 46 green, 4

amber and no reds. The four amber standards all have an action plan in place and cover guidance for practitioners working with sexually active children under 18 years. Staff who are required to use restrictive physical interventions have received specialist training to ensure that the use of restraint is always appropriate, reasonable, proportionate and justifiable to that individual.

3.3 Training figures

To achieve the CCG standard on adult safeguarding training the Trust needs to achieve 90% compliance. Data from ESR for training compliance for Adult Safeguarding show level 1 at 57% (non-clinical) and Level 2 at 61% (clinical).

Staff training figures continue to be a challenging area to achieve the contractual standard. The release of front line staff to attend training remains an obstacle due to the operational demands. A break down of the training figures indicate that it is staffs 3 yearly updates that are out of date and not new staff starting at the Trust. There can be a degree of confidence that all staff have at some point had awareness training and are aware of what to do if they have concerns. Work on using less traditional methods of delivering training are being explored for example workbooks and phone apps.

The Safeguarding Team has when ever possible adapted and changed training programmes to deliver training to small groups in clinical areas. These sessions have been well received but delivery to smaller groups reduces the overall compliance for training.

3.4 The Role of the Trust in delivering the *Prevent* agenda

The NHS Standard Contract 2013/14 included a requirement for the Trust to include in its policies and procedures the principles of the ***Prevent*** agenda and to ensure that it has a programme to deliver '**HealthWRAP**. Three out of the four objectives for this area were achieved and the fourth- the development of a policy to deliver a strategy is expected to go for ratification in July 2014. This will form one of the key objectives for 2014/15.

3.5 Safeguarding Policy reviews

The Safeguarding Vulnerable Adults Policy was reviewed and ratified by Clinical Governance, Audit and Quality Sub Committee in July 2013. Building on the existing policy additional key advice for staff now covers areas of increasing public scrutiny for example:-

- Honour Based Violence & Forced Marriages.
- The use of Critical Care indicators to provide front line staff with pre knowledge of safeguarding concerns on patients attending hospital.
- Guidance on visitors to vulnerable patients which includes celebrities and VIP.

3.6 Domestic Violence

In February 2014 the following Nice Guidance was published: - ***Domestic violence and abuse: how health services, social care and the organisations*** **they work with can respond effectively.** This strategy will be implemented during 2014/15. An action plan has been developed which focusses on an increasing awareness of front line to undertake the nationally recognised risk assessment "Domestic Abuse, Stalking and Harassment" (DASH) and then action appropriately.

3.7 Snap shot of Adult Safeguarding activity in 2013/2014

337 Electronic referrals via Meditech (order entries) (276- in 2012/2013)
360 Datix reviews
44 IMCA referrals (20 in 2012/2013)
59 Deprivation of Liberty Safeguard request (increase in over 200% from previous year)

15 Best interest meetings (5 in 2012/13)
12. High level investigation (include level 1, 2 and Multi Agency Reviews)

Total of 827 referrals

3.8 Service users and their family

At the centre of the Trusts safeguarding work are the patients themselves. Information in the form of leaflets and posters is provided around the trust to advise the general public on what to do if they have a concern or if they are a victim of abuse. A number of public signposting days have taken place through out the year specifically aimed at raising awareness with the general public and signposting them to the appropriate agencies. This has included participation in World Elder Abuse Day, Learning Disability Week, Career Week and Domestic Violence White Ribbon Campaign.

3.9 Summary of improvements and lessons learnt.

The Trust has seen an increase in the number of alerts being raised through safeguarding; this is in line with national figures. This is partly due to a raise within the organisation regarding safeguarding issues and also due to an increased public awareness, particularly following high profile cases. What is particularly encouraging is that the Trust referrals to the IMCA services is reported as the highest within the region for serious medical treatment. This group of patients by definition have 'no voice' or any family or friend to represent them. This improvement is further supported by the increase in complex best interest meeting that have been facilitated by the safeguarding team

The Trust has implemented a range of actions towards embedding robust governance processes. This provides stronger assurance that all potential safeguarding adult incidents are identified and captured from a range of different sources. This has included the triangulation of incidents reported via Datix, Complaints, Coroners and complex cases for internal review.

This has led to a range of internal improvements resulted in key lessons learnt from incidents that have included:

- the management of patient who express non- compliances with treatment plans
- pressure ulcer management,
- discharge processes,
- family involvement, particular when there is what appears to be a conflict of interest
- Consultant agreed care planning with GP to reduce unnecessary future admissions

The Safeguarding team remains highly motivated and committed to achieving the highest possible standard for all adults who attend the trust and are deemed 'at risk'. With further investment into the Safeguarding champions in the clinical areas we are sure that continuous improvement will be seen. The report continues with more detail breakdown of the specific areas related to adult safeguarding

4. Duties, Roles and Responsibilities

4.1 Director of Nursing and Organisational Development

The Executive Director of Nursing is the executive accountable to the Board of Directors for ensuring compliance with all safeguarding adult procedures within the Trust. The Deputy Director of Nursing, Quality and Patient Experience is the delegated lead for Safeguarding Adults.

4.2 Operational Leads

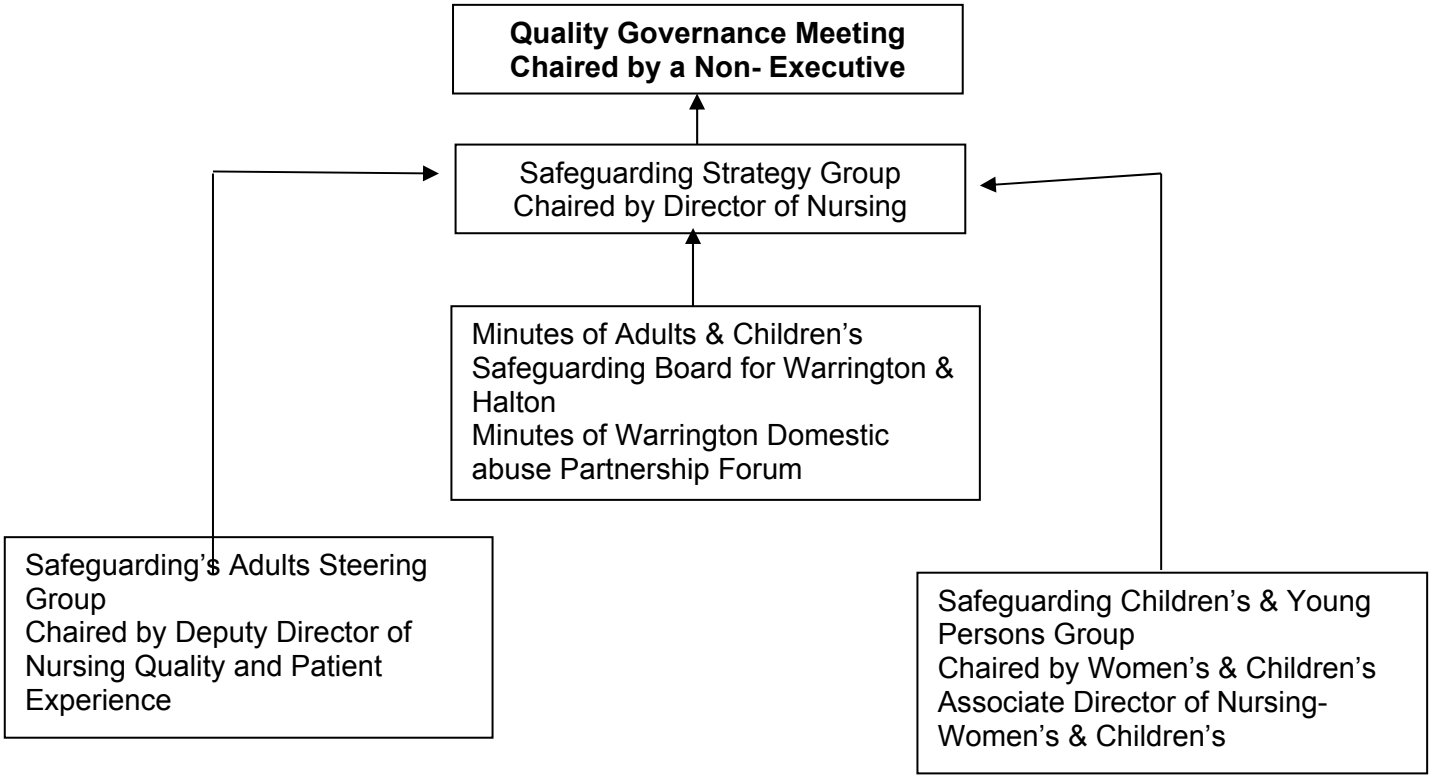
The Operational Lead is the Vulnerable Adults Safeguarding Matron supported by the Assistant Safeguarding Matron

4.3 Associate Divisional Directors (ADD)

The ADD have responsibility for ensuring that eligible staff have undergone awareness training and have access to all documentation and information required for successful implementation and compliance of this policy.

5. Trust reporting arrangements

5.1 The present reporting system is detailed below



5.2 Warrington and Halton Safeguarding Boards – Partnership working

The Trust has a seat on both boards and has representation at all sub groups of the Warrington Board which include:-

- Serious Case Review
- Performance monitoring
- Policy & Procedure
- Training & Development
- Quality intelligence Safeguarding
- Hate crime

There are 8 additional forums which the safeguarding team attend and work collaboratively with partner agencies.

- Safeguarding Adults Partnership Forum
- Mental Capacity Act
- Warrington Domestic Abuse Partnership Forum (WDAPF)
- Dignity Forum
- No second night out (Homeless)

Halton Safeguarding Board include:-

- Training & Development
- Policy & Procedure

- Mental Capacity Act

All groups meet quarterly and the key actions from these meetings are presented and discussed at the quarterly meetings of the Safeguarding Adults Strategy Group and the Safeguarding Adults Steering Group.

In addition to the above the safeguarding team also attends the following internal Trust forums to disseminate key safeguarding messages:-

- Nursing & Midwifery Advisory Committee (NMAC)
- Mental Health Forum
- Patient Engagement Group
- USC & SC Divisional updates

5.3 Safeguarding Strategy Group & Adults Steering group

The Safeguarding Strategy group is chaired by the Director of Nursing and Organisational Development and meets on a quarterly basis.

Member ship of the Safeguarding Strategy Group includes:-

- Director of Nursing and OD
- Deputy Director of Nursing , Quality and Patient Experience
- Director of Nursing, Women's & Children's Division
- Associate Director of Education and Development
- Adults Safeguarding Matron
- Named Nurse for Children's Safeguarding
- Women's and Children's Matron
- Clinical Commissioning Group (CCG)- Lead nurse for adults
- CCG- Lead Nurse for children
- Warrington Borough Councils-Safeguarding lead

5.3.1 The Safeguarding Adults Steering Group

This is chaired by the Deputy Director of Nursing, Quality and Patient Experience supported by the Safeguarding Matron **Appendix 3** shows the group membership and terms of reference.

Standard Agenda items include:-

- Strategic update
- Policy Review, Guidance and Standard Operational Procedures
- Training strategy
- Governance – (Datix Incidents, order entry referrals, MAR Action Plan)
- Actions from Safeguarding Adults Board and sub groups
- Matron report and lesson's to be learnt
- Regulation and Compliance - CQC update – Outcome 7
- Learning Disability – (Matrons Report, Death by Indifference, Self assessment Action Plan)
- Children's Safeguarding
- Domestic Violence
- Mental Capacity Act (DoL's and IMCA)

Appendix 3 shows the Terms of reference

Below shows the group meeting in progress

This group has met on 4 occasions for the period 2013/2014. The Safeguarding Matron produces a bi annual report that is provided to the Trust Clinical Governance, Audit and Quality Sub Committee and an Annual Report is provided to the Board.

Key objectives for this group:-

Objectives for Safeguarding Adults steering group	**Action**	**Outcome**
CIRIS Governance compliance system to be utilised to monitor Safeguarding action plans and contract.	Action plans put on CIRIS and updated	
Training compliance at level 1 and 2 to be 90%	Level 1 – 57% Level 2 – 61	
Identification of Prevent lead and strategy to implement awareness and reporting structure	DON appointed executive lead Completion of self assessment Development of a policy to implement the strategy.	
Develop of Safeguarding Adults champions across the key front line clinical areas	All wards and clinical areas have identified key individuals who are the key links for the safeguarding team and who help to deliver the message of safeguarding	

Increase awareness of domestic violence incidents in the elderly	Adult only referrals have been identified and full screening undertaken result in a number being referred to MARAC. Further training is required to front line staff totally embed this practice	

5.4 CQC- Outcome 7 and Inspections
In January 2013 the Trust received an unannounced CQC visit. Safeguarding was one of the areas that were assessed for compliance. The standard was met and the following judgement was made. ‘‘The provider was meeting this standard. People who use the service were protected from the risk of abuse, because the provider had taken reasonable steps to identify the possibility of abuse and prevent abuse from happening.” (CQC: March 2013).

- ***Outcome 7 Safeguarding:*** *Staff aware of the procedures and the patients said they felt safe. Relatives had no concern. The Inspectors noted the Safeguarding Adult Policy was under review. The Assessment of Capacity Form was the best they had ever seen in all the areas they had Inspected (Nursing Homes/Prison Services and Learning Disability locations)*

6. Policy, Procedures and Guidance

6.1 The Safeguarding Vulnerable Adults Policy
This was reviewed and ratified by Clinical Governance, Audit and Quality Sub Committee in July 2013.

Key changes and additional sections that have been included in the revised policy are guidance on:-

- Honour Based Violence & Forced Marriages
- How to manage conflict of opinion when there is a difference of professional opinion
- Use of Critical Care indicators to provide pre knowledge of safeguarding concerns fro patients attending hospital
- Guidance on visitors to vulnerable patients
- The Prevent Strategy
- Celebrities and VIP visits to hospital

This policy went out to a wide audience for consultation which included the lead for both Halton and Warrington Local Authority, the CCG’s Lead Named Nurse for Adult Safeguarding, Police and all Clinical Departments within the Trust represented on the Steering Group.

6.2 Prevent Policy
The purpose of this policy is to identify how staff will be supported to develop an understanding of the **Department of Health** ‘**Prevent Strategy’** and how they can utilise their existing knowledge and skills to recognise that someone may have been or is being radicalised. The policy will build on existing safeguarding policies and procedures already in place within the Trust.

The Prevent Key Objectives are:

1. Challenge the ideology that supports terrorism and those who promote it.
2. Prevent vulnerable individuals from being drawn into terrorism and ensure that they are given appropriate advice and support.
3. Work with sectors and institutions where there are risks or radicalisation.

Health sectors are expected to be involved in delivering objectives 2 and 3 only.

The trust had 4 objectives to achieve in 2013/14 for the Prevent programme as follows:-

Objectives for prevent programme	Action	Outcome
Identify an Executive Lead	Achieved- Director of Nursing	
Identify key individuals to be trained in the Department of Health HealthWrap-training programme	Achieved Business Continuity Manager Safeguarding Matron Head of Security	
Develop a policy that includes all areas identified in completion of the self-assessment project.	Part achieved Policy written and has been out to full consultation and awaiting ratification in July 2014	
Commence awareness training	Achieved- awareness training has commenced and will be part of induction market place for the following year	

7. Safeguarding Adults Training

7.1 Level 1 & 2 training

Training and development provides a basis for ensuring that vulnerable people are effectively safeguarded. The safeguarding training and development plan aim to provide for a skilled, informed workforce (of both clinical and non-clinical staff) that recognises abuse and its signs. The training delivered enables staff to appropriately respond and prevent abuse where possible, know what to do when abuse happens or raise a concern.

Training is delivered by:

- Trust Induction (clinical and non- clinical- level 1)
- E-Learning Programme- level 2
- Specific clinical group sessions- level 2
- To support clinical supervision
- Warrington & Halton Borough Councils

We receive positive feedback from staff about the training programme who feel that the information provided is appropriate and at the level they require.

Data from ESR for training compliance up to April 2013 for staff groups (excluding Junior Medical and dental) are:-

- Level 1 57%- non clinical
- Level 2 61%- clinical

Training figures for safeguarding need to be 90% compliant to achieve the CCG standard. Due to clinical demand it has been particularly difficult to release staff to attend training sessions particularly during the winter months. The Safeguarding Team has adapted and changed training programmes to deliver them in small groups on clinical areas. These have been well received but overall attendance numbers in are reduced when training is delivered by this method

Divisional breakdown of training and feed back summaries of training are detailed in **appendix 4**

We have worked collaboratively with the Learning & Development Team to produce a work plan to assist in achieving the 90% target. This included a full review of all staff on ESR and cross-checking of job titles to appropriate level of training and also the development of a work book to assess staff that need their 3 yearly safeguarding update.

During the year additional safeguarding training sessions have been completed to ensure that the message of 'safeguarding is everybody's business' and what to do if you have concerns have been arranged to supplement the ESR formal training figures.

Professional groups	Awareness raising	Venue	date
Critical care Doctors & Nurses	IMCA Awareness	ICU seminar room	8th April 2013
F1-Doctors	Safeguarding awareness	Post graduate-Warrington	15th May 2013
Unscheduled Care Division- Matrons	Safeguarding and Domestic violence	Post graduate – Warrington	27th June 2013
GUM staff	Safeguarding awareness	Bath Street	17th Sept 2013
Preceptorship - nurses	Safeguarding awareness	Halton post graduate	27th Sept 2013
Ward staff	White Ribbon Campaign Domestic violence	Each clinical ward	25th November 2013
Unscheduled Care Division- Ward Manages	MARAC process and DASH referrals	Post graduate-Warrington	28th November 2013
Scheduled care Ward Managers away day	Safeguarding update	Post graduate - Halton	10th December 2013

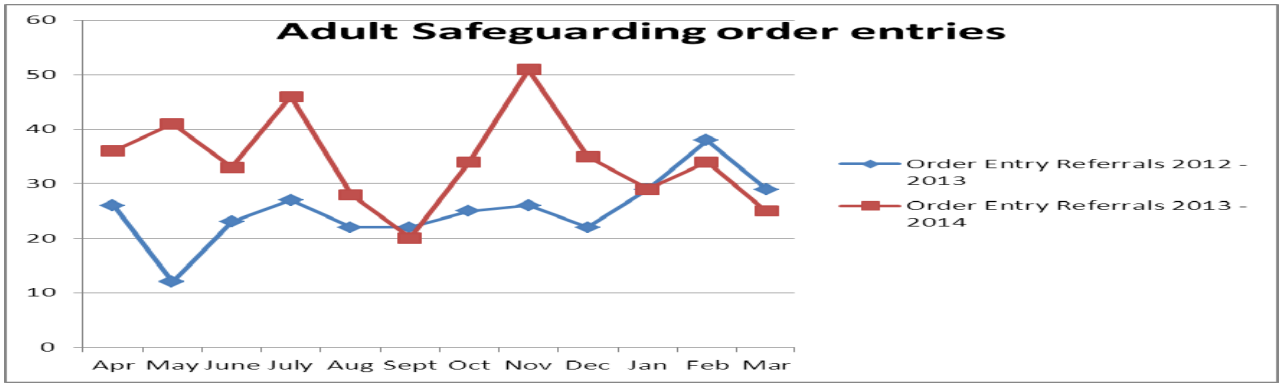
7.2 Additional training that support safeguarding assessments
Consent and Mental capacity training is an essential requirement for clinical staff to ensure that appropriate assessment are undertaken when assessing any safeguarding concerns. The trust figure for consent as of March 2014 were recorded as 55.72%

8 Safeguarding Referrals

8.1 Safeguarding Alerts and referrals to the trust safeguarding team
There has been a total number of 827 safeguarding alerts to the team. All staff can seek advice and direction from the safeguarding team by either: -

- Order entry on Meditech
- E-mail
- Telephone contact.

Over the past twelve months the team has seen an **increase of 23%** in contacts made to the team compared to the previous year and the trend continues into 2014/15. In 2013/2014 a total 337 order entries to safeguarding team was made compared with 276 from the previous year. The following chart shows the order entry alerts to the team for the past 2 years



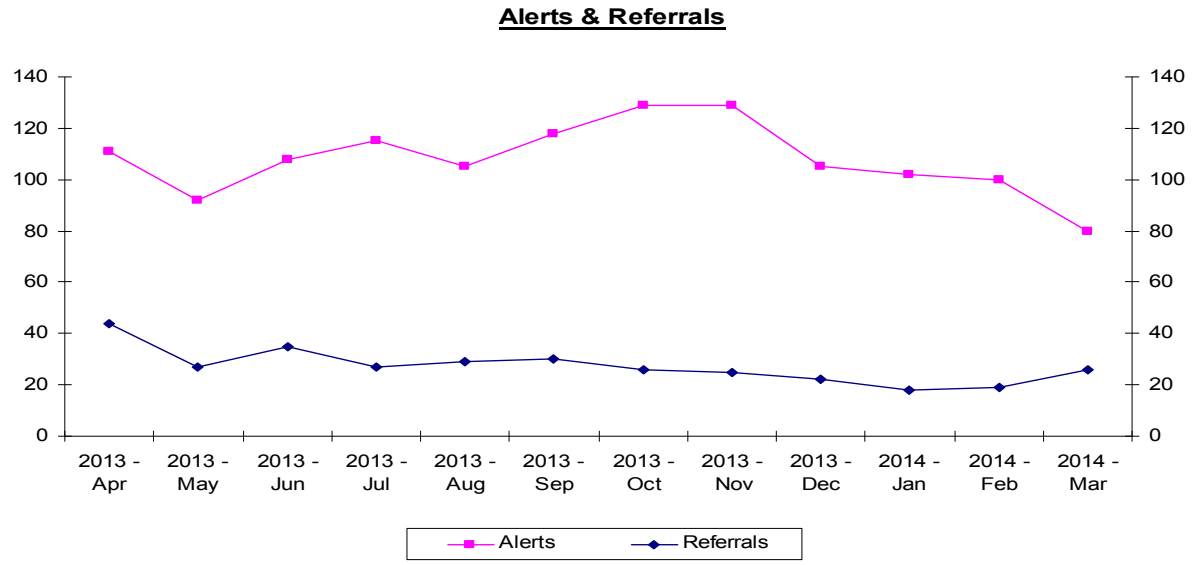
Once an alert has been received by the safeguarding team they then contact the referrer and work with them to determine if a formal safeguarding referral is required to the local authority to formally investigate the allegation. Depending on the reason for referral this may also result in a referral to the Public Protection Unit (PPU-Police) to determine if a potential criminal act has taken place.

8.2 Warrington Borough Council (WBC) have provided the following information for 2013/2014

There have been 1294 Alerts and 328 Referrals in 2013/14 to WBC for safeguarding compared to 239 alerts in 2012/13, of which 414 led to a safeguarding referral. For the year to date just over 25% of alerts resulted in a referral whilst 33.4% of alerts resulted in a referral the year before. Safeguarding audits undertaken last year indicated that there were still a number of referrals that were not appropriate for the safeguarding process.

The reduction in referrals this year would seem to be evidence of the success of the ongoing work around more effective risk assessment and management of the issues. For the current year to date 32.4% of safeguarding referrals were substantiated or partly substantiated.

WBC chart below shows month by month alerts and conversion rate to formal referrals.



A breakdown of who refers from all heath agencies shows the acute trust referrals are the highest

		18-64									
Source Group	**Source**	**Physical Disability**	**Mental Health**	**Learning Disability**	**Substance Misuse**	**Other Vulnerable**	**Not Yet on CF**	**18-64 Total**	**65+ Total**	**Grand Total**	**%**
A_Social Care Staff	Dom	2	1	2				5	2	**7**	2.1%
	Primary							0		**0**	0.0%
	Res	1	1	6				8	24	**32**	9.8%
	Day							0		**0**	0.0%
	SW/Care	10	13	16	1	2	3	45	27	**72**	22.0%
	Other	5	5	15	1	2	2	30	44	**74**	22.6%
	Social Care Staff Total	18	20	39	2	4	5	*88*	*97*	***185***	*56.4%*
B_Health Staff	Primary		1				5	6	8	**14**	4.3%
	Secondary	3	3	6		1	23	36	18	**54**	16.5%
	MH Staff		1			1	1	3	1	**4**	1.2%
	Health Staff Total	3	5	6	0	2	29	*45*	*27*	***72***	*22.0%*
C_Other	Dom							0		**0**	0.0%
	Self		1					1	5	**6**	1.8%
	Family Member						1	1	15	**16**	4.9%
	Housing						2	2	5	**7**	2.1%
	Police	1	2	1	1	1	1	7	4	**11**	3.4%
	Other	1	5	2		1	5	14	14	**28**	8.5%
	Other service user			1				1		**1**	0.3%
	Education/training			2				2		**2**	0.6%
	Other Total	2	8	6	1	2	9	*28*	*43*	***71***	*21.6%*
Grand Total		**23**	**33**	**51**	**3**	**8**	**43**	**161**	**167**	**328**	

The above analysis shows that acute trusts have the highest referral rate at 16.5% compared with 4.3% from primary care and 1.2 % from mental heath.

8.3 Datix Referrals to the Safeguarding Adult Team

The clinical incident reporting system supports next working day review in that the Clinical Governance Team will ensure that incidents relating to safeguarding concerns reported on datix will be alerted to the Safeguarding Matron for review.

There were 360 datix incidents referred to adult safeguarding team. Once the incident is reviewed, the safeguarding matron will categorise the incident as:-

- appropriate action was taken
- additional information is required
- incident needs further investigation or referral to social care

The team will then work alongside the lead investigator to ensure that all areas of safeguarding are addressed and actioned appropriately.

Appendix 5 shows a summary of the categories of safeguarding reviews for the year 2013/2014
.
A break down of the 360 datix incidents (excluding pressure ulcers) show the following top 5 categories selected for safeguarding concerns were:-

- Security Issue (including missing patients)
- Assault non physical
- Safeguarding concern
- Unexpected events
- Mental Health Act

8.4 High level investigations-

This category of referral include Sudden Untoward Incident's (SUI's), Level 1's and Safeguarding Boards Multi- Agency Reviews

During 2013/14 the Safeguarding team has been part of a number of high level investigation that include the following:-

Level 2 Investigations (Serious Untoward Incidents):-There were two level 2 investigations

1) Patient was missing from clinical area for 6 hours later discovered in bathroom deceased.

The findings indicated that the staff did appropriately activate the missing patients' policy. There were delays in the patient receiving medication that may have reduced confusion. Mental Capacity assessment had not formally been undertaken to assess the risk of the patient being allowed to leave the ward.

Additional training was provided to the clinical teams on assessments of the Mental Capacity Act, alcohol pathway

2) Following the death of a patient in June 2013 and the Post Mortem findings. The patient's wife raised concerns via social services safeguarding route that she believed the Trust had contributed to her husband's death. The Safeguarding matron undertook a case note review. Following this review the findings indicated that it required escalation to a level one investigation on completion of the level 1 the recommendation was that it met the criteria for level 2.

The findings indicated that the multiple admissions with embolic events over a relatively short period of time did not raise concerns and it possible should had included a diagnosis of bacterial endocarditis The blood cultures at the time of endocarditis being diagnosed (June 2013) contain the same bacteria as the histology sample of November 2012.The echocardiogram scans of November 2012 and May 2013 have missed the early signs of endocarditis. The patient died of Bacterial endocarditis

The Investigation has highlighted a system failure of review and follow up of results, compounded by poor records management and the number of clinicians involved in the patient's care.

Level 1 Investigations:-There were a total of six level 1 investigation identified Safeguarding concerns

1) Inappropriate use of force use by a staff memebers x 3
2) Medication error- resulting in a patient receiving the medication of a patient who had previously been in the bed space which resulted in HDU admission
3) Patient on patient injury
4) Possible missed fracture to pt returned to care home

All investigations have been 'signed off' by the executive lead and appropriate actions plans put in place. The Vulnerable Adults Steering group which is held on a bimonthly discuss the learning from these incidents and ensure that lessons learnt are dissemination, discussed and cascaded to all staff within the divisions.

Multi agency reviews (MAR's):-There were a total of 4 MARs:-

1) Two cases of self-neglect resulted in death and coroners investigation
2) Delay in identifying a suitable place of safety for a self harming mental health patient
3) Grade 4 pressure ulcers from care home
4) Patient removed from hospital by family whilst under c/o of DoLs at acute trust

Since the review there has been a formation of multi-partnership forum to review self neglect cases and provide guidance for staff.

9. Mental Capacity Act 2005 (MCA) & Deprivation of Liberty Safeguards (DOLS)

9.1 Mental Capacity Act

In June 2013 the Trust was one of a number of organisations who were asked to respond to a House of Commons Select Committee on the implication and impact of the Mental Capacity Act. The Associate Director of Governance and the Safeguarding Matron provide the Trust response.

In March 2014 the House of Lords published its findings: The committee's overall finding was that while the MCA is a 'visionary piece of legislation', the Act has 'suffered from a lack of awareness and a lack of understanding'. In total, the report made 39 recommendations. The two key recommendations were that:-

- an independent body is given responsibility for oversight of the Act in order to drive forward vital changes in practice
- they found that the Deprivation of Liberty Safeguards (DoLS), inserted into the Mental Capacity Act in 2007 by the Mental Health Act, are not fit for purpose. The Committee is recommending that the DoLS be replaced with legislation that is in keeping with the language and ethos of the Mental Capacity Act as a whole

In adult safeguarding the assessment of a patient's capacity is a key element in determining a 'best interest' decision or appropriate action to take when a patient lacks capacity to determine their own care plan.

The Trust Lead for MCA is the Associate Director of Governance (ADG) this includes responsibility for consent and mental capacity training for staff. The ADG audits the Trust documentation for MCA on a monthly basis and reports the findings at the quarterly Safeguarding Steering group.

Whilst the audits have shown that increase awareness of capacity assessments are being undertaken there remains confusion amongst the front line staff on key issues such as who can undertake a capacity assessment and who should be involved. Education and direct clinical supervision is undertaken by the safeguarding team but similar to the House of Lords findings the Trust still has a way to go to be confident that this piece of legislation is embedded in day to day practice.

9.2 Deprivation of Liberty Safeguards (DoLS)

DoLS is a process of assessment and actions that result in depriving a patient of their liberty or their choice in order to keep them safe from harm. For example a dementia patient that wishes to leave the ward and does not have the capacity to understand that if allowed to leave the ward it would put them in direct danger for example of being knocked down by a passing car. The ward therefore has to put in place a number of significant restrictions to stop the patient from leaving the ward. This may include sedation, 1 to 1 nursing, cot sides and in some instances full restraint.

The staff complete an urgent request to be assessed for a standard authorisation which if granted allow the staff to work within a legal framework to impose restrictions on patients to keep them safe and deliver appropriate care

The Trust has seen an increase in DoLS assessments over the past twelve months working closely with Warrington Borough Council MCA Coordinator to improve referral pathways and assessments, which has demonstrated increased awareness and understanding of this important assessment process. This was noted particularly by CQC in their inspection

During 2013/2014 there where 59 referrals (urgent and standard) assessments made to Warrington & Halton Local authority for the period compared with 20 for the same period 2012/2013 thus indicating over a 200 % increase.

In March 2014 the Supreme Court delivered a verdict known as the 'Cheshire West verdict' that will fundamentally change the way acute trusts and care homes assess patients for DoLs in the future. The Trust has been asked to review the judgment and to look at the implication and to co-ordinate a response in coordination with the Local Safeguarding Boards. The key change from the judgment is that a patients compliance will no longer be relevant to the decisions made, for example if a patient without capacity is assessed as requiring one to one care for their risk of falls and do not object, appear willing to have a member of staff sitting with them constantly, cannot consent and are not free to leave must undergo assessment and application of a DoLs. The revised test will be that all patients who lack capacity and is under continuous supervision and

control and is not free to leave, and can not consent to these arrangements will require an assessment and application of a DoLS.

9.3 Independent Mental Capacity Advocate (IMCA) referrals

The Trust continues to work with the 'Together' IMCA services that support the Trust in upholding the rights of some of the most vulnerable members of our society. A referral to IMCA services is a statutory requirement for patient who lack capacity, are un-befriended (have no family or friends), are over 18 years of age and can't participate in serious medical decisions or have a change to accommodation after 28 days. (including remaining in hospital)

HKWS IMCA 2013-14 Annual Report.pdf

9.3.1 IMCA statistics for Warrington and Halton Hospitals Trust 2013-14

There were a total of 44 referrals made in 2013-14 that is 24 more than in the previous year. Although there is a noted increase in a number of inappropriate referrals to the IMCA team, further exploration identified that staff need extra support on the referral criteria particularly around locating family memebers. However this did show that staff awareness for this valuable service had increased.

IMCA Referral Type

IMCA Referral Type	Number s of Referrals
Serious Medical Treatment	25
Change of Residence	5
Adult Safeguarding	0
Care Review	1
Inappropriate Referral	13
TOTAL	**44**

IMCA Referral Source

Referral Source	Numbers of Referrals	Referral Source	Numbers of Referrals
A&E	1	Surgical Pre-op	1
Alcohol Liaison		Ward A1	1
CCU	1	Ward A2	1
ICU/ITU	3	Ward A4	3
Midwifery	1	Ward A5	
O.CMTC-H	1	Ward A6	4
Obstetrics	1	Ward A7	5
Ophthalmology		Ward A8	1
Oral Surgeon	1	Ward A9	2
OT	2	Ward B1	
Safeguarding	6	Ward B12	4
Social Work Discharge		Ward B14	3
Surgery Matron		Ward B18	
Surgical Registrar	1	Ward C22	1

10. Domestic Violence (DV)

The lead for Domestic Violence is the Trust Safeguarding Children's team Named Nurse and detailed data on this is contained with their annual report. The Safeguarding Adult team work collaboratively with the Children's team to deliver the agreed strategy that is produced by the Warrington & Halton Domestic Abuse Partnership (WDAPF).

This year we have continued to work to increase the awareness of front line staff specifically in relation to the vulnerability of the elderly. This year has seen an increase in formal assessment of elderly victims involved in domestic violence and resulting in referral into the Multi-Agency Risk Assessment Conference (MARAC) process which is chaired by the Police.

Discussions are presently underway to introduce an Independent Domestic Violence Advocate for two days a week in the Trust to work alongside frontline staff to educate and assess patients that are disclosing DV. Training will be the key area of focus so that staff can assess correctly and action and signpost as required.

10.1 Nice Guidance

In February 2014 NICE issued guidance - *Domestic violence and abuse: how health services, social care and the organisations they work with can respond effectively.* The guidance is embedded for reference

The Trust DV lead (Named Nurse for Children's Safeguarding) has produced an action plan that is to be agreed at the next Safeguarding Strategy meeting in June 2014. Following approval at this committee the strategy and action plan will be implemented during 2014/2015.

NICE- guidance.pdf

10.2 Home office -Domestic Homicide Review -

Jan 2014 saw the publication of a Home Office Homicide Review undertaken in Warrington. This was a significant piece of work that included reviewing the attendances at the hospital for the victim, the perpetrators and their children over an 8 year period (extended for the victim to 25yrs). The report was finalised in 2013-2014 and the action plan will be overseen by the Community Safety Partnership. The Trust had 2 specific actions to complete which have been achieved. These were concerning adding of critical care indicators to patients record when DV had been part of the history for attendance and ensuring a wider audience of front line staff are aware of the how to undertake the risk assessment for patient who attend with DV history.

11 Learning Disabilities (LD)- Michele report to be added

The Trusts operational Lead for LD is the Patient Experience Matron. LD it is a standard item on the Vulnerable Adults steering group meetings so front line clinical staff are updated.

The Mencap reports *Death by Indifference* (2007) and *Death by Indifference: 74 deaths and counting* (2012) have been influential in steering the Trust in striving to ensure equal access to healthcare for all our patients. The CQC six indicators for learning disabilities have been used as the framework for an on-going action plan demonstrating the Trusts activities in promoting high quality and safe care for this group of patients.

A steering group has been formed to oversee the Trusts service provision for caring for people with learning disabilities admitted to the Trust for treatment of acute illnesses. Meetings with representatives of both the commissioners for learning disabilities services and community providers (for both Warrington and Halton) have once again highlighted the absence of a

specialised learning disabilities nurse liaison role as an impediment to the provision of excellence in care. This doesn't mean that there aren't good examples of this only that it tends to be the problems that receive more attention. At a clinical level there is an absence of specialist skills and knowledge to support healthcare teams in provision of appropriate and timely care. This has been raised on the corporate team risk register and the options available to develop this role will be taken up by the steering group.

An outcome of these meetings is that the learning disabilities teams for both areas have agreed to develop some development sessions for specific groups of staff:

- Safeguarding champions
- Pre-operative teams
- Accident & Emergency staff
- Clinic staff

The first of these will happen on the Safeguarding Champions update day on 3 July 2014. A senior learning disabilities nurse will speak to the group, accompanied by a service user who will sharing personal experiences of acute care.

The adult safeguarding team, now expanded, has taken on more of the support for these patients when requested. They have been able to support ward staff in preparing for admissions of patients needing reasonable adjustments and with the MCA/DOLS issues that might arise. The learning disabilities teams tend to contact either the Patient Experience Matron or The matrons for Vulnerable Adults if they feel they need some intervention or support with the care of a patient. These are often around communication between ward staff, family/carers, formal carers and the provider teams.

Plans:

- Develop spreadsheet to capture escalated issues
- Roll out training when developed
- Continue steering group meetings to ensure continued support and sharing with partners and commissioners
- Patient Experience Matron to act as link with council led learning disabilities forums
- Set up local group to oversee learning disabilities care provision and identify good practice
- Share more good practice examples with staff

11.1 Example of good practice shared by Assistant Matron for Vulnerable Adults:

.....Charge Nurse Greenhough attended to a lady with LD from the Byron Unit at Hollins Park she attended A&E with a fractured wrist. A back slab was applied and an appointment was made for fracture clinic. Unfortunately, the lady removed the back slab and this left the fracture unstable with a risk of further damage.

We discussed with Charge Nurse Greenhough if we could bring the lady through to the plaster room without the need to go through the A&E process. Not only did the charge nurse offer to back slab the limb himself but the way he greeted the lady was very reassuring and heart-warming and immediately put the lady and her escorts at ease. Further to this, the lady and her escorts have been advised by the charge nurse that if she does remove the cast again that they are to come straight back to minor injuries and the back slab will re-applied.

Appendix 6 provides a summary of Datix incidents from 01/04/13 - 31/03/14 if LD was chosen

12 Service Users and outcome for patients

The highest priority that we have at the Trust is to safeguarding our patients and to show that in doing so a positive outcome can be reached

To achieve this Trust needs to identify the patients who are requiring assistance or are vulnerable by the following:-

- Identifying any one at risk
- Delivering on a timely and appropriate response.
- Ensuring robust protections and support for the individuals at risk.
- Providing information that they have a right to receive and explanation of the process.
- Ensuring they or their family are included when ever possible in decisions about their care

Information is provided around the Trust for patients to access this is in the form of leaflets and posters which direct the general public on what to do if they have a concern or are a victim of abuse.

A number of promotional days have taken place through out the year specifically aimed at raising awareness with the general public and signposting them to the appropriate agencies:-

Directed to	Promotion	venue	Date
General Public	World Elder Abuse Day	Warrington bus station	14th June 2013
General Public	Learning Disability week	Main Entrance of hospital	22nd June 2013
General Public	White Ribbon Campaign Domestic violence	Main Entrance of hospital	25th November 2013

The Local Authority has introduced a Safeguarding Adult's – service user feedback form to assist in capturing the views of the service users. This is in its pilot form and early results show that service users, who go through this process, do feel safer and whilst they are generally satisfied with the outcomes that the process can generally be too long.

13 Work Plan for 2014/15

The key objectives for the Trust will be to continue to promote awareness of vulnerable adults and their right to be safe and to safeguard and promote the welfare and dignity of vulnerable adults and to take the appropriate steps to reduce abuse. It will ensure referral to the correct agencies as necessary.

In the next twelve months the safeguarding work plan will include:

- Implementation of Domestic Violence NICE recommendation
- Implementation of the Prevent Strategy to include formalisation of a training strategy.
- Review of Missing Person Policy
- Re audit of the use of the Trust Restraint Policy.
- Agree "Domestic Abuse, Stalking and Harassment" DASH reporting to CCG.
- Quarterly review of the Trust Clinical Commissioning Groups (CCG's) contract report ensuring supportive evidence is provided to meet the requirements
- A review of training strategy to further identify training needs within the acute hospital workforce. Working collaboratively with the Halton and Warrington Borough Councils
- To Monitor and manage the capacity and workload of the Safeguarding team in view of the implications from the 'Cheshire West Judgements'
- To continue to raise the profile of safeguarding and implementation of procedures across

the Trust and wider agencies.

- To improve on existing audit processes to monitor effectiveness of lessons learned upon safeguarding practice and outcomes for people who use our service

Appendix 1 Warrington Safeguarding Adults Board – responsibilities of members

This Memorandum of Agreement has been drawn up in relation to the roles and responsibilities of member organisations to the Safeguarding Adults Board agreed on the 27.7.2013

The signing of this memorandum constitutes the acceptance and agreement of to the following:

Warrington SAB member organisations agree to:

- Implement local multiagency procedures on safeguarding vulnerable adults
- Ensure all staff have appropriate awareness and training in safeguarding vulnerable adults
- Ensure their organisation has clear operational guidance which is consistent with local multi agency procedures
- Ensure the agency has rigorous procedures for recruitment and selection of staff
- Ensure robust procedures for responding to allegations against members of staff
- Publish a whistleblowing policy
- Monitor the quantity and quality of safeguarding work within their agency
- Ensure that they have mechanisms in place to report to the SAB in order that effective governance of all safeguarding arrangements is achieved
- Designate a lead officer for Safeguarding Adults and a suitably qualified representative for the SAB
- Agree and secure specified resources to support the work of the Safeguarding Adults Board (either financial contribution or through staff time and expertise)
- Contribute to the strategic direction of the Safeguarding Adults Board.
- Provide an annual report on work undertaken that is linked to strategic objectives and key tasks, for inclusion in the annual report

Signed by:

On behalf of the following Organisation:

Date:

Appendix 2

warrington [safeguarding] adults board

This Memorandum of Agreement has been drawn up in relation to the roles and responsibilities of member organisations to the Safeguarding adults Board agreed on the 27.7.2013

The signing of this memorandum constitutes the acceptance and agreement of to the following:

As my organisation's representative on the Warrington SAB I agree to:

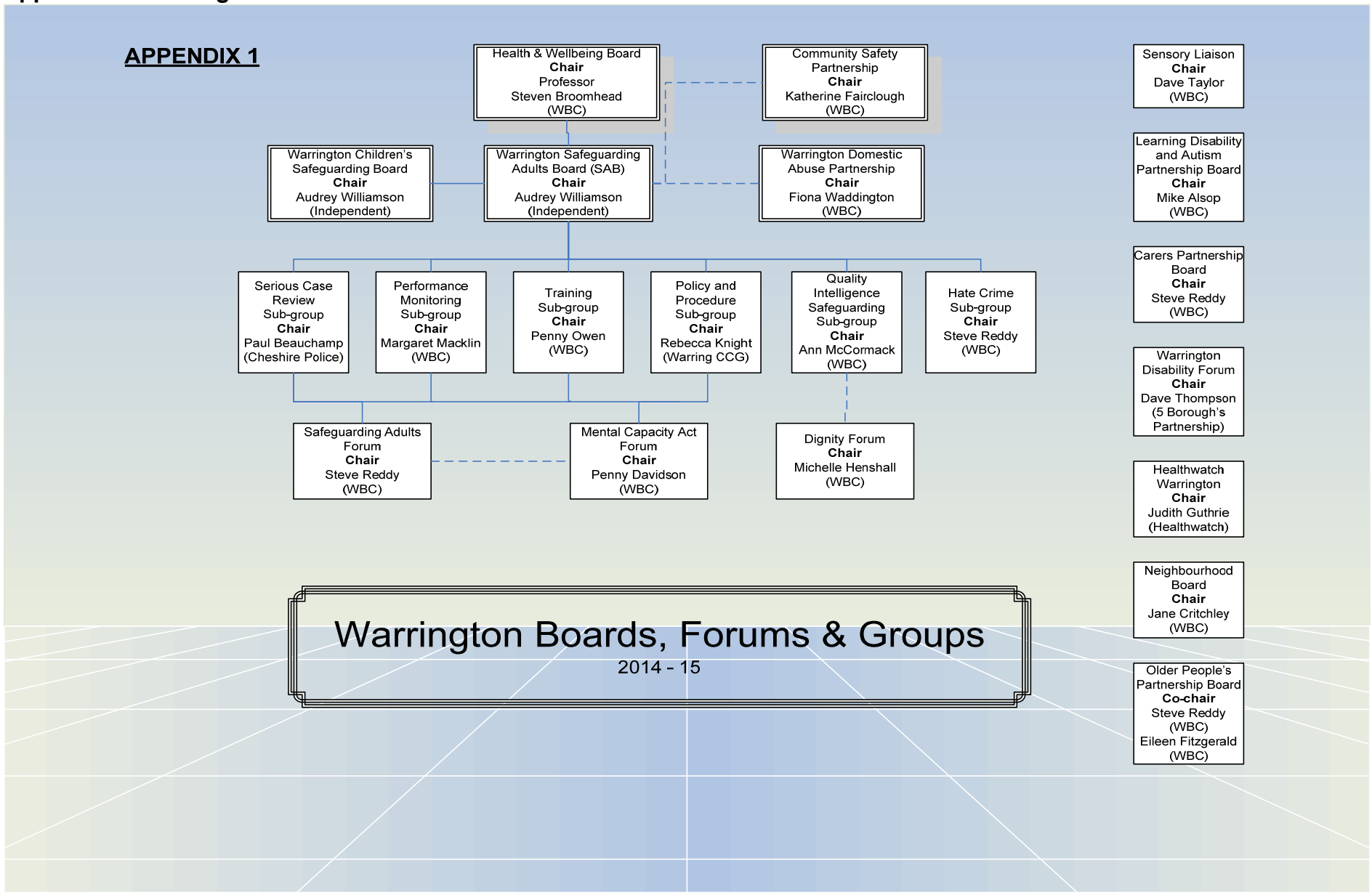
- Maintain regular attendance at the SAB and its sub groups
- Make an active contribution to the planning, development and implementation of strategic objectives including contribution to sub groups, workshops and task and finish groups including where required a chairing role
- Support the delivery of Development Plan priorities including the co-ordination, delivery and reporting of actions assigned to me personally or as a representative of my organisation
- Provide an effective link between the SAB and organisation to disseminate strategic and operational priorities and ensure that these are met
- To act as a safeguarding adults voice and to take the lead on behalf of SAB, within my own organisations networks and any relevant committees which I also attend
- On behalf of my organisation, promote and support information sharing with other agencies in order to protect vulnerable adults
- Alert the Board to any safeguarding issues that arise in my organisation and to provide information and updates as requested including on profile and serious issues/cases.
- Promote and coordinate staff engagement in relevant WSAB activities and initiatives, including training and awareness raising
- Secure and co-ordinate my organisation's participation as appropriate in multiagency reviews and IMRs
- Provide regular feedback to the Board, on my organisation's safeguarding work including an annual submission to the business plan report

Signed by:

Full Name:

Date:

Appendix 2 Warrington Boards and Forums



Appendix 3 Safeguarding Adults Steering Group Terms of Reference

Title: Safeguarding Adults Steering Group Terms of Reference **Authors Name:** Associate Director of Nursing/ Safeguarding Matron	Warrington and Halton Hospitals NHS NHS Foundation Trust
Scope:	**Classification:**
Replaces: Vulnerable Adults Steering Group	
To be read in conjunction with the following documents: N/A	
Unique Identifier:	**Review Date:** July 2014 **This document is no longer authorised for use after this date**
Issue Status:	**Issue No. 3** **Issue Date:**
Approved by:	**Ratification Date: June 2013**
Document for Public Display: Yes	

1. Purpose

- The Safeguarding Adults Steering Group will oversee the Trust's policies, strategies and procedures relating to the Trust's objectives on all matters related to Safeguarding of Adults.

- The Safeguarding Steering Group will be the conduit of information and operationalise the agreed policies of both Warrington and Halton Local Safeguarding Adults Board.

Close liaison will be maintained with the Safeguarding Strategy Group and Clinical Governance Sub-Committee and through them it will provide assurance to the Trust Board on the management of risks relating to the safeguarding of vulnerable adults and the Deprivation of Liberty Safeguards. An annual report will be submitted to the Safeguarding Strategy Group as part of the assurance process.

2. Accountability Terms of Reference

2.1 The Safeguarding Adults Steering Group will be a formally constituted group within the Trust and it will report directly to the Safeguarding Strategy Group chaired by the Director of Nursing and Organisational Development

2.2 The Chairman of the Safeguarding Steering Group will be the Associate Director of Nursing for Corporate

2.3 The terms of reference will be reviewed annually by the Steering Group.

3. Specific Requirements

1. Main Areas of Work of the Committee

- The principle areas of focus will be the scrutiny of performance against National and Local standards.

- The Steering Group will review Safeguarding Policies and ensure their effective implementation. Audit schedules for each policy will be agreed on an annual basis.

- The Steering Group will receive summary performance reports in respect of staff training and attendance.

- The Steering Group will monitor all untoward incidents/complaints related to vulnerable adults and ensure effective root cause analysis is undertaken in all unexpected and unexplained deaths. The Steering Group will make any necessary recommendations to the Executive Team if there is evidence of system or individual failure.

- The Steering Group will monitor the effectiveness of staff 'alert' to the safeguarding team and identify areas for improvement.

- The Steering Group will link closely to the work on Elder Abuse in the Trust to ensure that vulnerable adults who are actually or potentially involved are identified appropriately.

4. Membership

The membership of the Safeguarding Adults Steering Group shall be;

- Deputy Director of Nursing- Chair
- Trust Safeguarding Adults Matron- Deputy Chair
- Assistant matron for Safeguarding
- Divisional Head of Nursing Scheduled Care
- Divisional Head of Nursing Unscheduled Care
- Associate Director of Governance
- A&E Matron
- A Unscheduled Care Matron
- A Scheduled Care Matron
- Out Patient Manager
- Trust lead for learning Disability
- Therapy representative
- Regional IMCA Representative
- Older persons specialist nurse

Nominated Deputy to attend in situations of absence.

5. Frequency of Meetings

The Steering Group shall meet quarterly
The group will be considered quorate with at least 5 members from the above list present.

6. Delegated Powers

The Group will be delegated policy development and implementation responsibilities for policies and guidelines related to Safeguarding. Ratification on behalf of the Trust Board will be undertaken by the Safeguarding Strategy Group

Reporting Arrangements

i. The Safeguarding Adults Steering Group meetings will be minuted and the draft minutes reported quarterly to the next meeting of the Safeguarding Strategy Group on the work of the Committee.

7. Review

The Safeguarding Adults Steering Group will undertake a review of its Terms of Reference and membership, including the role of any Working Groups annually.

8. Managing Effectiveness

The Group will have formal minutes and these will be submitted to the Safeguarding Strategy Group. The Chairman will draw to the attention of the Executive Team, any issues that require disclosure to the full Board or those requiring Executive action.

The agenda and minutes of this meeting may be made available to public and persons outside Warrington & Halton Hospitals NHS Foundation Trust as part of the Trust's compliance with the Freedom of Information Act 2000.

Appendix 4 Training figures by division

	Safeguarding Procedures (Adults) - Level 1 1st March 2011 - 31st March 2014			Safeguarding Procedures (Adults) - Level 2 1st March 2011 - 31st March 2014		
	Heads	**Number Completed**	**% Completed**	**Heads**	**Number Completed**	**% Completed**
CORPORATE SERVICES						
Business Development	17	10	58.82%	7	5	71.43%
Business Planning	3	2	66.67%			
Communications & Membership Office	4	1	25.00%			
Research	10	7	70.00%	7	5	71.43%
Finance and Information	62	50	80.65%	0	0	
FSD	7	7	100.00%			
Finance & Supplies	55	43	78.18%			
Governance and Workforce	119	69	57.98%	17	8	47.06%
Education	48	40	83.33%	13	7	53.85%
Governance	24	13	54.17%	4	1	25.00%
HR & Payroll	47	16	34.04%			
IT	65	46	70.77%			
Nursing	39	33	84.62%	27	24	88.89%
Trust Executives	18	9	50.00%			
OPERATIONS						
Estates	61	23	37.70%			
Facilities	404	118	29.21%			
Central Operations	4	3	75.00%			
Scheduled Care	791	512	64.73%	660	422	63.94%
Critical Care	293	190	64.85%	277	173	62.45%
Scheduled Care Divisional Management	49	33	67.35%	26	22	84.62%
Surgery	298	184	61.74%	226	142	62.83%
Trauma & Orthopaedics	151	105	69.54%	131	85	64.89%
Unscheduled Care	770	451	58.57%	609	361	59.28%
Acute Medicine	118	79	66.95%	90	59	65.56%
Discharge & Palliative Care	15	10	66.67%	12	9	75.00%
Emergency Care	131	71	54.20%	92	49	53.26%
Medicine, Elderly & Stroke	234	137	58.55%	209	120	57.42%
Specialty Medicine	248	138	55.65%	202	120	59.41%

Unscheduled Care Divisional Management	24	16	66.67%	4	4	100.00%

Womens, Children & Support Services Division	1329	779	58.62%	853	504	59.09%
Audiology	22	21	95.45%	19	14	73.68%
Child Health	121	68	56.20%	114	60	52.63%
Pathology	134	77	57.46%	37	14	37.84%
Pharmacy	136	86	63.24%	33	23	69.70%
Radiology	165	67	40.61%	122	41	33.61%
Therapies	292	242	82.88%	264	217	82.20%
WCSS Divisional Management & Admin	84	31	36.90%	17	10	58.82%
WCSS Outpatient Department	181	88	48.62%	63	40	63.49%
Womens Health	194	99	51.03%	184	85	46.20%

TRUST TOTAL	**3679**	**2103**	**57.16%**	**2173**	**1324**	**60.93%**

Induction Programme - Summary of Feedback-Subject Areas

Session	**Safeguarding Procedures – Adult & Children**
Facilitator	Safeguarding matron and *Specialist Nurse, Safeguarding Children*

Evaluation forms currently ask delegates for feedback for each subject covered in relation to the following:

- Has the session met your expectations? If so, how?
- How could the session be improved?
- Was the information given clear, understandable and delivered at the right pace?
- Any further comments?

Comments Received: March Induction

- Good overview – lots of information
- Found this section to be very informative and full of useful information
- Very good information
- Clear and understandable
- Well presented
- Very sad but eye opening
- Important information given
- Expectations were met
- Very clear and understandable
- Delivered at the right pace
- Very interesting and well presented
- Very good session
- Lots of information given
- Well presented
- Interesting session and real life examples given
- Very important lecture

- Good use of Active Inspire/Expression

Doctors F1 26th February 2014

	VG	G	F	P	VP
The Session as a whole	37.50%	50.00%	12.50%	0.00%	0.00%
Content of the Session	37.50%	50.00%	12.50%	0.00%	0.00%
Presenter's Contribution to the Session	50.00%	37.50%	12.50%	0.00%	0.00%
Delivery Methods	37.50%	50.00%	12.50%	0.00%	0.00%
Explanations	50.00%	37.50%	12.50%	0.00%	0.00%
Tailoring of Session	37.50%	50.00%	12.50%	0.00%	0.00%
Examples and Illustrations	50.00%	37.50%	12.50%	0.00%	0.00%
Audience Confidence in Presenter's Knowledge	50.00%	37.50%	12.50%	0.00%	0.00%
Presenter's Enthusiasm	62.50%	25.00%	12.50%	0.00%	0.00%
Encouragement for Audience Interaction	37.50%	50.00%	12.50%	0.00%	0.00%
Availability of Additional Information	37.50%	37.50%	25.00%	0.00%	0.00%
Length of Session	37.50%	50.00%	12.50%	0.00%	0.00%
Relevance and Usefulness	37.50%	50.00%	12.50%	0.00%	0.00%
What aspects of this session contributed most to your learning?					
"well delivered, enthusiastic presenter" "very good thank you" "thanks"					
What aspects of this session detracted from your learning?					
no comment made					
What suggestions do you have for improving the session?					
no comment made					

Appendix 5 Datix incidents reported to the Safeguarding team for review

	13/14 Q1	13/14 Q2	13/14 Q3	13/14 Q4	Total
Fire	0	0	1	0	1
Assault non physical	9	1	3	5	18
Bed management	0	0	2	3	5
Collision / Hit by object	0	1	1	0	2
Community Midwives (Pick List)	1	0	0	0	1
Recognising Risk in Deteriorating Patient	1	1	1	0	3
Discharge Liaison	1	1	2	1	5
Domestic Abuse	0	1	0	0	1
Medicines	1	2	4	1	8
Emergency Medicine	2	0	0	0	2
Environment	0	0	0	1	1
Equipment - Non-Medical (non IT related)	0	0	1	0	1
Hospital @ Night	0	1	0	1	2
Breach of confidentiality and potential data loss - Internal Issue (verbal, electronic and paper)	0	1	0	0	1
Breach of confidentiality and potential data loss - external Issue (verbal, electronic and paper)	0	0	1	0	1
Communications Issue (verbal, electronic and paper)	2	6	1	2	11
Patient Choice	1	1	1	1	4
Infection control	1	0	0	1	2
IT/computer related	0	0	0	1	1
Consent & Mental Capacity Act	1	1	0	1	3
Mental Health Act	0	5	5	2	12
Neonatal Unit (Pick List)	1	0	0	0	1
Obstetric (Pick List)	1	1	1	0	3
Physical Assault to Other eg Patient Visitor	0	4	5	3	12
Physical Assault to Staff	0	0	1	0	1
Patient Transfer	0	1	1	0	2
Pressure Ulcer	**37**	**1**	**0**	**3**	**41**
Suspected Deep Tissue Injury - Community Acquired	1	0	0	0	1
Suspected Deep Tissue Injury - Hospital Acquired	2	0	0	0	2
Grade 2 - Community Acquired	20	0	0	1	21
Grade 2 - Hospital Acquired	5	0	0	0	5
Grade 2 - Acquired on a Previous Admission to another trust	1	0	0	0	1
Grade 3 - Community Acquired	6	1	0	1	8
Grade 3 - Acquired on a Previous Admission to another trust	1	0	0	0	1
Grade 4 - Community Acquired	1	0	0	1	2
Radiology	0	1	0	0	1
Resuscitation / Cardiac Arrest	0	1	0	1	2
Safeguarding Children	0	0	1	0	1
Safeguarding Adults	20	20	10	11	61
Security Issue	31	26	16	17	90

	13/14 Q1	13/14 Q2	13/14 Q3	13/14 Q4	Total
Staffing	0	3	1	0	4
Patient Slips, Trips & Falls	1	2	1	2	6
Treatment	0	2	2	2	6
Unexpected events	10	6	14	7	37
Verbal Assault/Threatening Behaviour	2	1	3	1	7
Totals:	123	91	79	67	360

Appendix 6 Summary of Datix incidents from 01/04/13 - 31/03/14 for LD

Disability is a mandatory field on *Datix* incident reporting system. These are all incidents where learning disability has been indicated.

Division	Ward/Department	Brief description
Scheduled Care	Clinic	Child DNA
	Recovery	Peg tube found taped under breast
	A4	Medication
		Slip/behavioural
		Blister
	A6	Staffing
	ICU/HDU	Emergency buzzer malfunction
	B4	Behavioural
	A9	Medications
		Slip
		Fall
		Cannula left in after discharge
Unscheduled Care	AED CDU	Level of care/treatment provided
		Behavioural
		Behavioural
		Pressure ulcer
	AED Resusc.	No out of hours physio provision
		Pressure ulcer
	AED Paeds.	Emergency
		Absconded
	MIU, Halton	Ambulance issue
	A1	Pressure ulcer
		Pressure ulcer
	A2	Pressure ulcer
		Pressure ulcer
		Absconded
		Patient taken from ward by relative
		Pressure ulcer
	A3	Fall
		Pressure ulcer
	A8	Staffing/workload
		Staffing/workload
		Pressure ulcer
		Fall
		Staffing/workload
		Staffing/workload
	B12	Staffing/workload
		Injury
		Blister
		Fall
		Medication
		Fall
		Slip
	B18	Injury from accident
		Cannula left in after discharge
	B1	Fall

Division	Ward/Department	Brief description
WCSS	B11	Admission issue
		Medication
		Medication
		Seizure/injury
		Injury/accident
		Medication
		Medication
		Near miss – fall
		IV fluid infiltration
		Medication
		Intruder
		Absconded
	PAU	Waiting time/behavioural
		Medication
	AED Paeds.	Safeguarding issue
		Behavioural
	C20	Medication/behavioural
	C23	Visitor fainted
	Pathology	Transfusion identifiers
	Home	Medication

Warrington and Halton Hospitals NHS
NHS Foundation Trust

W&HHFT/TB/14/120(ii)

BOARD OF DIRECTORS

Paper Title	Safeguarding Children – Annual report 2013/2014
Date of Meeting	30Th July 2014
Director Responsible	Director of Nursing and Organisational Development
Author(s)	Nicki Richardson –Named Nurse/ Midwife – Safeguarding Children
Purpose	This paper seeks approval of the content of the Safeguarding Children Annual Report

Paper previously considered (state Board and/or Committee and dates)	**Committee**	**Date**
	Womens and Children and Support Services DIGG	16/06/14

Relates to which Trust objectives	√ **appropriate**
• Ensure all our patients are safe in our care	√
• To be the employer of choice for healthcare we deliver	√
• To give our patients the best possible experience	√
• To provide sustainable local healthcare services	√

Key points arising from the Report/Paper (please include up to eight bullet points and reference page/paragraph as appropriate).

	Going Well	Page/Paragraph Reference
1	Increase in Hospital staff identifying and responding to 'Early help' Opportunities	**P2 & 6**
2	Establishment of Safeguarding Supervision process with increase in documented Midwifery Supervision	**Introduction p2 & p13**
3	Increase identification of Children's Safeguarding and a Domestic abuse cases	**Introduction P P5 and P14, 16-18**
	Current Challenges	
4	Improving training compliance across the Trust	**Review Objectives P3 & 14**
5	Maintaining response time and support for staff in view of the increased work load for the Safeguarding Children Team.	

Recommendation(s) (include what you require the Board to do; approve/note/ratify etc.)

The Board is asked to approve the Safeguarding Children – Annual report 2013/2014

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Child Protection / Safeguarding Children

Annual Report

April 2013 – March 2014

Report compiled by

Nicki Richardson – Named Nurse/Midwife
&
Katie Clarke – Specialist Nurse
Safeguarding Children

Contents:-

1. Introduction

This is the 10th annual report on Child Protection /Safeguarding Children. Safeguarding is a core part of our business and a CQC standard. This report gives assurance to the board that the Trust is meeting its obligations to safeguard children.

National picture:-

There were 28,830 children who started to be looked after during the year ending 31 March 2013, an increase of 2 per cent from the previous year's figure of 28,390 and an increase of 12 per cent from 2009.Much of the increase in 2013 is accounted for by the rise in the number of children aged 16 and over who started to be looked after. In the year ending 31 March 2013, 3,690 children in this age group started to be looked after. This represents an increase of 8 per cent from 2012. Number of young people leaving care 9,990 children aged 16 and over ceased to be looked after during 2013, an increase of 14 % from 2009 (Catch22 NCAS briefing, September 2013).

There were 593,500 referrals relating to 511,500 children for the year to 31st March 13. Referrals accepted by social workers have decreased year on year in England (since 2010/11). A quarter of referrals in England in 2012/13 were re-referrals (How safe are our children, Indicator 11- Referrals accepted by social services).

For children who need additional help, every day matters. Academic research is consistent in underlining the damage to children from delaying intervention. The actions taken by professionals to meet the needs of these children as early as possible can be critical to their future. Children are best protected when professionals are clear about what is required of them individually, and how they need to work together. *Working Together to Safeguard Children, HM Government 2013. WTG.*

Trust activity in 2013/14

- 24,320 children attended A&E/MIU
- 53,418 outpatient attendances
- 7210 Missed appointments (13%)
- 3199 babies delivered

Snap shot of Safeguarding children office activity in 2013/14:-

- 1950 contacts with the Safeguarding children office from hospital staff (annual increase of 90)
    - 661 - Regarding pregnant women (annual reduction of 54)
    - 1181 - Relating to children (annual increase of 111)
    - 108 - Relating to domestic abuse (annual increase of 33)
- 170 domestic abuse referral made via Safeguarding office (increase of 12)

(On average from all above, there are 16 cases per working day raised by hospital staff to Safeguarding children office)

- 1320 domestic abuse searches made for high risk domestic abuse case that are discussed at multiagency forum (last half of the year data)
- 58 children attended and staff suspected Non Accidental injury of which 44 had a child protection medical
- 98 (annual increase of 28) children have repeatedly not been brought for essential health appointments. Remedial action taken by SG team.
- 5 Rapid response meetings held (when a child dies unexpectedly and it is initially unexplained).

This report demonstrates the contribution Trust staff make to Safeguarding children at lower levels as well as child protection level.

2013 -14 was dominated with embedding Safeguarding supervision and recommendations from the Warrington Mock Inspection in January 13. The New WTG document was published in March 13. The Trust policy for Safeguarding Children was amended to reflect the changes.

2. Glossary of terms and abbreviations

	Term	Description/ definition
Safeguarding	Safeguarding and promoting the welfare of Children:	• Protecting children from maltreatment; • Preventing impairment of children's health or development; • Ensuring that children are growing up in circumstances consistent with the provision of safe and effective care; and • Taking action to enable children in need to have optimum life chances
CSC	Children's Social Care	Children's social care services
CAF	Common Assessment Framework	Is a shared assessment tool for use across all agencies. It aims to help early identification of need and promote coordinated service provision.
	Pre CAF	Referral form for a CAF – which is forwarded to a practitioner in health (usually a Midwife/ Health Visitor or School Health advisor)
DA	Domestic abuse	
MARAC	Multi Agency Risk Assessment Conference	Is a victim focused meeting where information is shared on the highest risk cases of domestic abuse between criminal justice, health, child protection, housing, IDVA's as well as other specialities from the statutory and voluntary sector.
IDVA	Independent domestic Violence adviser	Trained specialists who provide a service to victims, who are at risk of harm from intimate partners or family.
CP	Child Protection	
NAI	Non Accidental Injury	
CIN	Child In Need	Under section 17 of the Child Act – A child who is unlikely to reach or maintain a satisfactory level of health or development, or their health or development will be significantly impaired, without the provision of services, or a child who is disabled.
CHIC	Child In Care	Child in the care of the local authority
LSCB	Local Safeguarding Children's Board	WSCB- Warrington Safeguarding Children's Board HSCB - Halton Safeguarding Children's Board
ESR	Electronic Staff Record	
SUDIC	Sudden Unexpected Death in Infants and Children	

4. Review of objectives set for 2013/14 and Key achievements

Objectives for Safeguarding children	Action	Outcome
Ciris Governance system to be utilised to monitor Safeguarding action plans and contract.	Action plans put on Ciris and updated	
Training compliance at level 1 and 2 to be 85%	Level 1 – 58% (decrease of 3%) Level 2 – 50% (decrease of 3%)	
Maintain and improve on level 3 training figures	12-13 – level 3 - 83.61%. 13 -14 – level 3 – 76% Training booked for A&E staff and a Trajectory to improve training compliance by September 14	
Develop a Safeguarding Children Supervision process	Protocol developed and embedded in Maternity. Further role out to Paediatric areas required	
Work load / Nursing Safeguarding Children requirements to be reviewed in 2013/14	Work load increases and staffing level static due to current financial situation of Trust. Risk assessments in place for not flagging Warrington Children on Child Protection plans	

This is the first year that all objectives were not achieved. There has been increased activity and Trust pressures that have impacted on performance.

4. Audit of the trusts Safeguarding children pathways

The hospital safeguarding children concerns form was introduced in 2002/3 to monitor compliance with the national standards and to give a measure of performance against Laming recommendations.

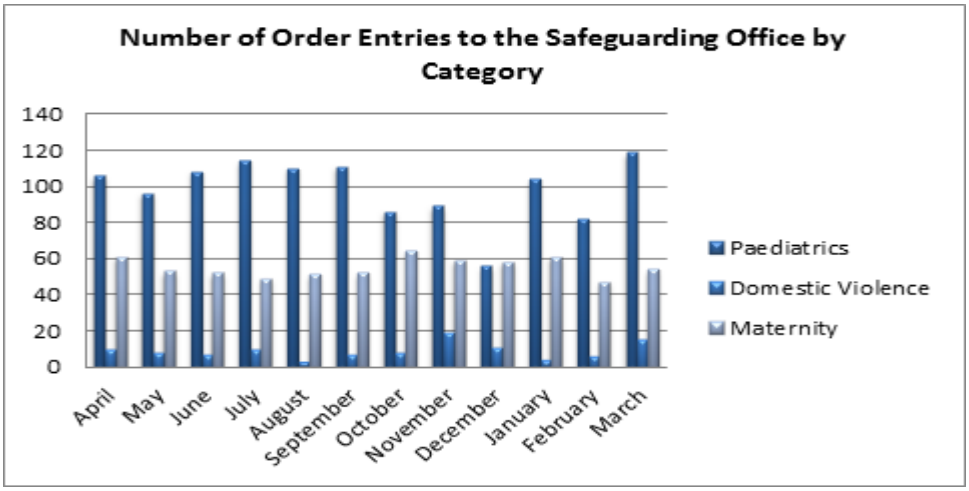
The 'Concerns form' is used in the trust to highlight safeguarding children concerns. The form ensure staff are alerted to issues identified for a child and what action plans are in place or completed, It contains a minimum data set for children that have been identified as 'potentially' requiring some level of 'Safeguarding'.

In the recent inspection report::- *Joint Inspection of multi-agency arrangements for the protection of children – Warrington (Ofsted 2013)*

Children and young people benefit from hospital staff, including nurses and midwives, being pro-active in gathering initial information on children and young people when they have any concerns and they liaise effectively with community health staff to undertake a full assessment. For example, children not attending essential hospital appointments are identified by consultants to paediatric nurses who ascertain the reasons for non-attendance and refer to children's social care if necessary.

Order entries

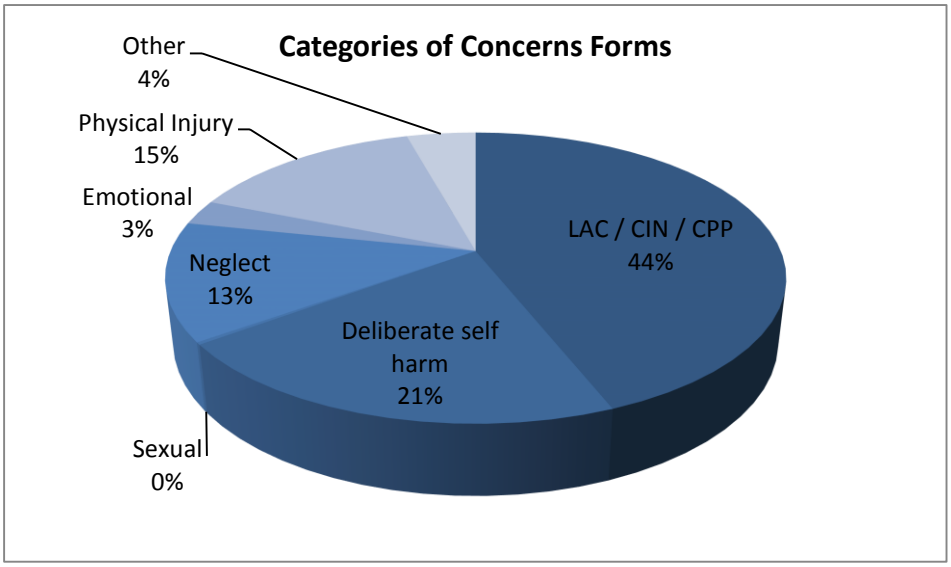
In 2011 an electronic information system (Order Entry) was introduced for information to the hospital Safeguarding team. This was introduced to aid communication and ensures there is an audit trail present on information passed about any Safeguarding Children/ Maternity or domestic abuse issues. The last year has seen a 5% increase in notifications, which is a stabilisation of the increase seen over the last few years. This being due to the implementation of a maternity pathway /criteria. Information is available for staff to view previous report to the safeguarding team and is an auditable process for information sharing.



Concerns Forms Audit

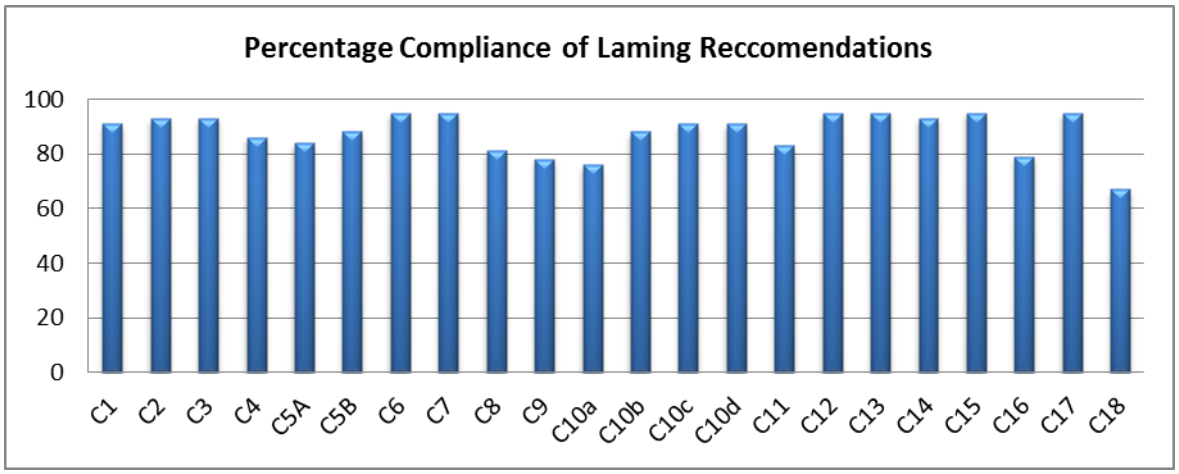
- 396 Concerns forms were commenced – these are cases practitioners sought advice /guidance on (🡻21).
- 15 % commenced for physical abuse which were the audit sample used for 2013 - 2014 audit

For Audit questions- see appendix 1.



Over the past 5 years there has been a steady increase in the number of forms commenced as demonstrated below however this has now plateaued.

Year	Forms commenced	Forms commenced for Suspected Physical abuse numbers and as a percentage	
2007	192	58	30 %
2008	178	80	45 %
2009	240	70	29 %
2010	283	80	28 %
2011-12	363	73	20 %
2012 -13	417	69	16.5 %
2013-14	396	58	15 %



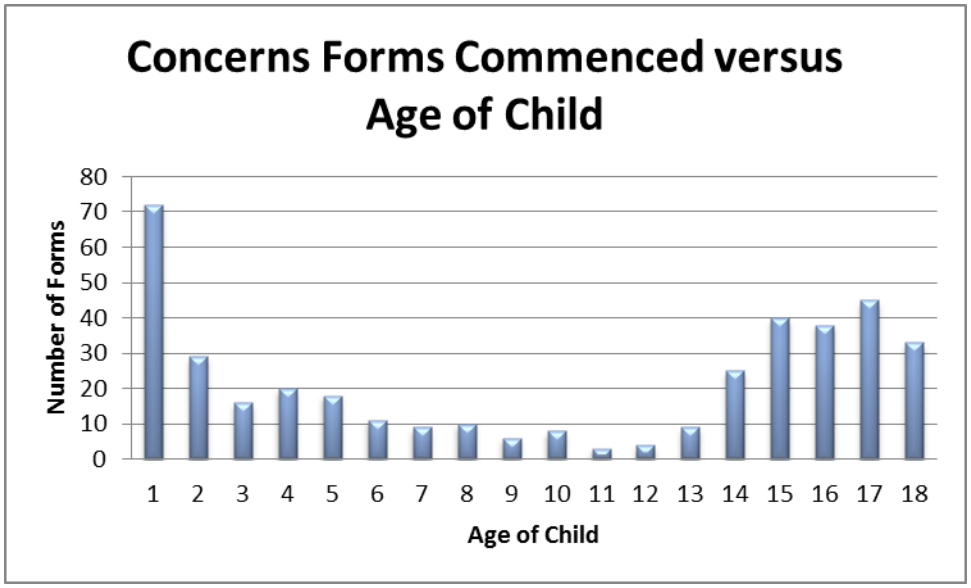
5a - 2 % ↑

10b - 7%↑

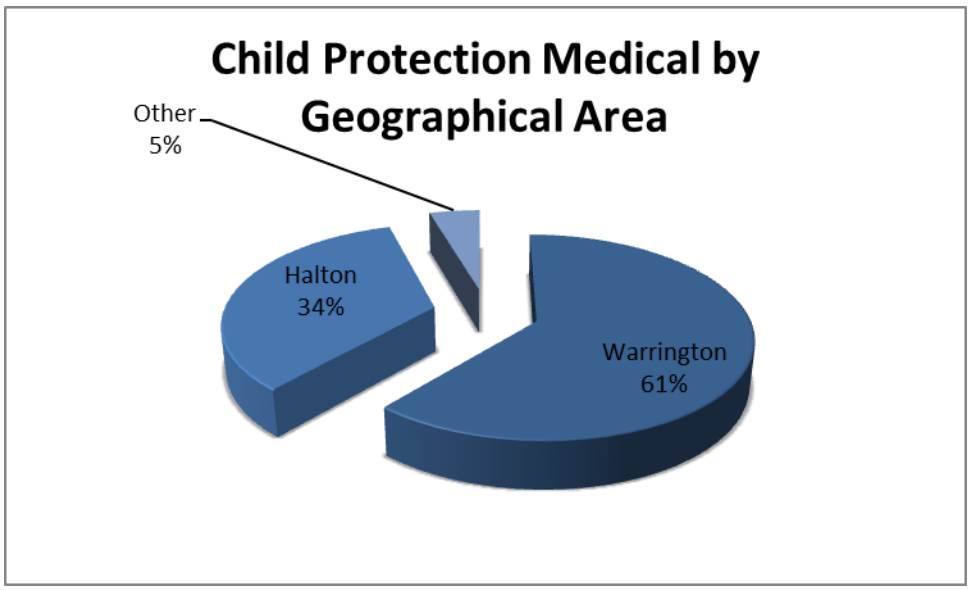
10c - 9% ↑

14 - 23%↑

17 -19%↑



Similar trend to previous years.



Numbers of CP medicals:-
2011 /12 - 60
2012 /13 - 50
2013/14 - 44

The majority of Child protection medicals are performed out of office hours. When community Paediatricians are unavailable.

Peer Review

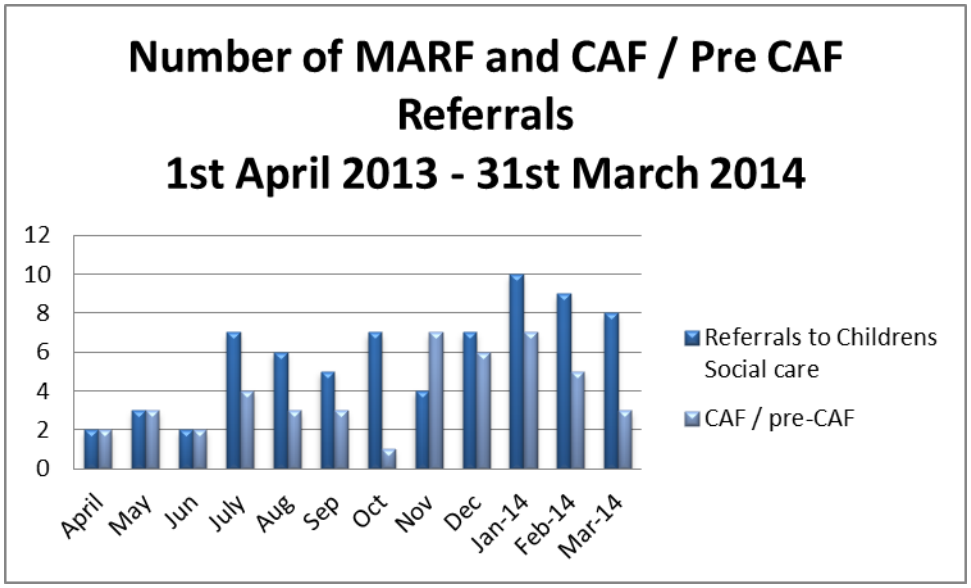
Peer review of child protection medicals is advised by the Royal College of Paediatrics and Child Health to allow safe discussion of cases to share and improve knowledge and report quality. Child Protection Medicals Peer Review Meetings commenced November 2012. All Paediatric Consultants and Safeguarding Children Specialists are invited and attendance has been good and well supported.

- Meetings are held monthly.
- All CPM reports have been discussed in the year 2013- 2014. In addition to all cases that attended with suspected physical injury that did not go to CP medical or perhaps were deferred to attend community for a medical in working hours(where appropriate) or in one incident sent to SARC (Sexual Assault Referral Centre).

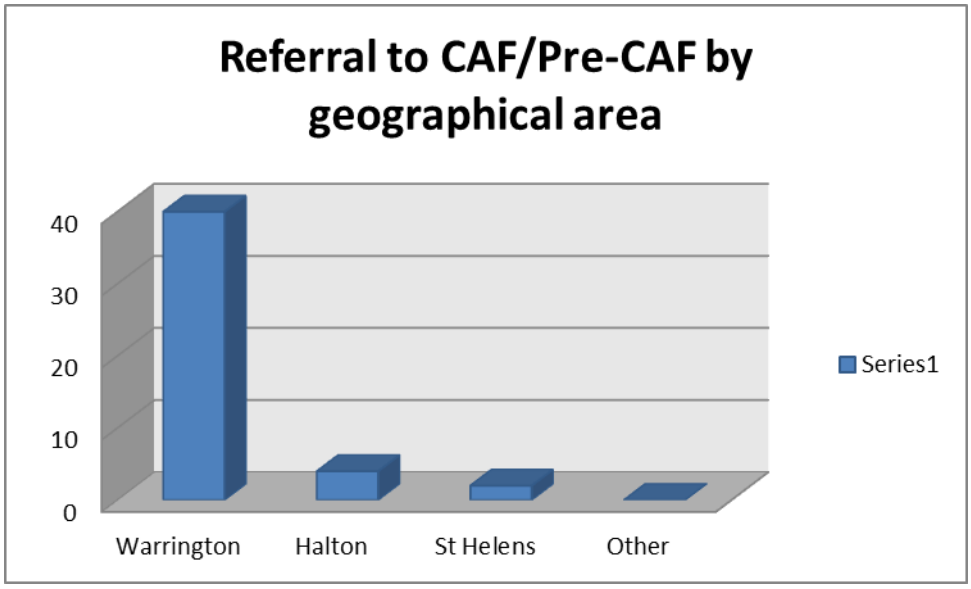
Referrals to Children's social care

Obtaining support for families at lower level then social services provide is an important feature of Laming enquiry as well as the Monroe report. Agencies are required to have pathways and demonstrate that they are linking families into lower level support. In addition to providing information for paediatric liaison health visitor and school health advisors around children's attendances. The CAF provides a holistic assessment linking them into lower level support.

All CAF's are reviewed by the safeguarding team and help given to develop the CAF. During the last 12 months multiagency audit of CAFs has demonstrated the high calibre of CAF's from the hospital.



The number of written referrals to children's social care has increased by 54 %. This is likely to be due too staff awareness to ensure a copy is sent to Safeguarding Children office.

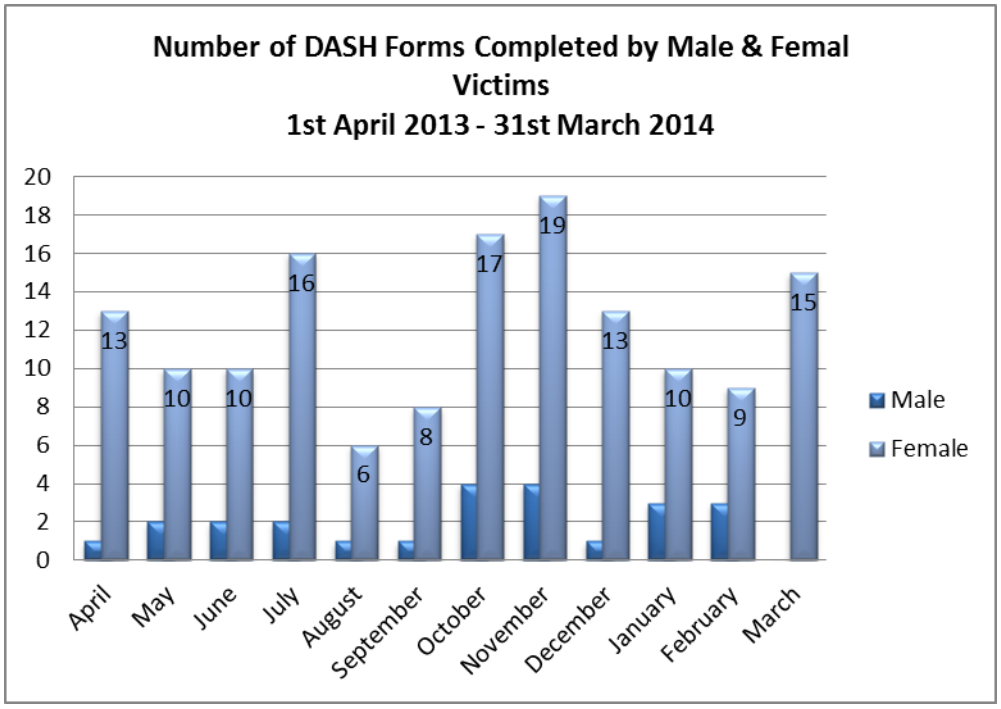


The number of CAF's and pre CAF's have risen by 59 % . These referrals demonstrate staff awareness to work at 'lower levels of need' and link into support services for families instead of referring lower levels of concerns to Children's social care. The majority of CAF's undertaken are on unborn babies by Community Midwives or the Teenage Pregnancy Midwife

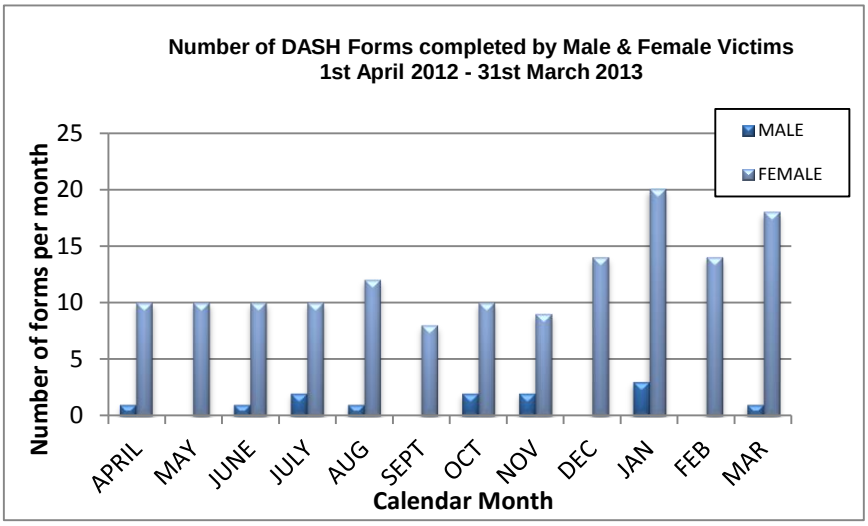
5. Domestic Abuse

The trust continues to support Coordinated Action Against Domestic Abuse (CAADA) and is represented on both the Warrington and Halton domestic abuse strategic groups.
The Trust Safeguarding children team lead on domestic abuse and review all domestic abuse disclosure information made to hospital staff prior to information being shared with other agencies.
A&E and MIU remain the primary sources within the hospital to identify domestic abuse. A number of disclosures are made in maternity where midwives routinely screen pregnant women at first point of contact and throughout the pregnancy. There is an agreed multi agency referral pathway and information is reviewed by the named nurse/midwife or the specialist nurse or midwife, who ensures referrals are clear.

In 2013/2014 a total of 170 domestic abuse forms were completed and sent to the Safeguarding team.



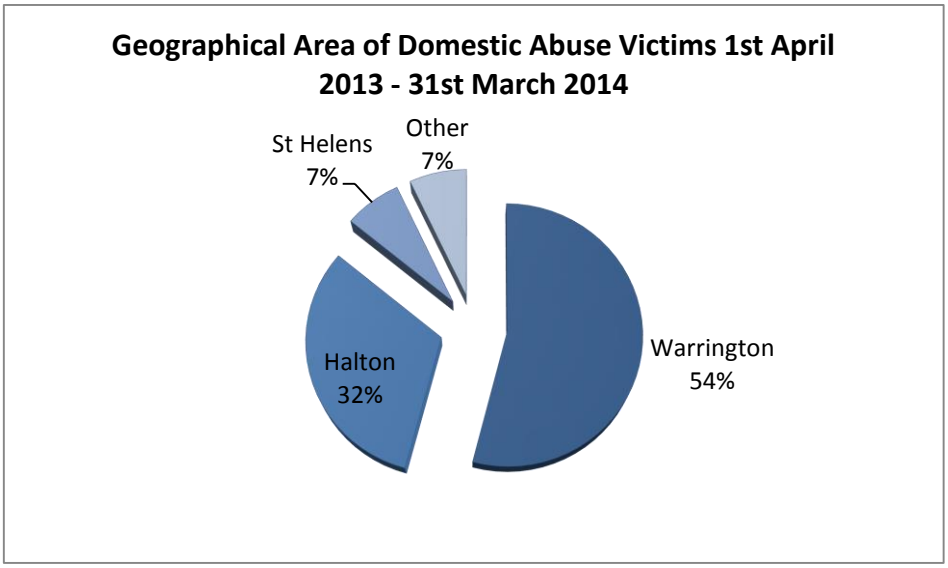
A steady increase has been seen in the number of male victims disclosing domestic abuse. This may be attributed to an increased awareness of the male victim through training and media.



Sex – 146 female victims
24 male victims

Pregnant at time of incident – 13 victims

60 % had children or pregnant at time of incident.



Practitioners are skilled in identifying domestic abuse and completing risk assessments. Warrington cases account for 53 % of the referrals which is an increase from last year and an on-going trend being seen year on year. 80% of referrals to safeguarding office had signed consent from the victim.

The Safeguarding team produces information for the multi-agency risk assessment conferences (MARAC) for three geographical areas, Warrington, Halton and St Helens. The reports include a review of attendances to the trust for both victims and perpetrators for incidents identified as high risk. Alerts are placed on the hospital computer system to flag victims discussed at MARAC with a view to identifying repeat domestic abuse and allowing practitioners access to this information.

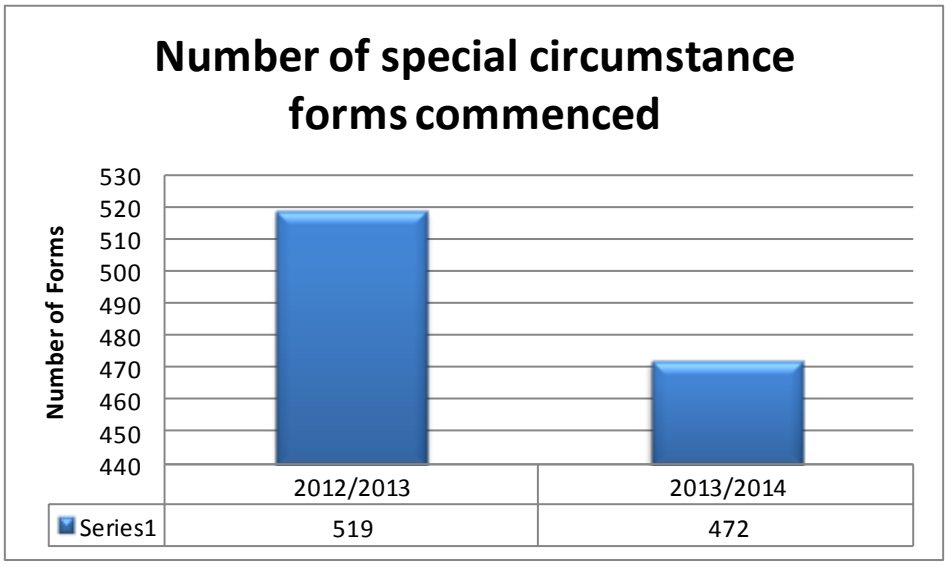
Representatives from A&E and maternity attend the Warrington MARAC where information is shared and agencies work together to provide support and advice to those families involved. Information is then cascaded to the practitioners involved with the family. For the Halton and St Helens MARACs, reports are completed and sent to the meeting with all the necessary information.

Data collection of the number of MARAC searches was commenced in October 2012. In the last year the team undertook:-

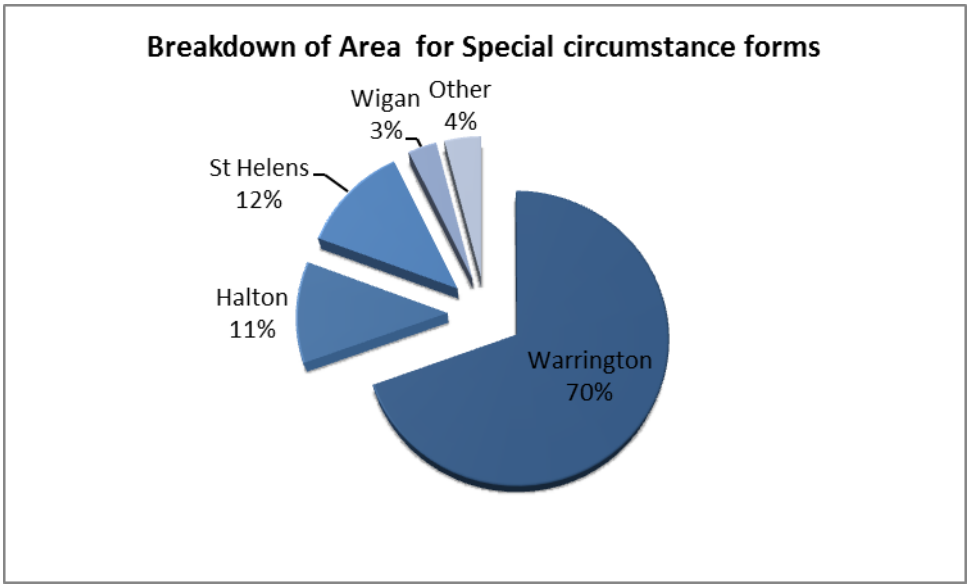
- 1320 MARAC searches over the three geographical areas.
- 42 cases were identified as high risk from the hospital thus referred into MARAC. ↑ from previous year s
- Each MARAC contains on average 10-15 cases where searches will be carried out on 2 or more adults in the household.

6. Safeguarding Children in Maternity

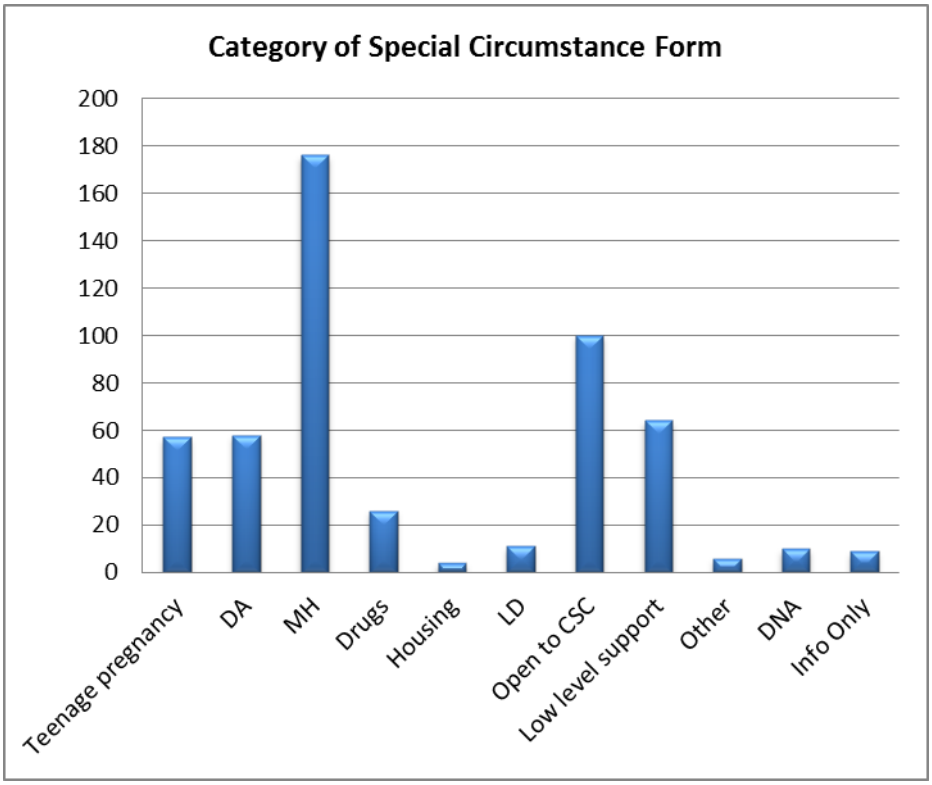
Maternity services continue to be proactive in safeguarding children. In 2013/2014, midwives identified 472 women who were commenced on 'special circumstance forms'. 661 Order entries were completed on pregnant women (annual reduction of 54). These are often updates of information following multiagency meetings when there are higher levels of concern. The reduction in Order entries are likely due to the embedding of the pre birth pathway and less inappropriate referrals.



The majority of concerns are raised for women residing in the Warrington area (70%), which is as expected. 30% of concerns are raised for women residing 'out of area' in Halton, St Helens and Wigan and booked for delivery in Warrington. The remaining 5% reside 'out of area' in areas such as Salford, Chester, Liverpool, Northwich and Manchester.



Breakdown of cases by category:-



Mental health remains the primary reason for commencing special circumstance forms. There has been an decrease in the category domestic abuse(from 83 to 58 cases). Midwives screening for domestic abuse at maternity booking and should screen throughout pregnancy. The local domestic abuse group has identified monies to enable an IDVA (independent domestic abuse advocate) to be allocated to the hospital and will link in with Midwives to increase understanding and screening by midwives of how to sensitively enquire.

Hospital Joint Liaison Meeting

Warrington pre-birth assessment guidelines were ratified in September 2012 by WSCB. The liaison meeting forms part of the pre-birth process. Meetings are held monthly and provide a multi-agency approach to cases at level 1-4 ensuring a plan of care is in place to support women and their unborn. Attendance includes: midwives, health visitors, mental health, family support and children's social care. It is used to share information between agencies with the knowledge and consent of the woman. For example: women who have severe mental health problems would be discussed at the meeting in order to ensure close monitoring of mental health and to consider supporting the woman under a CAF.
It was highlighted in the recent Inspection:-

Multi-agency forums such as the hospital liaison group provide an excellent focus on risks to unborn babies ensuring that timely and effective supports are in place to reduce risks'. Joint Inspection of multi-agency arrangements for the protection of children – Warrington (Ofsted 2013)

.
In 2013/2014, a total of 196 cases were discussed with the majority being discussions about 'Unborn babies' referred into the meeting by Midwives. Encouragement has been given to other agencies to refer cases to this meeting in an effort to improve communication and sharing of information thus providing a multi-agency approach.

Medical History Forms forwarded to the hospital for children that are in care

Medical history forms for 'looked after children' (now usually referred to as children in care) are required by the Local Authority. A medical history is completed by either an Obstetrician or Midwife on the mother's past medical and obstetric history, and a separate form completed by a paediatrician on the baby's condition at birth and subsequent health information.

The steady rise over the previous years has reduced in 12 -13. The number last year is lower than the previous 5 years.

	2010	*2011-12*	*2012-13*	*2013 – 14*
Medical history - Forms completed	55	94	39	103

In 2012 *An Action Plan for Adoption: Tackling delay* was launched in which the Coalition government outlined a range of measures that are designed to 'accelerate the whole adoption process so that more children benefit from adoption and more rapidly' (Department for Education, 2012a, p.3).

All agencies were asked examine factors affecting adoption timescales and causes of delay. It had been suggested previously that there was a delay in receiving 'medical History information' which then delayed the medical and a knock on effect to the adoption process. A review of 'turnaround' of the history form was undertaken. The audit identified that the hospital delivered within the 8 week time scale.
Obstetric History - audit was on average less than 10 working days (5 days shortest , longest 27).
Paediatric History - audit 6.5 working days (1 day shortest, longest 24 days)
Which is within the 40 working day time scale for obstetric history.

8. Child Deaths

The hospital Safeguarding Children team work closely with Consultant Paediatricians and the SUDIC Paediatrician when a Child dies or there is a neonatal death. All deaths are a tragedy for families the aim of the child death process is to identify any lessons that could be learnt and ensure coordinated support for families.
The child death process involves:-
- Ensuring all deaths are reported to agencies promptly
- Ensuring a rapid response meeting is held on unexpected deaths (not including Neo natal deaths)
- Ensuring the different Child Death Overview Panels has information on child deaths from children that lived in their geographical area. In the last year there were 6 baby/child deaths at the hospital. All were from the Warrington Area.

Type of death		**Rapid response meeting**
5	Unexpected death of children or babies (explained and unexplained)	5
3	Expected deaths	-

Following the update to WTG (2013) neonatal deaths before 22 weeks gestation or planned terminations no longer require notification to LSCB's. This changed has been welcomed by maternity units as often late terminations are very sensitive and parents have grappled with the difficult decisions when the prognosis for their baby has been bleak.

9. Inter-agency Quality Assurance

Case File Audit

In order to quality assure safeguarding children across agencies LSCB's have developed a programme of routine inter-agency case file audits. The Trust had involvement with a number of cases identified for review.
The safeguarding office contributed by:
- Identifying workers that have been involved with the unborn or family
- Completing chronologies
- Reviewing if Trust and Local Safeguarding Children Board(LSCB) policies and procedures have been followed
- Identifying if there was evidence of appropriate decisions being made and if management oversight was sought.
- Evidence to support whether this was achieved needed to be demonstrated.

The process involved: Identifying single agency recommendations and an initial action plan for the Trust; Trusts' reports were submitted; Agencies involved with the cases meet together to discuss their agencies involvement and ways in which all agencies could improve services and inter-agency communication.

In 2012/13 the safeguarding office were involved in:- 2 Warrington and 1 Halton multi agency case file audits.

Outcomes of audits for 2013- 14

Action
Maternity care plans to be returned in a timely manor after post natal discharge. System is in place to monitor return of care plans. Register to be checked to see if care plan is recorded as being returned.
Information on the condition of the children and their needs/wishes to be noted in all reports resulting from attending incidents of domestic violence
All members of the immediate family to be included in the assessment process when possible. Although it was identified that when an acute hospital trust contribute to an assessment the patient may be the only family member seen.
Practitioners need to clearly document that the patient / carer has been asked regarding social care input.
To enquire if letters completed in ophthalmology need to be uploaded to medicor. This would then allow other practitioners to view what letters have been typed and where they have been sent to. If this is not possible then copies of letters need to be placed in the ophthalmology notes, these are separate form hospital notes.
HSCB - Audits were completed on 16 cases.
WSCB - Audits were completed on 4 cases.

8. Safeguarding Governance and assurance arrangements

Child protection makes a regular report of significant issues and audits to Women, children's and support services DIGG. Monthly statistics are provided to NHS Warrington – Clinical Quality and Contract Review Meeting. There was previously bi monthly meetings with safeguarding children's commissioners, which review audits and contracts.

Incident reporting (Datix)

Over the past 12 months incidents with a safeguarding children element have been reviewed by the Named Nurse /Midwife. Incidents are reviewed and deemed: Appropriate action taken; Additional information required or incident needs further investigation. April 2013 – March 2014 there were 91 incidents reviewed, this is an increase from 106 the previous year.

9. Safeguarding Supervision

Following the January 2013 inspection in Warrington it was identified that

'Immediate action should be taken that all front line practitioners benefit from regular and high quality child protection supervision'. Safeguarding supervision in the Trust is currently under review with the aim of ensuring good quality supervision is demonstrated.

Supervision continues to be developed in Safeguarding. The majority of supervision in the past was 'reactive' i.e.

- Supporting and reflecting with a practitioner on a case they wish to discuss.
- Fresh eyes on report for case conference
- Fresh eyes on CAF's
- Identifying when referral pathways have not been followed
- Ensuring practitioners have a clear understanding for future cases.

Planned supervision has been developed more for Midwives over 2013-14 with Group supervision for team midwives taking place on a regular basis.

10. Training report

Level 1 & 2 training

Data from ESR to look at training compliance up to April 2013 for staff groups (excluding Medical and dental).

Level 1 - 58 %

Level 2 - 50 %

Level 3 - 76 %

The Safeguarding team has worked with the Training department over the last year to devise innovative ways of increasing training compliance. However these have failed to produce the desired results. The Safeguarding children team has completed all training action plans however training events have been poorly attended. The Trust has been under pressure over the last year and training suspended in order to cover workloads. The training department continues to working with managers across the trust to ensure training figures improve for all mandatory training. Reports are collated quarterly and reviewed by Safeguarding where action plans are in place to allow for improved training compliance.

Level 3 training

Training has also been suspended in Maternity and Paediatrics due to work load commitments this has impacted on the training compliance at level 3. A&E has worked with the Safeguarding team to ensure new staff are trained and up to date with level 3 and the training officer has produced a training trajectory and all staff should have completed training by September 14. However staff need to remain up to date by ensuring training is refreshed as per collegiate document.

11. Multi Agency Groups associated with Safeguarding children

Area	**Representative**	**Group /** meetings in blue are new meetings set up in the last 12 months
Warrington:	Karen Dawber	WSCB;
	Dr Mir	Child death overview panel
	Nicki Richardson	Training pool; Policy and practice; Case Review Group
	Katie Clarke	Domestic abuse operational group; Safeguarding operational group
	Alison Lynch	Warrington Domestic abuse Strategic group, Complex families steering Group
Halton:	Karen Dawber	HSCB, HSCB Health Sub group
	Nicki Richardson	Safeguarding Unit Meeting , Domestic Abuse Strategic; CQC Inspection Operational group ; HSCB Health Sub group
	Katie Clarke	Safeguarding Children Operational Group

12. Objectives for Safeguarding Children in 2014 -15

- Training compliance at level 1 and 2 to be 85%
- Maintain and improve on level 3 training figures
- To Embed the Safeguarding Children Supervision process
- Work load / Nursing Safeguarding Children requirements to be reviewed in light of additional pressures.

Appendix 1

1. Was the purple form commenced before discharge?
2. Are there two identifiers? I.e. name, DOB, unit no on the record?
3. Is the Consultant responsible name clearly identified on the record?
4. Is there an identified GP on the record?
a) Is there evidence of an inquiry re previous admissions to hospital? 5. b) Has this information been obtained and reviewed by the consultant in charge of the case?
6. Have enquires of current involvement with Social Services/ Health Visitors etc been recorded?
7. Are all entries signed?
8. Has the first examination been recorded?
9. Have all concerns got a completed action plan or outcome and is it signed off prior to discharge?
Discharge Process- if Child Protection 10. Medical reports: a. Has the medical report been circled? b. Is there a copy in the notes? c. Has the medical report been signed by the Consultant c. Has a copy been sent to GP / Designated DR / Social Worker
11. Notified GP,SS been completed
12. Has a full physical examination been performed within 24 hours?
13. Is there evidence that inter-agency/ multidisciplinary collaboration/ communication has and is taking place?
14. Is there written evidence that supervision advice has been followed?
15. Has the purple form been filed in the notes
16. In child protection concerns is there evidence that the consultant in charge or paediatric consultant/registrar has given permission for discharge.
17. Is there a documented plan for the future care of the child including follow-up arrangements?
18. Has a written referral to SS been done within 24 hours?

Appendix 2

Safeguarding Children Training up to 31/03/14

	Level 1	Level 2	Level 3
CORPORATE SERVICES	% Completed	% Completed	% Completed
Business Development	52.94%	57.14%	100.00%
Business Planning	33.33%		
Communications & Membership Office	50.00%		
Research	60.00%	57.14%	100.00%
Finance and Information	85.48%		
FSD	100.00%		
Finance & Supplies	83.64%		
Governance and Workforce	72.27%	41.18%	
Education	79.17%	38.46%	
Governance	66.67%	50.00%	
HR & Payroll	68.09%		
IT	100.00%		
Nursing	74.36%	66.67%	
Trust Executives	61.11%		
OPERATIONS			
Estates	39.34%		
Facilities	28.47%		
Central Operations	75.00%		
Scheduled Care	52.34%	39.70%	
Critical Care	57.00%	40.43%	
Scheduled Care Divisional Management	42.86%	30.77%	
Surgery	46.64%	34.07%	
Trauma & Orthopaedics	57.62%	49.62%	
Unscheduled Care	51.30%	42.69%	59.74%
Acute Medicine	61.02%	51.11%	
Discharge & Palliative Care	53.33%	16.67%	
Emergency Care	67.94%	69.57%	60.53%
Medicine, Elderly & Stroke	44.87%	37.32%	0.00%
Specialty Medicine	42.34%	34.16%	
Unscheduled Care Divisional Management	66.67%	25.00%	
Womens, Children & Support Services Division	69.45%	61.49%	80.71%
Audiology	77.27%	47.37%	
Child Health	89.26%	86.84%	84.38%
Pathology	62.69%	29.73%	
Pharmacy	72.06%	35.14%	
Radiology	69.70%	66.39%	
Therapies	66.10%	46.59%	
WCSS Divisional Management & Admin	59.52%	47.06%	80.00%
WCSS Outpatient Department	50.83%	49.21%	85.71%
Womens Health	85.57%	82.61%	78.49%
TRUST TOTAL	**57.81%**	**49.52%**	**76.26%**

Appendix 3

ACTION PLAN 2014 / 2015

Safeguarding Procedures (Children) Mandatory Training Compliance – 2014

Key

1 – Agreed but not yet actioned

2 – Action in progress

3 – Made partial implementation

4 – Full implementation completed

	Actions	Responsible Person	Change stage (see Key)	Date Action(s) to be Completed
1	Named Nurse/Midwife Safeguarding Children to review the quarterly compliance reports for all levels of training, in order to ascertain which staff require specific levels of training.	Named Nurse/Midwife Safeguarding Children	4	**Completed 2013**
2	Named Nurse/Midwife Safeguarding Children to ensure facilitation of specific 'stand-alone' Level 1 Safeguarding Procedures (Children) in order to target specific staff groups and increase training compliance.	Named Nurse/Midwife Safeguarding Children	4	**Completed 2013**
4	Trust wide communication sent out to all staff via 'The Week' and target e-mails to Divisional Managers, Divisional Nurses, Modern Matrons and all Doctors and SAS regarding drop-in e-learning sessions 26th November to 6th December.	Sharon Harper – Education Governance Officer	4	**Completed 2013**
5	E-learning user guide to be created for safeguarding children mandatory training to be used for drop-in sessions.	Phil Goodier – Learning and Development Analyst	4	14th November 2013 **Completed**
6	E-learning drop in sessions to be held 26th November to 6th December for staff to access safeguarding mandatory training e-learning.	Phil Goodier – Learning and Development Analyst /	4	6th December 2013 **Completed**

		Sharon Harper – Education Governance Officer		
7	Named Nurse / Safeguarding Children to meet with A&E Nurse Matron Kelly Burns to discuss training for A&E.	Named Nurse/Midwife Safeguarding Children	1	30th December 2013 **Completed**
8	Named Nurse / Safeguarding Children to meet with A&E Nurse Educator Trudi Lowe and review the action plan formulated by A&E	Named Nurse/Midwife Safeguarding Children	2	April 2014 **Completed**
9	The Trust is currently working towards a competency based workforce which is a large scale project over the next few years. A self-assessment tool for ward managers has been developed which has within it a safeguarding element and will be rolled out.	Director of Nursing and OD	2	**On-going**
10	Promotion of e-learning for all staff via Trust Communication 'The Week' highlighting the importance of completion of safeguarding training	Training Team	4	June 2014 **Completed**
11	Communication regarding completion of safeguarding training raised at Senior Nurse Meetings and NMAC by Associate Director of Education and Development	Associate Director of Education and Development	4	May / June 2014 and **on-going**
12	Continued re-audits of compliance quarterly to all teams and Divisions.	Training Team	2	Quarterly **– on-going**
13	Named Nurse / Midwife Safeguarding Children to review copy of the detailed report regarding training in order to identify staff groups who are out of date with training and to contact Managers / Divisional Nurses for assistance in improving training compliance within their areas of influence. From Level 3 downwards.	Named Nurse / Midwife Safeguarding Children	2	October 2014

Warrington and Halton Hospitals NHS
NHS Foundation Trust

W&HHFT/TB/14/121(i)

BOARD OF DIRECTORS

Paper Title Infection	Infection Prevention and Control Annual Report
Date of Meeting	30th July 2014
Director Responsible	Director of Nursing and Organisational Development
Author(s)	Lesley McKay Matron/ Associate Director Infection Prevention and Control (ADIPC)
Purpose	This report outlines the Trust's arrangements, activities and achievements relating to infection prevention and control for the April 2013 to March 2014 financial year

Paper previously considered (state Board and/or Committee and dates)	**Committee**	**Date**

Relates to which Trust objectives

	√ **appropriate**
• Ensure all our patients are safe in our care	√
• To be the employer of choice for healthcare we deliver	√
• To give our patients the best possible experience	√
• To provide sustainable local healthcare services	

Key points arising from the Report/Paper (please include up to eight bullet points and reference page/paragraph as appropriate).

Page/Paragraph Reference

- **See content of Report**
-
-
-

Recommendation(s)

The Board is asked to note that the Infection Control Team wish to extend surveillance of surgical site infections. This will provide information on the quality of services provided and assist patients in making an informed choice on provider for their care.

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

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Director of Infection Prevention and Control
Healthcare Associated Infection
Annual Report
April 2013 – March 2014

Karen Dawber
Director of Infection Prevention and Control (DIPC)
14th June 2014

Table of Contents

Executive Summary

Organisation

Warrington and Halton hospitals NHS Foundation Trust is a secondary care organisation providing healthcare services across the towns of Warrington, Runcorn, Widnes and the surrounding areas. The Trust operates across two sites, has approximately 600 inpatient beds, an annual budget in the region of £200 million, employs over 4100 staff and provides access to healthcare for over 500,000 patients as either an outpatient and/or inpatient.

The Trust's vision, to provide high quality, safe healthcare to all of our patients places both quality and safety as the highest priorities for the organisation.

Good infection prevention and control practices are essential to ensure that people who use healthcare services receive safe care. The effective prevention and control of infection is part of everyday practice and is embedded at all levels of this organisation.

Activities

This report outlines the arrangements, activities and achievements of the Trust relating to infection prevention and control for the April 2013 to March 2014 financial year.

Infection control action plan for the year

The Infection Control Team worked towards delivery of the annual work plan. Extreme pressures and a significant period of reduced staffing had an impact on full achievement of the work plan. There has been a delay in completing some policy reviews.

A robust work plan (appendix 1) has been devised for the forthcoming financial year. This will ensure that the Trust complies with all mandatory surveillance requirements, policy reviews are completed within appropriate timescales, reports are received from the Divisions, and unannounced spot checks are carried out.

Progress against action plans

Progress has been made to achieve the objectives set out in the following action plans:-

- Health and Social Care Act (2008) Code of practice on preventing infections and related guidance (2010)
- NHSLA/CNST Risk Management
- Meticillin-resistant *Staphylococcus aureus* (MRSA) bacteraemia reduction

- Meticillin-sensitive *Staphylococcus aureus* (MSSA)
- Clostridium difficile reduction

Despite this focus of activity, the Trust saw a rise in the number of hospital acquired cases of Clostridium difficile and MRSA bacteraemia.

Work on these action plans will continue to seek continuous improvements in the prevention and control of infection. Objectives have been set to assist in further reducing the risks of healthcare associated infection to patients, staff and visitors.

This report builds on previous annual reports submitted to the Board to give a whole year account of infection control activity.

Karen Dawber
Director of Infection Prevention and Control (DIPC)
14th June 2014

Acknowledgements

George Creswell	Associate Director of Estates and Facilities
Julie McGreal	Facilities Manager
Marcia Anthony	Facilities Manager
Rachel Cameron	Antibiotic Pharmacist
Cathy Jones	Matron Scheduled Care
Dr Thamara Nawimana	Consultant Medical Microbiologist/Infection Control Doctor
DR Zaman Qazzafi	Consultant Medical Microbiologist
Andrew Sargent	Infection Control Nurse
Natalie Crosby	Interim Matron Intensive care
Karen Smith	Infection Control Nurse
Paula Halsall	Infection Control Nurse

Description of Infection Control Arrangements

Infection Control Team

The Infection Control Team meets weekly.

Membership includes:-

- Director of Infection Prevention and Control:
    - Karen Dawber

- Consultant Medical Microbiologists:
    - Dr Zaman Qazzafi
    - Dr Thamara Nawimana

- Matron/ADIPC:
    - Lesley McKay

- Infection Control Nurses:
    - Andrew Sargent (0.4WTE from May 2013)
    - Paula Halsall
    - Karen Smith (from December 2013)

- Antibiotic Pharmacist (part time):
    - Rachel Cameron (0.4 WTE)

- Infection Control Administrator (part time):
    - Vicky Smith (0.8WTE until 7th June 2013)
    - Karen Brobyn (0.6WTE from December 2013)

Infection Control Sub-Committee

The Trust Infection Control Sub-Committee meets monthly.

Membership includes:-

- Consultant Medical Microbiologist (Chair)
- Director of Infection Prevention and Control (Deputy Chair)
- Consultant Microbiologist/Infection Control Doctor
- Matron/Associate Director Infection Prevention and Control
- Infection Control Nurse Specialists
- Antibiotic Pharmacist

- Divisional Infection Control Lead Consultant Scheduled Care
- Divisional Infection Control Lead Consultant Unscheduled Care
- Divisional Infection Control Lead Consultant Women, Children and Clinical Support Services
- Associate Directors of Nursing/Head of Midwifery
- Matrons Scheduled Care
- Matrons Women, Children and Clinical Support Services
- Matrons Unscheduled Care
- Workplace Health and Wellbeing Nurse Manager (formerly Occupational Health)
- Consultant for Communicable Disease Control/PHE Representative
- Estates Department Representative
- Facilities Department Representative
- Community Healthcare Trust Representative (Infection Control Nurse - Commissioning)
- Deputy Director of Public Health
- Workplace Health and Wellbeing Consultant (co-opted as required)

Reporting line to the Trust Board

The links are via:-
- Director of Infection Prevention and Control
- Governance Sub-Committee

Links to Drugs and Therapeutics Committee

The links are via:-
- Consultant Medical Microbiologists
- Antibiotic Pharmacist
- Antimicrobial Management Steering Group meetings

Links to Governance Sub-Committee and Safety and Risk Sub-Committee

The links are via:-
- Director of Infection Prevention and Control
- Minutes of Infection Control Sub-Committee/High level briefing papers
- Infection control significant issues reports
- Incident reporting
- Post infection review of MRSA bacteraemia cases
- Root cause analysis of Clostridium difficile toxin positive cases
- Root cause analysis of MSSA bacteraemia cases

- Serious untoward incident investigation of patient deaths (part 1 death certification) from healthcare associated infections
- Divisional Infection Control Groups
- Infection Control Link Staff Group
- Weekly infection control reports to Executive Directors and Senior Managers

DIPC reports to the Trust Board (Summary)

Board reports

Reports, which included target organism surveillance and outbreak/incident and investigation reports were submitted to the Trust Board in:-

- April 2013
- May 2013 – (Annual report on previous years activity)
- June 2013
- July 2013
- September 2013
- October 2013
- November 2013
- January 2014
- March 2014

Annual action plan

The infection control annual work plan was devised to give assurance to the Infection Control Sub-Committee that each element of the Health and Social Care Act (2008) is discussed and that appropriate evidence of compliance is available. This work plan is underpinned by action plans and a robust programme of audit that provides evidence of policy/guideline implementation and compliance.

The Matrons submit reports at each Infection Control Sub-Committee meeting as a standing agenda item. This allows the Infection Control Sub-Committee to give assurance to the Governance Committee and the Trust Board that compliance with the Act is maintained and that there is a programme of continued improvement.

There were 4 action plans which are all reviewed on a quarterly basis. These include:-

The Health and Social Care Act (2008) Action plan

This action plan sets out the 10 criteria against which the Care Quality Commission (CQC) judge a registered provider on how it complies with the cleanliness and infection control requirement set out in the regulations.

Compliance at the end of March 2014 and areas requiring further input are:-

Criterion	Assessment	Action required
1. *Systems to manage and monitor the prevention and control of infection*	Partially compliant	A review of how surveillance is conducted is required
2. *Provide and maintain a clean environment in managed premises*	Partially compliant	Upgrades to some hand washing sinks required. Occasional concerns have been raised about standards of cleanliness and cleaning and monitoring services are under review
3. *Provide suitable and accurate information on infections to service users and their visitors*	Compliant	
4. *Provide suitable accurate information on infections to any person concerned with providing care in a timely fashion*	Compliant	Continuous improvements in communication about patients conditions when transferring patients (inter/intra hospital transfers and to social care facilities are sought)
5. *Ensure that people who have or develop infections are identified promptly and receive appropriate management to reduce transmission*	Compliant	
6. Ensure all staff are fully involved in the process of preventing infection	Partially compliant	Improvement is required in attendance at infection control training
7. *Provide or secure adequate isolation facilities*	Partially compliant	Review of side room capacity in progress. Recently published guidance on isolating and screening inter-hospital transfers is impacting on these resources. Continuous liaison with the Patient Flow Team occurs to maximise use of side rooms for appropriate isolation of patients
8. *Secure adequate access to laboratory support*	Compliant	
9. *Have and adhere to policies that will help to prevent and control infections*	Compliant	Local surveillance policy in production Policies for immunisation of service users in production Some policies are beyond review date – a recovery plan is in place
10. *Ensure healthcare workers are free from and prevented from exposure to infections*	Compliant	

NHSLA/CNST action plan

This action plan was formulated in response to an NHSLA risk management initiative as directed by the Trust's solicitors. This was in response to a number of claims against the Trust dating back to 2007. The Action plan has been agreed as completed by the Infection Control Sub-Committee.

MRSA bacteraemia action plan

This action plan sets out the work required to reduce the risks of MRSA bacteraemia.

The Trust reported 5 MRSA bacteraemia cases (3 hospital acquired, 1 contaminant and 1 community acquired). This is an increase of 2 cases compared to the previous financial year.

All hospital acquired MRSA bacteraemia cases are incident reported and undergo post infection review. This is particularly useful in identifying risks of acquisition and focusing on areas requiring improvement.

Table 1 – MRSA bacteraemia investigation findings

Case	Root cause(s)	Areas for care improvement
1	Respiratory tract infection	Improve compliance with MRSA admission screening policy to include chronic wounds Improve knowledge of staff in relation to accessing IV Team services Promote appropriate antibiotic choice to cover MRSA where patients are colonised
2	Contaminant	Develop an SOP for paediatric blood culture specimen collection
3	Urinary tract infection	Improve documentation of urinary catheter insertion and on-going monitoring Make improvements to timely prescribing and administration of MRSA suppression treatment
4	Peripheral cannula	Improve compliance with the policy on peripheral cannula management Provide education on the MRSA policy in relation to admission screening

MSSA action plan

The Trust was identified as an outlier for methicillin sensitive *Staphylococcus aureus (*MSSA) bacteraemia cases (higher than the average rate) both nationally and in the northwest region during 2012/2013. This outlier position continued into the start of this financial year.

Public Health England (June 2013) have identified that measures to reduce MRSA bacteraemia have not impacted on MSSA bacteraemia cases/rates. Work in this action plan focusses on care improvements in clinical areas where there has been a higher incidence of cases.

The Trust reported 45 MSSA bacteraemia (17 hospital acquired and 28 community acquired) cases. This is a decrease of 9 hospital acquired cases from the previous financial year.

Local surveillance identified cases were occurring in a variety of clinical locations with a higher incidence in the adult Intensive Care Unit (ICU). The Infection Control Team has worked in partnership with ICU colleagues to investigate cases arising. The results identified that the majority of patients who developed an MSSA bacteraemia whilst being cared for on ICU were colonised with MSSA at the time of admission. A protocol to provide suppression therapy and antibiotic prophylaxis for invasive procedures was implemented for MSSA colonised patients. The effectiveness of these interventions is under review.

At the end of year, the Trust was no longer an outlier for MSSA bacteraemia cases.

Clostridium difficile action plan

The Clostridium difficile objective for this financial year was challenging for the NHS as a whole and for many Trust's individually. The annual threshold of 19 cases was not met. The Trust reported a total of 56 cases of Clostridium difficile, 31 of which were classified as hospital acquired. Compared to the previous financial year this equates to an increase of 12 hospital acquired cases.

The Infection Control Team focussed a vast amount of activity on Clostridium difficile to recover the position. This included:

- Surveillance of cases/monitoring for increased incidences in defined locations
- Cohort facility maintained
- Antimicrobial steering group – governance strengthened
- Fidaxomicin introduced for treatment of patients with recurrent *Clostridium difficile* infection
- Text alerts for *Clostridium difficile* cases to senior managers
- Increase in ward based training for management of infectious diarrhoea, viral gastroenteritis outbreaks and use of personal protective equipment
- Weekly multi-disciplinary team review of *Clostridium difficile* patients
- Safety alerts on management of potentially infectious diarrhoea
- Revision to hand hygiene signage and awareness raising events
- External review of governance arrangements
- Introduction of ribotyping
- Establishment of a multi-agency *Clostridium difficile* action group

An appeal was submitted against apportionment of 9 of the cases which was not successful. The appeal process has sharpened focus into investigation of cases. It is envisaged this will to support learning from cases and is aligned with guidance in next year's objective to examine cases more closely and implement relevant learning

Next year's objective sees an increase in thresholds for many organisations including this Trust where the threshold has increased to 26 cases.

Incidents/outbreak reports

A number of incidents occurred which were managed by the Infection Control Team. These were:-

Measles in Healthcare Worker - (April 2013)

During a period of increased incidence of measles in the community, a healthcare worker from the respiratory team was serologically confirmed to have measles infection. This member of staff has been employed at the Trust for several years

The member of staff had been on duty during the infectious period. A staff and patient look back exercise was undertaken. No high risk contacts (pregnant or immunosuppressed) were identified and no further cases were identified in relation to this contact.

The Occupational Health Department are reviewing measles vaccination and immunity across the Trust to prevent incidents of this nature re-occurring.

Tuberculosis exposure incident – (May 2013)

A patient admitted to the Trust with respiratory illness, which was later given a differential diagnosis of tuberculosis (Tb). Infection control precautions were implemented immediately. Following clinical investigations pulmonary tuberculosis was confirmed.

As the patient had been in a bay overnight with other patients an incident meeting was held. The community Tb services have been involved in contact tracing (6 patients). A notification exercise was undertaken to ensure the patient contacts and their GPs were made aware of the exposure and to be vigilant for signs and symptoms.

Salmonella – (May 2013)

Two patients, cared for on the same ward, were identified to have Salmonella in urine specimens. Further investigation identified the Salmonella species (Kedougou) from both patients to be identical. Transmission is thought to have occurred during a viral

gastroenteritis outbreak. Education on hand hygiene and use of personal protective equipment was provided to the ward staff.

Whooping cough – (September 2013)

The Occupational Health Department was informed of a confirmed case of Pertussis (whooping cough) in a member of staff. Advice was obtained from the Consultant for Communicable Disease Control (CCDC) at the local Public health England Unit and two incident meetings were held.

The healthcare worker had worked during the infectious period in a high risk areas of paediatrics. Assessment of the situation suggested contact time (less than 1 hour) with these patients was not deemed 'significant' to transmit the bacteria.

The paediatric team was asked to increase their index of suspicion for Pertussis when reviewing cases of respiratory illness. At the time of the second incident meeting, a second incubation period of 21 days had passed (total time 42 days) and no increase in cases had been observed. The CCDC advised that any cases arising after this time would be from a community source.

The healthcare worker had provided documentary evidence of 3 doses of Pertussis vaccination. Immunity to Pertussis is known to wane over years. There is currently no recommendation from the Joint Committee on Vaccination and Immunisation that revaccination of healthcare workers against Pertussis is required.

Information on signs and symptoms of Pertussis was added to the intranet and targeted at staff working in areas with vulnerable patients, e.g. pregnant women and infants under 1 year. No linked cases were identified in either staff or patients.

Rash illness ward A4 – (December 2013)

Rash illness was reported amongst 2 members of staff and several patients. The rash illnesses were fully investigated by a dermatologist. A scabies outbreak was ruled out and rashes were diagnosed as eczematous with a possible seborrhoeic component.

Rash illness Paediatrics – (February 2014)

Within paediatrics a suspected case of chickenpox was reported in a staff member and a suspected case of measles was reported in a patient. Both incidents were fully investigated in respect of appropriate clinical investigation and staff and patient contact tracing. The investigation results ruled out both as active cases of infection, resulting in no further action being required.

Chickenpox exposure incident – (March 2014)

A patient was admitted to the GP assessment unit with a rash which was later confirmed as chickenpox. The patient had been in the assessment unit for 1 hour before

being placed in isolation. This was a significant exposure time and contact tracing of staff and other patients was undertaken.

All staff in contact with the case reported immunity. There were 5 patient contacts. Four patients had been discharged, so consequently a patient notification exercise was undertaken to advise them of the exposure. The remaining inpatient had immunity to chickenpox so no further infection control precautions were required.

Work is in place to promote timely isolation by improving identification of infection risks when patients are referred to the GP assessment Unit and to review signage about infectious conditions within the assessment area.

Clostridium difficile periods of increased incidence

The Infection Control Team has developed a robust system for monitoring Clostridium difficile and detecting periods of increased incidence (PII). A PII is defined as two or more new cases (occurring after 48 hours post admission, not relapses) in a 28-day period in a defined location. Both toxin positive and PCR cases are reviewed.

During the reporting period, 5 periods of increased incidence were investigated.

Table 2 - Wards with Clostridium difficile PIIs

Cases	Month	Year	Ward	Ribotyping	Comment/ areas of concern
2 CDT	05	2013	B18	015; 002	Cluster of 2 different cases – not an outbreak
3 CD PCR	07	2013	A3	N/A	Antibiotic prescribing compliance concerns
2 CD PCR	09	2013	B18	N/A	Staffing levels below agreed level Hand hygiene compliance below 95%
1 CDT 1 CD PCR	10	2013	B14	020	2 patients nursed in the same bay. Unable to ribotype the PCR case to rule out link
2 CDT 1 CD PCR	12	2013	A3	015; 126	Cluster of 2 different cases – not an outbreak SIGHT compliance improvements required UTI prophylaxis long term prescribing Antibiotic prescribing compliance concerns Documentation of stools requires improvement
2 CDT 1 CD PCR	01	2014	A8	003 (unable to ribotype)	Lower than 80% prescribing compliance identified at point prevalence audit

Common themes emerging from the review meetings are poor documentation of stools, delay in isolating symptomatic patients and antibiotic prescribing. Feedback of investigation findings for shared learning has taken place and additional education provided.

Viral gastroenteritis including Norovirus

Outbreaks of diarrhoea and vomiting affecting patients and staff presented a problem on several occasions throughout the year. The causative organisms were identified as rotavirus and Norovirus.

Table 3 - Viral gastroenteritis incidents

Month	No of wards affected	Causative organism
Apr 2013	7	Norovirus
May 2013	2	Norovirus Rotavirus
Jun 2013	4	
Jul 2013	1	
Aug 2013	1	
Sep 2013	3	
Oct 2013	1	
Nov 2013	2	Norovirus
Dec 2013	8	Norovirus
Jan 2014	3	
Feb 2014	2	
Mar 2014	5	

The rapid implementation of infection control measures and support from Operational Management to keep wards/bays closed to admissions, until 48 hours after the last symptoms were detected, assisted in ensuring the outbreaks were not prolonged.

This demonstrates the close working relationships within the Trust between the Infection Control Team; the Patient Flow Team and Matrons. This is critical in managing outbreaks effectively. It is recognized that closure of beds; bays and wards places significant pressure on operational teams and there has been no hesitation in accepting the Infection Control Team's recommendations on bed closures, which has substantially enhanced the overall management of the outbreaks.

Budget allocation to infection control

The budget allocation to infection control Includes:-

- Pay expenditure
    - 1 WTE Nurse band 8b
    - 1 WTE Nurses band 7
    - 1 WTE Nurse band 6
    - 0.6 WTE Admin and Clerical band 3

- Non-pay expenditure
    - General equipment
    - Stationary
    - Mileage

Healthcare associated infection statistics

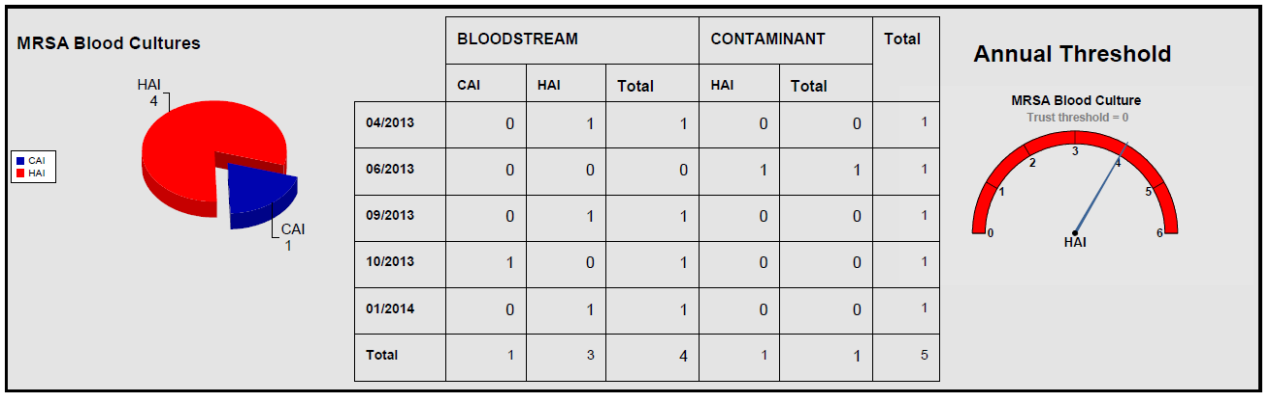
Results of mandatory reporting

The Trust participates in the mandatory reporting of the following healthcare associated infections.

MRSA bacteraemia

The Trust reported 5 cases of MRSA bacteraemia (1 community acquired; 1 contaminant and 3 hospital acquired). This is an increase in 2 hospital acquired cases compared to the previous financial year. Figure 1 depicts the MRSA bacteraemia cases, source of acquisition and the Trust's position against the annual threshold.

Figure 1 – MRSA bacteraemia cases/source of acquisition/position against annual threshold

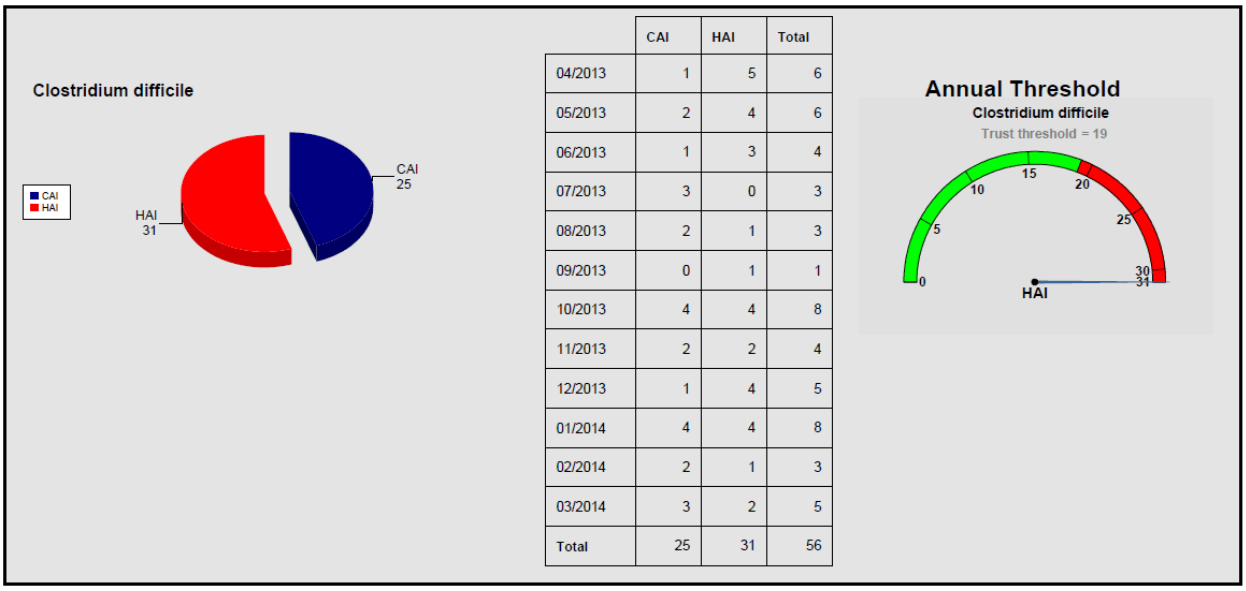


	BLOODSTREAM			CONTAMINANT		Total
	CAI	HAI	Total	HAI	Total	
04/2013	0	1	1	0	0	1
06/2013	0	0	0	1	1	1
09/2013	0	1	1	0	0	1
10/2013	1	0	1	0	0	1
01/2014	0	1	1	0	0	1
Total	1	3	4	1	1	5

Clostridium difficile

The Trust reported 56 cases of Clostridium difficile (25 community acquired; 31 hospital acquired). This is an increase in 12 cases hospital acquired cases compared to the previous financial year. Figure 2 depicts the Clostridium difficile toxin positive cases, source of acquisition and the Trust's position against the annual threshold.

Figure 2 - Clostridium difficile cases/source of acquisition/position against annual threshold

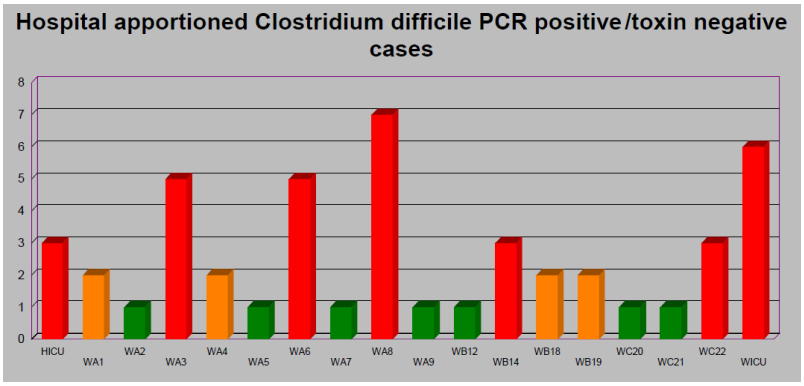


	CAI	HAI	Total
04/2013	1	5	6
05/2013	2	4	6
06/2013	1	3	4
07/2013	3	0	3
08/2013	2	1	3
09/2013	0	1	1
10/2013	4	4	8
11/2013	2	2	4
12/2013	1	4	5
01/2014	4	4	8
02/2014	2	1	3
03/2014	3	2	5
Total	25	31	56

Diagnostic testing methods for Clostridium difficile infection distinguished between patients who are colonised with Clostridium difficile (PCR positive), and those with Clostridium difficile (toxins present) more likely to indicate infection. The Infection Control Team are conducting local surveillance on the patients who are Clostridium difficle PCR positive without the presence of toxins. These patients are at a higher risk of developing Clostridum difficile infection.

Inpatients falling into this category are reviewed by the Infection Control Team. Patients exhibiting symptoms are nursed in isolated and treatment advice is provided. Figure 3 demonstrates the results for the patients who are Clostridium difficile PCR positive and toxin negative at the time of testing. Some of these patients have subsequently tested positive for Clostridium diffcile toxins.

Figure 3 - Clostridium difficile PCR positive/toxin negative hospital acquired cases



Collaborative work with colleagues in Warringtoin Primary Care Trust continues to inform future antibiotic prescribing for this group of patients.

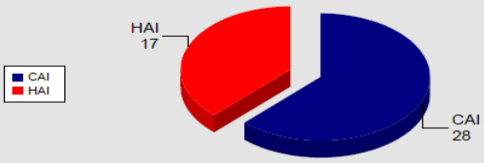
Glycopeptide resistant enterococci (GRE) bacteraemia

The Trust has not reported any cases of GRE bacteraemia during the report time period.

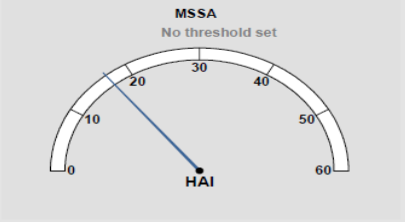
MSSA bacteraemia

The Department of Health has not set targets for the reduction of meticillin sensitive Staphylococcus aureus (MSSA) bacteraemia. Figure 4 shows the cases of MSSA bacteraemia identified within the Trust and their source of acquisition.

Figure 4 - MSSA bacteraemia cases/source of acquisition



	CAI	HAI	Total
04/2013	1	4	5
05/2013	1	1	2
06/2013	2	4	6
07/2013	4	2	6
08/2013	2	0	2
09/2013	1	1	2
10/2013	3	0	3
11/2013	4	1	5
12/2013	1	2	3
01/2014	1	0	1
02/2014	5	2	7
03/2014	3	0	3
Total	28	17	45



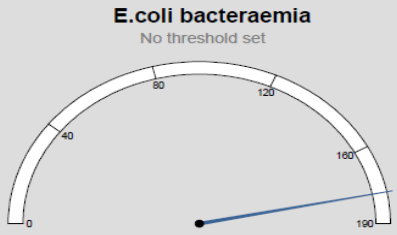
Escherichia coli (E. coli)

The Department of Health has not set targets for the reduction of E. coli bacteraemia. Data is being collated for surveillance purposes only. The data capture system does not make a distinction between hospital/community apportioned. Figure 5 shows the total number of cases reported between April 2013 and March 2014.

Figure 5 - E. coli bacteraemia cases April 2013 – March 2014

E Coli blood cultures

	Total
04/2013	12
05/2013	13
06/2013	8
07/2013	15
08/2013	16
09/2013	15
10/2013	17
11/2013	11
12/2013	15
01/2014	22
02/2014	18
03/2014	16
Total	178



MRSA screening

The Trust continues to provide MRSA screening for patients in line with the Department of Health guidance. Monthly compliance rates for MRSA screening are 100%.

Orthopaedic surgical site infection

The Trust conducts continuous surveillance on both total hip and knee surgery. This goes further than the mandatory surveillance period of 3 months. The surveillance demonstrates a zero infection rate at 60 days post procedure.

Due to the nature of implant surgery infections can manifest themselves beyond this surveillance period. Details on patients requiring revision surgery due to possible infectious cause during the reporting period are included in appendix 2.

Hand hygiene

Hand hygiene

Audits of compliance with the Hand Hygiene Policy are undertaken weekly at ward and department level. The hand hygiene compliance rates have been sustained above 95%.

The National in-patient survey 2013 included questions to rate cleanliness and infection control. The Trust scores were:-

1. Availability of handwash gels - 10/10
2. Cleanliness of rooms or wards - 9/10
3. Cleanliness of toilets and bathrooms - 9/10

The revised hand hygiene auditing tool was launched and has been successfully rolled out to the majority of areas within the Trust.

Decontamination

The Decontamination Group, chaired by the Director of Operations with Infection Control Team input, provides assurance that the Trust has the appropriate policies and training in place to be compliant with the Health and Social Care Act (2008) and Care Quality Commission standards.

All surgical instruments are decontaminated off site by a company that provides decontamination services for several Trusts within the region. There is a programme of internal and external validation. The Trust is compliant with Department of Health and NHS Estates guidance.

Facilities - Cleaning Services

Management arrangements

All of the domestic staff working across Warrington and Halton Hospital sites are employed in-house and are part of the Facilities Team, managed by a Domestic and Portering Services Manager on each site.

The Domestic Team provide 24/7 cover, including out of hours support at Halton site by the Portering Team and are supported by "as and when" staff who cover for vacancies and partially for annual leave and sickness.

The Domestic Task Team at Warrington continues to provide a valuable service, dealing with emergency leaks/spills, routine and emergency curtain changes, terminal

cleans and any infection outbreaks. They also form the core team progressing deep cleans in clinical areas.

Budget allocation

The budget allocation for domestic services for 2013/14 was £3.2m and the number of staff 154 WTE.

Monitoring arrangements

There is a dedicated Monitoring Team within Facilities, who monitor standards of cleanliness within clinical and non-clinical areas at both sites. This team is managed separately from the Domestic team to ensure there is no conflict of interest.

The monitoring of ward kitchens is undertaken by the Catering Department, who monitor cleanliness and food hygiene standards. A schedule is in place to routinely monitor ward kitchens.

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

Very High Risk Areas	Theatres, Neonatal Unit, ITU, Endoscopy
High Risk Areas	Wards, Accident & Emergency, Public areas, Pharmacy, Ward Kitchens
Significant Risk Areas	OPD, external entrances
Low Risk Areas	Chapel, Offices

Copies of the monitoring reports are circulated to the Matrons, Ward Managers, Domestic and Portering Manager and Estates, for information and remedial action. If there are any specific areas of concern, this is reviewed and focus is given to address the issue. When necessary the frequencies of monitoring are increased to address any problem areas.

To positively encourage high standards, the Domestic Team working on an area which achieves 100%, will be given a certificate in recognition of the hard work and commitment.

The 2013 monitoring scores were:
Halton: 93%
Warrington 94%

PLACE

In 2013 PEAT assessments were replaced by PLACE assessments (Patient Led Assessments of the Care Environment). The first of these assessments took place in May 2013 initially on the Halton site and Patient Representatives from Health watch Warrington and Halton and St. Helens will form part of future Assessment Teams.
The Warrington inspection took place on the 12th June 2013. Results from the two assessments are detailed below, with the exception of 'Condition, appearance and maintenance' the Trust scored above the national average in all elements.

Table 4 – National in-patient survey results

Criteria	Warrington	Halton	National Average
Cleanliness	96.84%	98.48%	95.74
Condition, appearance & maintenance	86.16%	89.72%	88.75
Privacy, dignity & wellbeing	89.19%	88.93%	88.87
Food & hydration	85.45%	89.83%	84.98

Following completion of both assessments an action plan was produced and circulated to the Divisions to progress any issues in their areas. Capital bids were also produced by Estates for areas of flooring and lighting that needed addressing.

User satisfaction measures

The 2013 National In-Patient Survey showed that there has been an increase in cleanliness standards percentages:

	2009	2010	2011	2012	2013
The hospital room or ward was very clean	70%	70%	65%	67%	89%
The toilet or bathroom you used was very clean	64%	65%	60%	63%	86%

2013 saw a real improvement in cleanliness scores for the Trust, in particular in bathroom areas.

Corporate reporting

A report is submitted by Facilities to the Infection Control Sub Committee on a monthly basis re cleanliness standards, including terminal cleans, ward kitchen monitoring and linen and on a quarterly basis re waste and pest control.

Training

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

Following DOH guidance in 2012 relating to Pseudomonas in Augmented Care settings, the Trust revised its method of cleaning hand-wash basins and has subsequently carried out a number of refresher training sessions to domestic staff.

Random audits are also carried out the ensure staff are following the correct procedure when cleaning hand-wash basins.

Refresher training sessions have also been delivered to the domestic staff in the correct use of Chlor-clean which is a cleaning product used for terminal/deep cleans and whilst patients with certain infections are being cared for.

Additional ward based “shadowing” has now also been incorporated into the Domestic Induction training.

Clinical access/responsibility

The domestic staff are centrally managed by Facilities, however, the Ward Manager and the Housekeeper are able to direct the domestic staff based on the ward re day to day priorities re cleaning. There is also close liaison with the Matrons, who have a specific responsibility for cleanliness standards for their Division.

Facilities also have a close working relationship with the Ward Housekeepers. The Domestic Task Team at Warrington respond to terminal/deep cleans and also liaises closely with the Infection Control Team re infection outbreaks.

There are cleanliness standards notices displayed in wards, departments, public corridors and sanitary areas highlighting the frequency of cleaning in that area and also giving details of who to contact with any issues relating to cleanliness over a 24/7 period.

Audit

Infection Control Nurses Association (ICNA) Audit

The ICNA audits were conducted between November 2013 and January 2014. Reductions in compliance were noted across several areas with a slight decrease in overall compliance to 94%. Table 5 provides the 2013 audit result for comparison with result from 2008 onwards.

Table 5 - Comparison of ICNA Audit Results 2008 – 2012

All Areas	2008	2009	2010	2011	2012	2013	
Ward Environment	90%	87%	93%	93%	92%	88%	↓
Ward Kitchen	75%	84%	80%	92%	89%	88%	↓
Handling and Disposal of Linen	87%	88%	90%	94%	97%	94%	↓
Departmental Waste	94%	83%	89%	92%	95%	95%	↔
Safe Handling and Disposal of Sharps	94%	89%	92%	94%	96%	95%	↓
Patient Equipment (General)	92%	95%	97%	95%	98%	97%	↓
Hand Hygiene	92%	94%	94%	96%	96%	93%	↓
Personal Protective Equipment	97%	98%	97%	97%	98%	98%	↔
Urethral Catheter Management	70%	81%	89%	89%	99%	92%	↓
Peripheral Intravenous Lines	77%	93%	93%	97%	98%	98%	↔
Isolation Precautions	70%	86%	94%	94%	98%	92%	↓
Average	85%	89%	92%	94%	96%	94%	↓

All areas have produced action plans to address the areas identified for care improvement.

Sharps audit

The Infection, Prevention and Control Team invited the Sharps bin supplier into the Trust to undertake a sharps safety audit. This was completed in February 2014. The aim of the audit was to:-

- raise sharps awareness
- assess practice
- discuss problems
- advise on compliance to current legislation

The audit results demonstrated good compliance with sharps bin management. The audit recommendations were to:-

- keep sharps containers off the floor

- train staff to use the temporary closure mechanism when unattended or moving the bins
- train staff to match lid and label correctly
- use brackets in areas where appropriate
- re-audit within 1 year

Unannounced Audits

The programme of unannounced audits, using the ICNA audit tool, has been implemented. These audits are prioritised according to the ward/department self-audit results or in response to healthcare associated infections. Feedback is provided to each ward and to the Infection Control Sub-Committee. Action plans are produced to address the areas identified for care improvement.

Saving Lives/High Impact Interventions

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

Both Theatres and the Accident and Emergency Department have been reported to have reduced compliance. The Infection Control team have established working groups within both of these areas to support improvements.

Antibiotic Prescribing

Joint Consultant Microbiologist and Antibiotic Pharmacist Ward Rounds

A joint Consultant Microbiologist and Antimicrobial Pharmacist ward round has been occurring once per week since 2011. The number of patients who have had their antimicrobial therapy reviewed on this ward round has increased year on year.

Patients are identified for review in two ways –

1. At the request of medical, nursing or pharmacy staff.
2. From the pharmacy computer system as having been supplied with a "target antibiotic"-
   (a) Piperacillin/tazobactam (Tazocin®)
   (b) Meropenem
   (c) Ciprofloxacin
   (d) Teicoplanin

(e) Cefuroxime
(f) Levofloxacin

These antibiotics are targeted because they are either associated with the development of *Clostridium difficile* infection or they are antibiotics where it would be critical if resistance develops. Table 6 depicts the number of patients/antibiotics reviewed

Table 6 - Number of Patients Reviewed

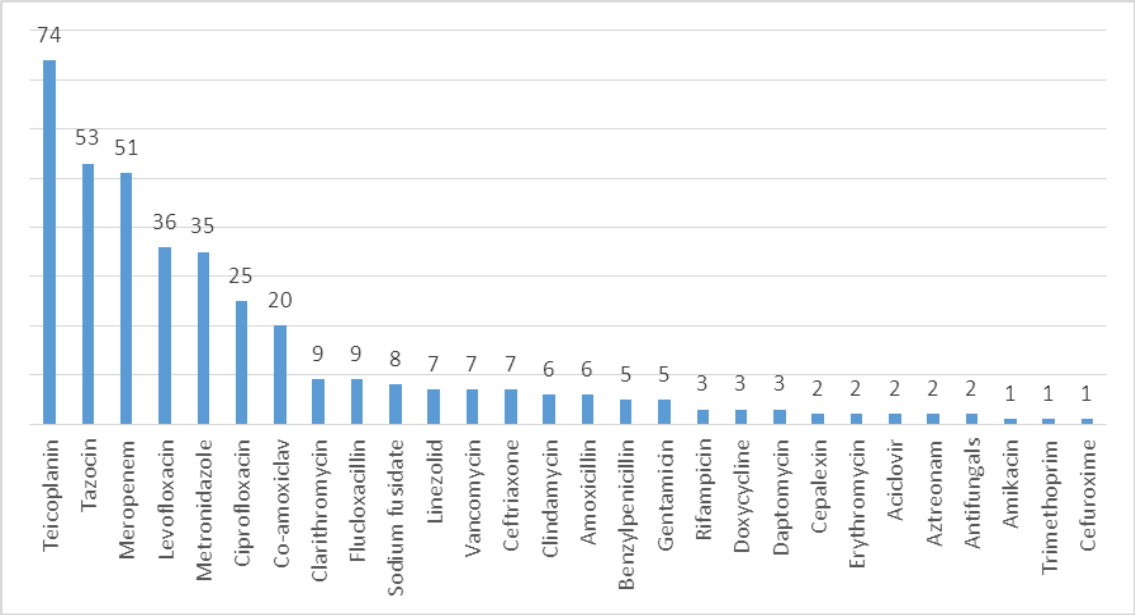
Time period	Number of patients reviewed	Number of antibiotics reviewed
April 2011 – March 2012	165	221
April 2012 – March 2013	232	310
April 2013 – March 2014	267	384

267 patients were reviewed on the wards by the Consultant Microbiologist and Antibiotic Pharmacist Team between April 2013 and March 2014 and a total of 384 antibiotics were reviewed. This is an increase of 24% in the number of antibiotics which were reviewed in the same period of 2012-13.

Summary of Antibiotics Reviewed

As stated above 384 antimicrobials were reviewed. The graph in figure 6 below indicates which antibiotics were reviewed on the ward round. 8 patients were reviewed who were not on antibiotics but required intervention due to laboratory reports, and in 6 of these cases antibiotics were initiated.

Figure 6 – Graph to demonstrate antibiotics reviewed



62.5% of the antimicrobials which were reviewed were the “target antibiotics.” Table 7 provides a summary of the interventions made.

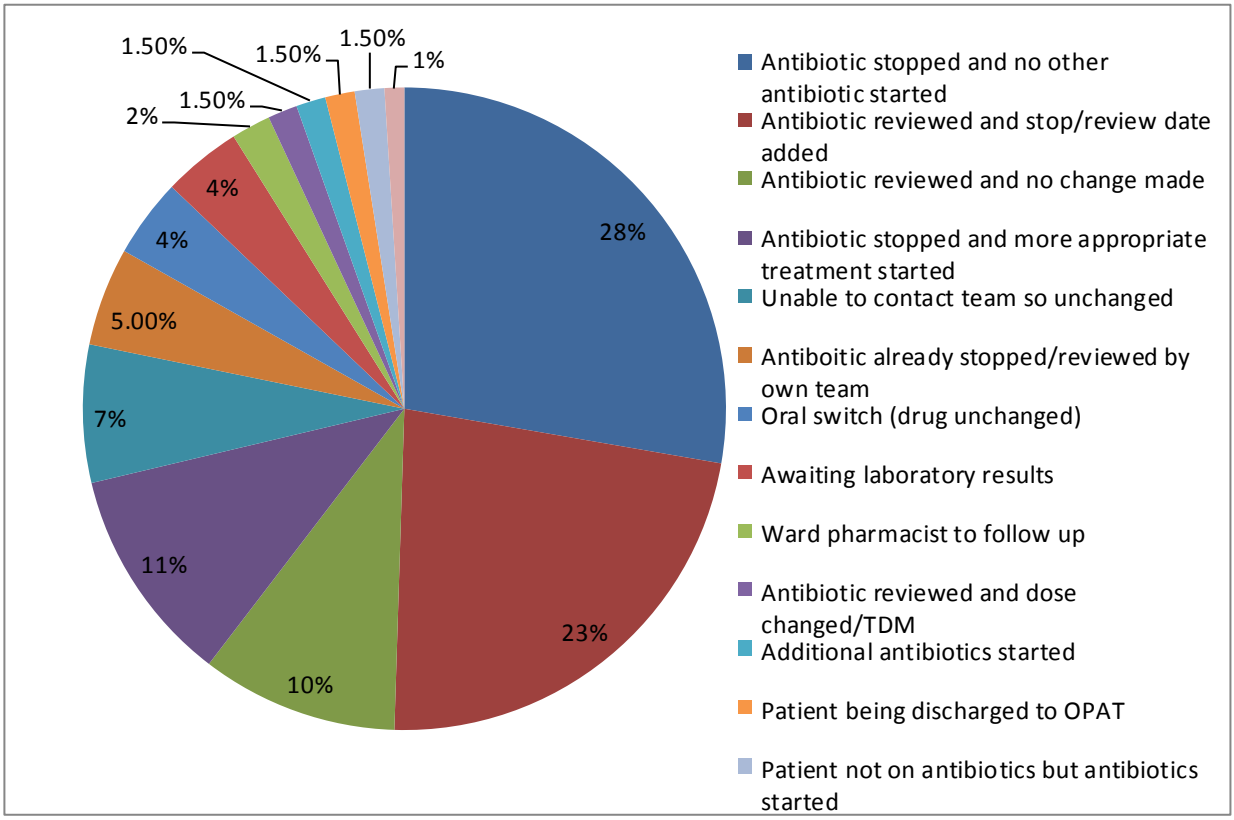
Table 7 - Summary of Ward Round Interventions

Intervention	Number of antibiotics
Antibiotic stopped and no other antibiotic started	107
Antibiotic reviewed and stop/review date added	88
Antibiotic reviewed and no change made	40
Antibiotic stopped and more appropriate treatment started	41
Unable to contact team so unchanged	28
Antibiotic already stopped/reviewed by own team	21
Antibiotic changed from IV to oral (drug unchanged)	15
Awaiting laboratory results	15
Ward pharmacist to follow up	7
Antibiotic reviewed and dose changed/TDM	6
Additional antibiotics started	6
Patient being discharged to OPAT	6
Patient not on antibiotics but antibiotics started	6
Patient not on antibiotics - advice only	1

An essential part of the review is checking the microbiology results of the patient, as this can identify patients on inappropriate antibiotics. 11% of patients were identified as needing more appropriate antibiotic treatment due to microbiology results.

28% of the antibiotics which were reviewed on the ward round were stopped. This was only done if the team with clinical responsibility for the patient could be contacted.
23% of the antibiotics which were reviewed had a stop date or further review date added. The results of the review are summarised in figure 7.

Figure 7 Results of antibiotic ward round review



Microbiologist/Antibiotics Pharmacist ward rounds will continue in order to have an influence on prescribing at ward level.

Point Prevalence Audits

Point prevalence audits are conducted quarterly. Prescribing compliance with the Trust's Antibiotic Formulary is in the region of 90%. A steady and sustained improvement (from 35% - 80%) has been seen with documentation of stop or review dates following the introduction of the new drug charts in September 2012.

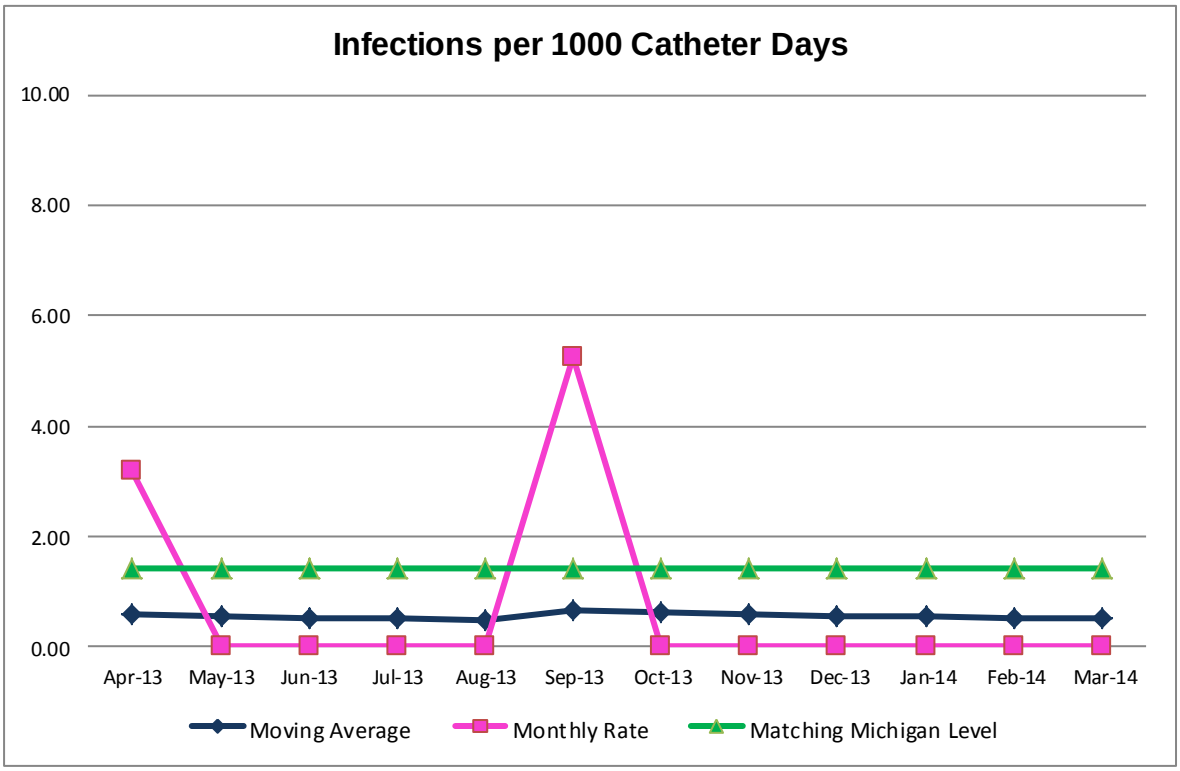
Results of the prevalence audit are fed back to Divisional governance meetings. Specific areas of non-compliance with the Trust's Formulary are discussed at the Antimicrobial Steering Group (AMSG).and fed back directly to the Consultant in charge of the patients care.

Both the point prevalence audit and the joint Consultant Microbiologist and Antibiotic Pharmacist ward rounds are of great value. A business case is in production to increase the hours of the Antibiotic Pharmacist to drive further prescribing improvements.

Matching Michigan

The Trust's ICU is participating in this initiative to reduce the incidence of central venous catheter infections. The data for the 2013 – 2014 financial year is displayed in figure 8.

Figure 8 - Matching Michigan data



The adult ICU reported 1 catheter-related bloodstream infection in September 2013 (MSSA bacteraemia). The Trust's overall rate has been consistently below that of Michigan since January 2011.

Targets and Outcomes

Activities

The Infection Control Team has been involved in a number of initiatives to promote the importance of infection prevention and control. These include:-

- Antimicrobial Management Steering Group
- Water Safety Group
- Decontamination Group
- Clostridium difficile Action Group
- Hand hygiene awareness raising events

- 24 hour on-call service (Medical Microbiology and Infection Control)
- Unannounced spot checks
- Infection prevention and control link staff group
- Response to complaints
- Response to litigation
- Response to FOI requests
- Involvement in SUI investigations

Updated policies and guidelines

The following documents were revised during the financial year and ratified by the Infection Control Sub-Committee:-

- Multi-drug resistant organism guidelines
- Measles Policy
- Infection Prevention and Control Team Infrastructure
- Hand Hygiene training booklet
- Infection Prevention and Control Information for Contractors
- Infection Control Information for Volunteers and people on work experience placements
- Guidance for Adult Peripherally Inserted Catheters (Midlines)
- Guideline for Adult Venepuncture
- Guideline for Adult Peripheral Venous Cannulation excluding Neonatal Unit
- Trust Policy on Uniforms and Work Wear
- Policy for the Management of Water Systems including the control of Legionella and other opportunistic Pathogens (including Pseudomonas)
- Laundry Policy
- Waste Management Policy
- Waste Segregation, Handling and Disposal at Ward/Department Level Guidelines
- Standard Operating Procedure: Screening of adult patients for Carbapenemase Producing Enterobacteriaceae (CPE) and Vancomycin Resistant Enterococcus (VRE) carriage admitted via inter hospital transfer
- MRSA Screening – algorithms
- Standard Operating Procedure – Mattress Inspection and Cleaning

Infection control web community/Trust policies database

Revised and updated infection control policies, procedures and information leaflets are available on CIRIS which is accessed via the Trust's intranet.

Capital Projects

The Infection Control Team participated in the following capital projects:

- B12 Dementia project
- Building materials survey
- IR project
- Cabling for wireless network
- Window upgrade works
- AED flooring
- Maternity Upgrade works
- Delamere Centre upgrade

External groups

The Infection Control Team participated in the following external groups:

- Health Economy group to review root cause analysis for HCAIs
- 5 boroughs Partnership Mental Health Trust Infection Control Committee
- Bridgewater Community Trust Infection Control Committee

Training activities

The Infection Control Team continues to provide a structured annual programme of education. This includes an Infection Control e-learning package for clinical staff. The following sessions are included in the infection control training plan. Attendance at training sessions is below the expected level and an action plan is in place to improve compliance.

Trust corporate induction

All new starters

Mandatory training

All staff

Infection Control Link Staff

1 day placements/shadowing scheme

F1 Doctors
Student Nurses/ Medical Students

Medical Students

Infection Prevention and Control
Various infection/microbiology topics

F1/F2 Doctors

Induction and updates
Blood culture specimens (Indications and technique)
Antimicrobial prescribing
Hand washing
Prevention of sharps injuries

Consultant Mandatory Infection Control Training

Ad hoc clinical based teaching

Single point lessons in response to incidents on:

- MRSA screening and suppression therapy
- Clostridium difficile management
- Use of personal protective equipment
- Viral gastroenteritis outbreak management

Grand round presentation on Infection Control issues –"Infection Control Targets - the Good, the Bad and …" May 2013

Teaching night nurse practitioners - aseptic technique on blood culture collection

Presentation on ESBL producing Enterobacteriaceae for 5BP doctors

Infection control activities

The Infection Control Team has worked hard throughout the year to deliver the annual work plan. This includes provision of clinical advice, education and training, audit, policy development/review, surveillance, and input into complaints FOI requests and Estates and Facilities issues.

Training attended by Infection Control Team Members

Dr Zaman Qazzafi - Consultant Microbiologist

Apr 2013 – Mar 2014 Grand Rounds Warrington Hospital

4th Apr 2013	Future insights into Posaconazole mechanism of action - the effect of intracellular Antifungals in Aspergillus infection – by Dr Don Sheppard, Canada
6th Jun 2013	*Clostridium difficile* Infection – advances in management
30th Sep 2013	UTI regional Audit attended at regional Micro audit meeting
30th Oct 2013	Antimicrobial stewardship (AMR) by Prof David Livermore
5th -6th Dec 2013	Orthopaedic infections meeting, Sheffield
6th Feb 2014	Water master class (water related infections)
12th Feb 2014	Table top outbreak control exercise – organised by PHE
27th Mar 2014	The Changing Landscape of Infections caused by Gram Positive Bacteria – by Prof Peter Hawkey

Dr Thamara Nawimana – Consultant Microbiologist/Infection Control Doctor

Apr 2013 – Mar 2014	Grand Rounds Warrington Hospital
4th Apr 2013	Role of intracellular anti-fungals in preventing aspergillus infections
25th Apr 2013	Lecture on Molecular Diagnosis in the District General Hospital
2nd May 2013	Measles: an update on diagnosis and management BMJ e-learning
3rd Jul 2013	Clinical audit: Characteristics and clinical outcome of bacteraemic patients with E coli
9th Jul 2013	Septic arthritis a guide to diagnosis and management BMJ e-learning
15th Aug 2013	Norovirus –How to reduce transmission and management of hospital outbreaks BMJ e-learning
11th-13th Nov 2013	Action on infection: Federation of infection societies 2013 conference in ICC Birmingham
6th Jan 2014	Lower UTI symptoms and management BMJ e-learning

Lesley McKay - Infection Control Matron/ADIPC

30th Oct 2013	Antimicrobial stewardship lecture on AMR by Prof David Livermore
5th Nov 2013	NORWIC meeting: PVL pneumonia, Neonatal MSSA, Manchester Measles outbreak, CJD issues, Changes to immunisation programme, VHF guidelines, IV access service and the Challenge of Multidrug Resistant Infections; the past, present and future
28th Nov 2013	Taps and Infections – PHE Biosafety Unit
20th Dec 2013	Webinar – HCAI regional shared learning
6th Feb 2014	Water master class (water related infections)
12th Feb 2014	Table top outbreak control exercise – organised by PHE
13th Mar 2014	Infection Prevention, innovations in vascular access and EPIC 3 guidelines – Andrew Jackson
May 13 – Jan 2014	Masters level module on research methodology

Paula Halsall ***Infection Control Nurse***

Jan 29th	HCAI forum PHE
13th Mar 2014	Infection Prevention, innovations in vascular access and EPIC 3 guidelines – Andrew Jackson

Karen Smith – Infection Control Nurse

Sep 13 – Jan 2014	Identification, Prevention and Management of Infections Degree Module
28th Nov 2013	Taps and Infections – PHE Biosafety Unit
13th Mar 2014	Infection Prevention, innovations in vascular access and EPIC 3 guidelines – Andrew Jackson

Conclusion

This has been a very challenging year for the Infection Control Team due to several incidents, diarrhoea and vomiting outbreaks and a period of reduced staffing. It is to their great credit that these issues have been managed alongside a proactive agenda to address the increase in cases of both MRSA and Clostridium difficile.

Assurance on the prevention and control of infections is provided by a matrix approach of updating policies in light of best practice/legislation; robust and regular auditing of policies and practice; spot checks and self-assessment.

The assurance framework, which is forwarded to Commissioners each month, demonstrated compliance with the Health and Social Care Act (2008) Code of practice. Alongside the monthly Board reports, these documents give the Trust Board assurance about infection control activities and outcomes.

The Board is asked to receive the Infection Control Annual Report and note the progress made.

Karen Dawber

Director of Infection Prevention and Control

June 2014

Appendix 1 - Infection control work plan 2014 - 2015

The Infection Control Work Programme has been devised to give assurance to the Infection Control Sub-Committee that each element of the Health and Social Care Act (2008) is discussed and the appropriate evidence of compliance is available. This will allow the Infection Control Sub-Committee to give assurance to the Trust Board that compliance with the Act is maintained and there is a programme of continued improvement.

It is essential that each subject, when discussed at the Infection Control Sub-Committee, is reviewed against the evidence required by the Care Quality Commission in its spot check visits as defined in the Code of Practice 2010. An action plan is in place to ensure continued compliance. Any changes in compliance need to be notified to the Infection Control Sub-Committee and addressed irrespective of the Work Programme reporting.

Additional items of work will be added to the Work Programme as required. Written reports will be submitted from the Matrons at each meeting as a regular agenda item.

This work programme is underpinned by objectives which have been set for individual members of the Infection Control Team.

The action plans in place (Health and Social Care Act, MRSA and Clostridium difficile) are under quarterly review and will identify priorities for action.

The robust programme of audit will provide evidence of policy/guideline implementation. Action plans will be produced to rectify any compliance issues identified.

Reports on progress in relation to the annual work programme will be included in the DIPC annual report.

Division/Department	LEAD	RECEIPT OF APPROVED MINUTES REQUIRED	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR
Update on compliance with Infection Control Action Plans														
Health and Social Care Act	ADIPC													
Clostridium difficile	ADIPC													
MRSA bacteraemia Reduction	ADIPC													
MSSA bacteraemia Reduction	ADIPC													
Infection Control Team submissions														
Antibiotic Prescribing Compliance Audit Report	AP													
HCAI surveillance data	ICNs													
HCAI investigation summary feedback	ICNs													
Isolation Facilities Audit	ICNs													
Laboratory Mandatory Enhanced Surveillance Data	CMM													
Policies/guidelines (as per review dates)	ICT													
Training statistics	ICNs													

Warrington and Halton Hospitals NHS Foundation Trust Infection Control Sub-Committee Work Plan 2013

Division/Department	LEAD	RECEIPT OF APPROVED MINUTES REQUIRED	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR
Annual planned ICNA audit report	ICNs													
DIPC Annual Report	ADIPC													
Infection Control Risk Register	ICT													
CQC Hospital Intelligent Monitoring Report (As and when updated)	ADIPC													
Trust wide sharps audit (external)	ICNs													
IV Team report	CNS IV Therapy													
Other Committee/meeting minutes														
Decontamination Group	ICT	✓												
Water Safety Group	ICT	✓												
Antimicrobial Management Steering Group	CMM	✓												
Clostridium difficile Action Group	CMM	✓												
Divisional Reports to be received and reviewed														
Unscheduled Care														

Division/Department	LEAD	RECEIPT OF APPROVED MINUTES REQUIRED	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR
Accident and Emergency	Matron													
Acute medicine (AMU)	Matron													
Cardio-respiratory medicine (A2, A7, C21, CCU, Catheter Lab)	Matron													
Specialist medicine (C22, B14, B18 & Endoscopy)	Matron													
Clostridium difficile (HII) audits B18	Matron													
Elderly care and stroke (A3, A8 & B12)	Matron													
Scheduled Care														
Warrington site Trauma and Orthopaedics (A9 and B19)	Matron													
Theatres (Warrington site)	Matron													
General Surgery (A4, A5, A6)	Matron													
ICU, Orthodontics, Ophthalmology	Matron													
CMTC T&O and Halton site	Matron													
WC&SS														
Women's Health	Matron													
Children's	Matron													

Division/Department	LEAD	RECEIPT OF APPROVED MINUTES REQUIRED	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR
GUM, Rheumatology, ANC, ANDU community midwives	Matron													
Therapies	Matron													
Other Departmental Reports														
Estates (Legionella management, theatre ventilation, capital projects)	Operational Estates Manager													
Facilities (Environmental hygiene, Laundry and waste management, Pest control)	Facilities Manager													
Occupational Health	OHM													
Community Infection Control Report (verbal)	Community ICNs													
Reports received Totals														

Legend

ADIPC	Associate Director of Infection Prevention and Control
AP	Antibiotic Pharmacist
CMM	Consultant Medical Microbiologist
ICN	Infection Control Nurse
ICT	Infection Control Team
OHM	Occupational Health Manager

Appendix 2 - Orthopaedic Surgical Site Infection Surveillance (SSI) Jan 2013- Jan 2014

In June 2003 the Chief Medical Officer announced that surveillance of SSI in orthopaedic surgery would become mandatory from April 2004 requiring each hospital performing Total Hip and Total Knee Replacement surgery to submit at least 3 months SSI data per year. The scheme was run by the Health Protection Agency at the time. Following the absorption of the HPA into Public Health England, the scheme is now managed by the Healthcare Associated Infection and Antimicrobial Resistance Department of PHE. From 2010 however the Orthopaedic Department at Warrington and Halton Hospitals have been undertaking continual surveillance as requested as part of the LIPS programme.

Over the last few years there has been a marked reduction on the length of stay in hospital following elective surgery. As a result many SSI's do not become apparent until after the patient has been discharged and as such, the rate of SSI based on inpatient data alone underestimated the true rate of infection.

Patients who develop superficial infections of the surgical site post-discharge are less likely to be detected by readmission surveillance. Therefore the detection of SSI's by trained staff in an outpatient or review clinic appears to be the best method of detection.

Data submission and reconciliation needs to be within 90 days of closure of the previous quarter and therefore it has become a continual collection and submission process.

There are 3 types of Surgical Site Infection Classification identified, these being:-Superficial infections, those involving the skin or subcutaneous tissue of the incision; deep infection involving the facial and muscle layer of the incision; and organ/space infections, involving any other areas other than the incision opened or manipulated during the procedure.

Infections acquired in hospital, including surgical site infection, can cause anxiety and discomfort, complicate illness and delay recovery. It has been estimated that the annual cost nationally is almost £1 billion. It has been estimated that each patient with a surgical site infection requires an additional hospital stay of 6.5 days and hospital costs are doubled (Plowman *et al* 2001).

The data submitted for both Hip and Knee replacement surgery is displayed in the tables overleaf.

No. of surgical site infections (SSI) for Knee Replacement surgery January 2013 to January 2014

Type of Surgery	No. of forms submitted 2012	No. of forms submitted 2013	No. of SSI's detected	Type of SSI Organisms identified
Primary Total Knee	280	463	0 detected after the 60 day monitoring period	**nil**
Bilateral total knee		1 (2 Joints)		
Revision Knee Surgery	19	26	3 indicated infection as primary indication for surgery.	Patient 1 7 tissue samples – 6 no growth One sample- Streptococcus viridans scanty growth query significance Patient 2 Joint fluid- No growth Bone tissue -Scanty Staphylococcus aureus Patient 3 Joint Fluid- No growth Tissue samples- no growth
Total	**299**	**491**		

Total knee replacement patient's who's primary indication for surgery was infection

Patient 1- 65 year old Male, Revision right knee 2013

The patient had an initial Revision Total knee at Warrington in Oct 2012. It is unclear where his primary surgery took place. The patient continued with infection problems despite having antibiotic therapy. In Aug 2013 he had a 1st stage revision and the 2nd stage was completed Dec 2013.

Samples sent for microscopy;-

4/08/13 - 7 tissue samples – 6 no growth, one sample Streptococcus viridans scanty growth and wound swab tibia right knee - No growth

Patient 2- 64 year old female, Revision total knee surgery 2013

The patient had a right knee arthroscopy and partial menisectomy 2010 at Warrington hospital. In April 2013 the patient had Bx's taken from her right TKR. It is unclear where this lady had her Primary surgery. In Aug 2013 1st stage Revision was performed and the patient

had a long line inserted to allow administration of antibiotics. In Nov 2013 the 2nd stage was completed.
Samples sent for microscopy;-
09/07/13 Joint fluid - No growth
23/08/13 Bone from right femur Scanty Staphylococcus aureus

Patient 3- 66 year old male, Revision surgery 12/12/13
This patient had bilateral knee arthroscopies in June 2011 at Warrington. In July 2005 the patient had Bilateral TKR at Warrington. October 2013 1st stage revision was performed by one Consultant and 2nd stage complex Revision was completed with two Consultants in Dec 2013.
Samples sent for microscopy;-
24/10/13 Joint fluid - no growth & 8 tissue samples – no growth

No. of surgical site infections (SSI's) for Hip Replacement surgery January 2013 to January 2014

Type of surgery	No. of forms submitted 2012	No. of forms submitted 2013	No. of SSI's detected	Type of SSI Organisms identified.
Primary Hip Surgery	202	332	0	**nil**
Bilateral		2 (4 joints)		
Revision Hip Surgery	30	17	2 indicated infection as primary indication for surgery.	Patient A Various samples- Staphylococcus aureus Patient B Fluid and tissue- No growth
Total	**232**	**353**	**0**	

Total hip replacement patient's who's primary indication for surgery was infection

Patient A- 77 year old male,bilateral revision hip replacements for infection, 2013. The patient had Primary Hip Replacements in June 2011 at Whiston Hospital and was admitted to Warrington Dec 2011 - with an abscess formation to the left Hip. The patient required revision surgery.
Samples sent for microscopy;-
11/01/2013- Pus swab right hip sinus- No organisms seen.
14/01/2013-

- Tissue granulation tissue from capsule left hip - Scanty *Staphylococcus aureus*
- Tissue granulation tissue from left femur - Scanty *Staphylococcus aureus*
- Tissue granulation tissue from left acetabulum - Moderate *Staphylococcus aureus*
- Tissue right femoral canal - No growth
- Swab of P right femoral deep fascia & Swab of P acetabulum - No growth

Patient B- 55 year old male, revision right hip 2013,
Primary surgery performed at Spire. The patient dislocated after surgery and had on-going problems with his hip, requiring revision surgery in 2013.
Samples sent for microscopy:-
28/01/13 - Fluid aspiration from right hip - proteus
07/02/13 -Tissue right hip **-** scanty proteus
26/06/13- Tissue synovium right hip & Joint fluid right hip- no growth

Conclusion

The surveillance information collected during January 2013 - January 2014 has indicated a zero notable infection rates for Primary THR and TKR within the first 60 days post-surgery.

The infections noted above are deep / space infections which have manifested themselves a number of months/years' post- primary surgery requiring revision surgery to be performed.

The information also indicates again this year that some of these patients have had their primary surgery at other hospitals, but have been referred to our Orthopaedic Consultants for management and revision surgery.

This data and information demonstrates the importance of joint replacement monitoring, which needs to be continual over the life–time of the patient at specified times as per BOA guidelines.

Cathy Johnson (Jones)
Matron, T&O,
Scheduled Care Division,
June 2014

W&HHFT/TB/14/121(ii)

BOARD OF DIRECTORS

Paper Title	Infection Prevention and Control Trust Board Report
Date of Meeting	30th July 2014
Director Responsible	Karen Dawber Director of Nursing and Organisational Development/Director of Infection Prevention and Control
Author	Lesley McKay Matron/Associate Director Infection Prevention and Control
Purpose	To inform and update the Board on issues relating to infection prevention and control in the Trust

Paper previously considered (state Board and/or Committee and dates)	**Committee**	**Date**

Relates to which Trust objectives	√ **Appropriate**
• Ensure all our patients are safe in our care	√
• To be the employer of choice for healthcare we deliver	√
• To give our patients the best possible experience	√
• To provide sustainable local healthcare services	

Key points arising from the Report/Paper (please include up to eight bullet points and reference page/paragraph as appropriate).

	Page/Paragraph Reference
• Clostridium difficile cases	**2**
• MRSA bacteraemia case	**3**
• Tb exposure incident	**3**
• Emerging threat of CPE	**4**

Recommendation(s) (include what you require the Board to do; approve/note/ratify etc.)

The Board is asked to receive the infection control report, note the progress made and consider the recommendations to drive further improvements.

Infection Prevention and Control Trust Board Report

Executive Summary

This report provides a summary of infection control activity in quarter 1, 2014 and highlights the Trust's progress for infection prevention and control against key performance indicators.

Clostridium difficile

The Trust reported 12 cases of *Clostridium difficile*, 7 of which are hospital apportioned against the financial year threshold of 26 cases (appendix 1). The Trust is currently 1 case above the planned trajectory.

Staffing within the Infection Control Team is now at establishment and a much more proactive approach to prevention of *Clostridium difficile* is being taken. This includes:-

- hand hygiene and antibiotic prescribing awareness raising events are being planned for later in the year
- Liaison with the Patient Flow Team has increased and access to isolation facilities optimised
- Training is scheduled to extend the use of hydrogen peroxide vapour for environmental decontamination of side rooms outside the cohort facility
- Ward based training was pledged and is being delivered as part of NHS change day
- Investigation (level 1) of hospital apportioned cases has been strengthened
- A business case to increase Pharmacy time, to support antibiotic ward rounds, (from approximately 15 hours/week to full time) is being compiled

In December last year the Infection Control Team was instrumental in setting up a multi-agency *Clostridium difficile* action group. This group is undertaking innovative work and has engaged both community providers and commissioners to unite the approach to tackling *Clostridium difficile*.

The Group has directed antibiotic prescribing audits within the community and areas to improve prescribing practices have been identified. This has the potential to benefit *Clostridium difficile* reduction and the current antimicrobial resistance strategy.

The Trust continues to perform 3 stage testing for *Clostridium difficile.* This allows identification of PCR positive/toxin negative cases. Of the 31 cases identified 18 were hospital apportioned. Individual case investigation was introduced however has ceased as, due to the number of cases was proving labour intensive. Clusters of cases will be investigated as per previous practice.

Bacteraemias

MRSA bacteraemia

The Trust reported 1 hospital apportioned MRSA bacteraemia case in May. The investigation did not identify a root cause for this infection. It did identify the patient received antibiotics appropriate to his treatment that are known to exert an MRSA selective potential, which may explain why the infection occurred.

MSSA bacteraemia

The Trust reported 9 cases of MSSA bacteraemia, 2 of which are hospital apportioned (appendix 1). Case 1 was associated with management of a peripheral cannula and case 2 was associated with management of a central venous catheter. Work is in place to improve care and management in the areas where these incidents occurred.

E. coli bacteraemias

The Trust has reported 40 cases of E. coli bacteraemia. The Medical Microbiologists review all cases of E. coli bacteraemia. The majority of the cases are unlikely to be associated with healthcare.

Outbreaks/Incidents

Viral Gastroenteritis

A total of 9 wards were under surveillance and part or fully closed due to symptoms of viral gastroenteritis. The OPAL Unit (Ward A3) experienced 2 prolonged outbreaks with causative organisms identified as Adenovirus and Norovirus. A review of the ward was undertaken and a number of recommendations have been made to reduce the likelihood of prolonged outbreaks in the future (appendix 2).

All the wards were re-opened as soon as it was safe to do so.

Tuberculosis exposure incident

The Infection Control Team undertook a look back exercise following confirmation of a case of tuberculosis. The patient's infectivity status was unknown at the time of admission and therefore precautions to prevent exposure risk were not in place.

An incident meeting was held with external partner agencies which included Public Health England, North West Ambulance Service (NWAS) and Warrington Tb Services. Investigation identified significant exposure (procedure related or greater than 8 hours within the same room) occurred to 2 members of NWAS staff, 2 patients and 16 members of Trust staff. One member of Trust staff was identified to be at increased susceptibility risk and was referred to the Workplace Health and Wellbeing Department for screening, which proved negative.

A patient and staff notification exercise is underway to inform the other contacts of the exposure and signs and symptoms of the disease. Contact details to signpost any enquiries have been included.

Emerging diseases

Carbapenemase-producing Enterobacteriaceae

Carbapenemase-producing Enterobacteriaceae (CPEs) have been highlighted as one of the most serious emerging infectious disease threats. The Infection Control Team has been working to adopt the isolation and screening guidance published by Public Health England in 2013.

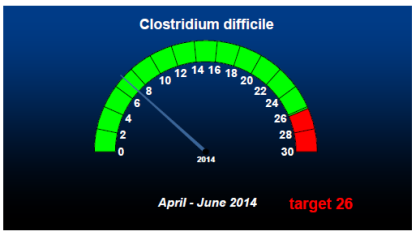
There is a nationally recognised problem in terms of limited access to side room facilities for isolating patients admitted via inter hospital transfer. To date screening has identified one case of CPE (returning traveller from India).

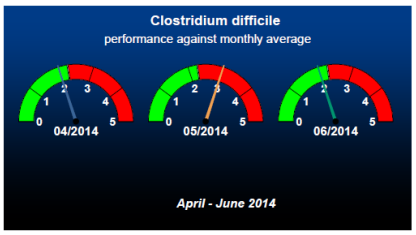
Screening performed thus far, of patients transferred from UK hospitals has been negative and therefore a risk based approach to isolating patients is being adapted. Screening will continue as per national guidance. This should assist contractual obligations for key services and ensure delays in patient repatriation do not occur.

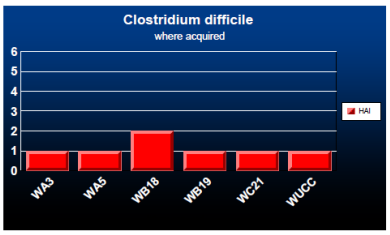
Lesley McKay
Associate DIPC
18th July 2014

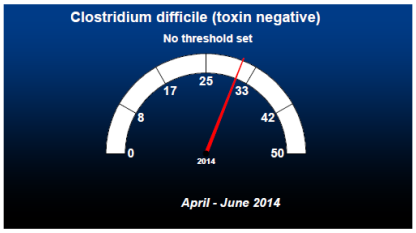
Appendix 1 HCAI Dashboard April - June 2014 Quarter 1

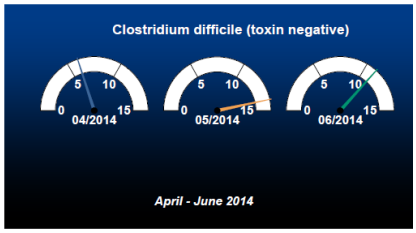
Clostridium difficile

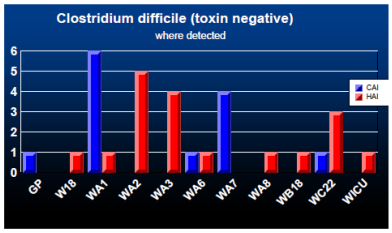












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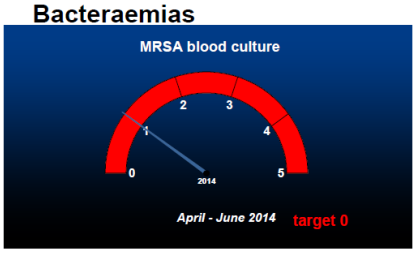
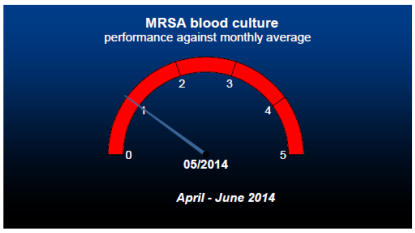
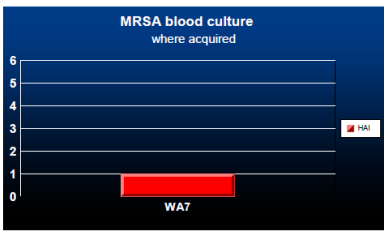
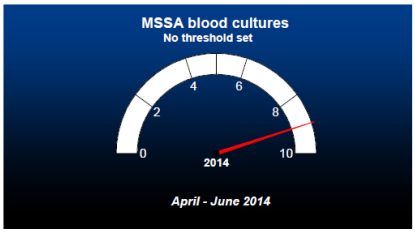
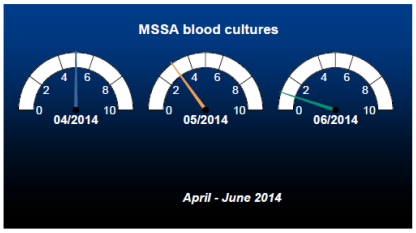
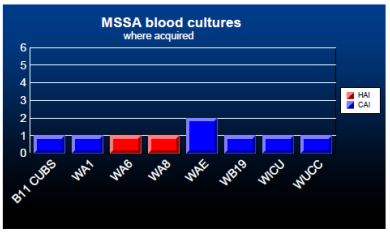


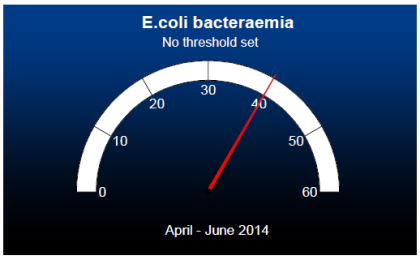


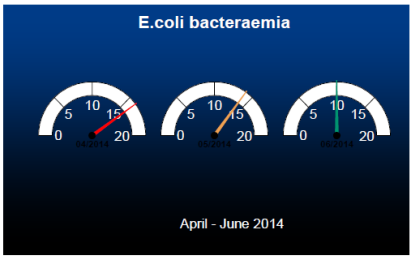


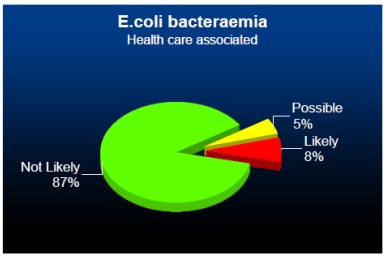












Quarter 1 - 2014

- 7 hospital apportioned toxin positive *Clostridium difficile cases* against the predicted trajectory of 6 cases
  - 2 cases on B18 not linked (different ribotypes)

- 1 hospital apportioned MRSA bacteraemia case - root cause not identified from the post infection review

- 2 hospital apportioned MSSA bacteraemia cases - post infection reviews in progress

- 40 cases of *E. coli* bacteraemia. 87% assessed as unlikely to be associated with healthcare

Appendix 2

SBAR report on prolonged outbreaks of diarrhoea and vomiting Ward A3

Situation

Ward A3 has been significantly affected by symptoms of viral gastroenteritis amongst patients, relatives and staff. This has affected the ward on 2 separate occasions with causative agents identified as:-

- 20/03/14 - 03/04/14 - Norovirus
- 20/04/14 - 05/05/14 - Norovirus and Adenovirus

The duration of ward closure on both occasions was longer than the usual turn-around time (5 – 10 days) for viral gastro-enteritis outbreaks.

Due to the rapid notification of the situation by ward staff and implementation of infection control precautions, the outbreak was isolated to Ward A3 and transmission to other wards/departments did not occur.

Background

Public health syndromic surveillance (laboratory reports/GP visits) during April reflect the situations we have seen in the hospital i.e. an increase in number of confirmed cases.

Hospital outbreaks of viral gastroenteritis can have a significant impact on patient care as both patients and staff can be affected. This can lead to ward and sometimes hospital closures.

Transmission of infection can occur by:-

- vomiting - aerosol dissemination of virus particles
- faecal - oral route
- environmental contamination (indirect contact transmission)
- via contaminated water and food (ingestion)

Interventions include:-

- notification of the suspected outbreak to infection control
- infection control review to advise precautions required
- communication of the situation to relevant personnel

- lock down of the area (exclusion of non-essential staff) and stopping patient transfers to other wards/ discharges to other care facilities in order to prevent further transmission

Assessment

The ward was under infection control surveillance for the duration of the outbreaks. Several issues were identified that potentially impacted on the prolonged duration of symptoms. These include:-

Ward Environment and cleanliness

- the ward was cluttered which will have impeded effective cleaning
- in early April environmental hygiene standards were reported to be poor:-
    - beds dusty
    - table tops dirty
    - floors gritty and dusty
- standards of terminal cleans were reported as not performed to an acceptable standard
- there is a lack of hand washing and slop hopper facilities in the sluice
- the store room has been converted into an office for therapy staff resulting in products being stored inappropriately in bathrooms (risk of product contamination)
- there have been several macerator breakdowns (possibly due to inappropriate items being placed in the sluice master due to there being no slop hopper)

Infection control practices

- Adherence to infection control precautions has been variable
    - personal protective equipment worn for non-specific tasks (not being changed appropriately)
    - large amounts of equipment was stored in bays (risk of contamination)
    - faecal soiling noted on equipment and sink
    - hazardous waste bags were not positioned within the bays during outbreak
    - trolleys for patient care and comfort rounds were overstocked
    - used incontinence pad left on a windowsill
    - communal items of equipment in the bathroom
    - frequently touched surfaces (call bells) were dirty
    - a member of staff may have worked whilst symptomatic

Communication

- information provided by ward staff on symptoms has been conflicting. This has impacted on the Infection Control Team's ability to accurately risk assess the area
- miscommunication between ward staff has resulted in new admission patients being placed in unclean bays
- relatives have continued to visit with symptoms and/or in the 48 hour period when symptoms have stopped but may still be infectious

Patient factors

- This ward has an elderly (over 75yrs) cohort of patients. Most of the patients require discharge to home with a package of care or residential/nursing care. This has had a greater impact on the turn-around time as no discharges were permitted (risk of affecting other agencies) whilst the outbreak was in progress
- The management of patients' bowel habit has been complex. Patients may have had diarrhoea due to viral gastroenteritis or constipation with overflow. If symptoms were due to constipation with overflow the patients would have continued to excrete virus in their stools and present an infection risk

The ward underwent deep cleaning including removal of radiator panels in one bay prior to re-opening.

Recommendations

- De-clutter the ward (Productive Ward approach)
- Reinstall hand washing and slop hopper facilities in the sluice
- Review the use of the storage room currently in use as an office for therapy staff
- Educate staff on appropriate waste disposal via macerator
- Ensure cleanliness monitoring is reviewed timely to address issues
- Reintroduce signoff sheet for use after terminal cleaning has been completed
- Single point lessons on outbreak management to be provided to all Ward A3 staff
- Review number and siting of personal protective equipment dispensers and ensure responsibility for cleaning is identified
- Improve standards of communication during outbreak management to ensure patients are not admitted into affected areas of the ward
    - ICNs to continue daily attendance at bed meetings
    - ICNs to speak to Patient Flow Managers at the week-ends (in addition to email updates) in relation to outbreak situations
    - Outbreak e-mail distribution list to be reviewed

- Matron to be contacted to discuss the outbreak with relatives who wish to visit against advice
- Introduce an action for the Ward Clerk to telephone all patients' next of kin and advise against visiting

The ward staff have been receptive to the advice and support provided and will work in partnership with the Matron and Infection Control Team to address the issues identified.

Viral gastroenteritis 04 2014.pptx

Lesley McKay
Associate DIPC
14th May 2014

W&HHFT/TB/14/122

BOARD OF DIRECTORS

Paper Title:	Complaints Quarterly Report 2014/15 Quarter 1: April – June 2014
Date of Meeting	30 July 2014
Director Responsible	Karen Dawber, Director of Nursing and Organisational Development
Author(s)	Michele Lord, Patient Experience Matron
Purpose	To provide the Board with an overview of complaints and feedback that the Trust has received from patients, relatives and other service users from 1 April to 30 June 2014. The report is written in accordance with the NHS Complaints Regulations (2009).

Paper previously considered (state Board and/or Committee and dates)	**Committee**	**Date**
	none	

Relates to which Trust objectives	✓ **appropriate**
• Ensure all our patients are safe in our care	✓
• To be the employer of choice for healthcare we deliver	✓
• To give our patients the best possible experience	✓
• To provide sustainable local healthcare services	✓

Key points arising from the Report/Paper (please include up to eight bullet points and reference page/paragraph as appropriate).

	Page/Paragraph Reference
○ This is the first quarterly report providing an overview of complaints received by the Board.	2
○ The Trust received a total of 117 formal complaints between 1 April and 30 June 2014, which is a decrease of 11 on the previous quarter.	4
○ Three complaints were requested for review by the PHSO in Quarter 1.	4
○ 455 people contacted PALS in Quarter 1. Of these, 7 became formal complaints.	4
○ 13 formal compliments letters were sent to the Chief Executive.	6
○ Graphs demonstrate a more accurate breakdown of the subjects of complaints for the Trust and by division.	8
○ 96.51% of complaints were closed within agreed timescales in Quarter 1.	10
○ Examples are provided of learning from complaints by the clinical divisions	14

Recommendation(s)

The Board is asked to:

- ○ Note progress in the management of complaints
- ○ Note improved information on subjects of complaints

Executive Summary

This is the first quarterly report providing an overview of complaints received by the Trust from 1 April to 30 June 2014. The report is written in accordance with the NHS Complaints Regulations (2009) and complements the patient experience annual report presented in May 2014.

In addition to numbers and categorisation of complaints received by the Trust, this report provides an opportunity to identify any themes or trends overall and within divisions. The addition of some new subjects and editing and addition of many new sub-subjects in the complaints module of the *Datix Management System* provides a better breakdown of causes for the Trust, divisions and teams to support improved learning.

Key points:

1. Background

In accordance with the *NHS Complaints Regulations* (2009), this report sets out a detailed analysis of the nature and number of formal complaints. A recent inspection by the CQC included the complaints system, at divisional and corporate level in the evidence examined. We await the formal report.

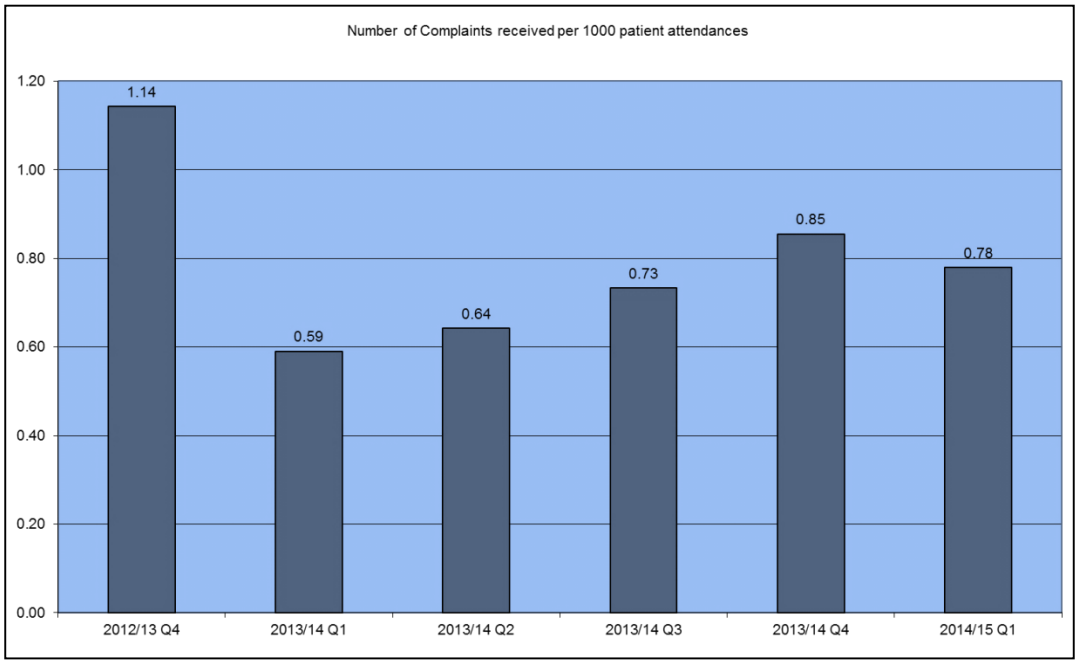
1.1 Complaints overview

During Quarter 1 there were 150,093 attendances to our services.

Table 1: Trust activity 1 April – 30 June 2014

Activity	Type									
2014	Day case	Inpatient	Non-elective	New	Follow up	A&E	MIU	Ward attender	Outside clinic attend-ance	**Grand Total**
April	2,566	442	3,248	9,997	23,706	7,054	1,489	1,077	67	49,646
May	2,631	470	3,410	9,889	23,180	7,637	1,537	1,255	88	50,097
June	2,588	495	3,308	10,145	23,563	7,445	1,632	1,098	76	50,350
Total	7,785	1,407	9,966	30,031	70,449	22,136	4,658	3,430	231	150,093

Figure 1: Complaints received per 1000 patient attendances for Quarter 1



The Trust received a total of 117 formal complaints between 1 April and 30 June 2014, which is a decrease of 11 on the previous quarter.

Table 2: Formal complaints received in Quarter 1

Quarter	Formal complaints received
Quarter 1, April – June 2014	117
Quarter 4, Jan – March 2014	128
Quarter 3, Oct – December 2013	106
Quarter 2, July- Sept 2014	101

Table 3: Risk rating of complaints, by quarter

	2013/14 Q2	2013/14 Q3	2013/14 Q4	2014/15 Q 1	Change from last Quarter
Complaints Received	**101**	**106**	**128**	**117**	⇩
Low	31	35	54	54	⇨
Moderate	51	56	60	43	⇩
High	19	15	14	19	⇧

All formal complaints were received in the English language with no requests made by a complainant (or enquirers) for the use of the Trust Interpreter Service. There were no formal complaints from patients who stated they had learning disabilities or from carers of patients with learning disabilities. There were three patients reporting a physical or sensory disability.

Parliamentary Health Service Ombudsman (PHSO)

During Quarter 1, there were 3 requests from the PHSO for complaint files and associated medical records. These are currently with the PHSO for deliberation. Eight complaints referred to the PHSO in the previous financial year have been closed during Quarter 1. Of these 2 were upheld and the Trust was required to formulate and implement action plans. 10 cases are ongoing from 2013/2014.

One case partly upheld by the PHSO was referred to Trust solicitors. The PHSO had recommended that, if the complainant sought a financial remedy, they would suggest remuneration of £15,000. It was felt that the PHSO decision was at odds with the findings of both clinicians who investigated the original complaint and the decision of the Coroner. The Trust is awaiting a response from the PHSO.

1.2 Patient Advice and Liaison Service (PALS)

455 people contacted PALS in Quarter 1. Of these, seven became formal complaints. The PALS service continues to be well utilised by patients and members of the public. Patient Experience Officers offer support to the PALS Officer, but the complaints workload makes it difficult to offer the extent of support that is needed and the response time for PALS is sometimes much longer than desirable for this service. We are continuing to develop ways in which can improve on the current situation and will provide update in the next report. An additional member of staff, currently not able to work clinically, is proving very useful.

Table 4: Examples of the type of issues that have been raised with PALS

Month	Number of contacts
April	137
May	181
June	137

Examples of PALS contacts from Quarter 1

Issue	Outcome
Patient had been given the shingles vaccine two weeks previously by GP. Had suffered swollen legs and became unwell. Family very concerned and wanted to know if the vaccine could have been the cause.	PALS made arrangements for the doctor to meet the family to discuss concerns. Family were satisfied with explanations and information given and case closed.
Patient admitted with fractured right neck of femur. Had surgery 7 May2014. The discharge summary had the wrong date of admission and discharge. Concerned about these errors.	PALS arranged for notes to go to ward for ward manager to ensure necessary amendments made to records and copies to be sent to GP and patient. Apologies passed on and case closed.
Patient had been treated for thyroid cancer and transferred to Royal Liverpool for surgery. Follow up treatment continued at WHH. Two ENT doctors had told patient her symptoms were not due to her operation. The consultant at Liverpool said the symptoms were related and patient was upset by inconsistencies.	Contacted Liverpool and they sent leaflets detailing possible symptoms following surgery. Arranged for patient to meet consultant to discuss concerns. Apologies were passed and the consultant committed to sharing concerns with team in ENT. Case closed.

1.3 NHS Choices

Patients and visitors can post comments about their experience in our hospitals on the *NHS Choices* website. *NHS Choices* calculate a star rating for each site, based on the feedback, with 5 stars being the highest. Comments posted on this site are monitored by the Communications team and responses are passed to the appropriate service for action if needed.

Table 5: Number of patient comments left on *NHS Choices* for Quarter 1, by site

Star rating	Warrington	Halton	CMTC
★★★★★	13	8	2
★★★★	2	0	0
★★★	0	0	0
★★	0	0	0
★	9	0	0
Total for Quarter 1 Apr/May/Jun = 34	24	8	2

Comments received to the *NHS Choices* website

What a difference a ward makes.

Following a terrible experience in A&E and CDU this changed once moved to A9 and my relative received excellent care. You could see the staff were very busy but they never used this as an excuse to be abrupt and appear uncaring as we'd experienced on the other wards. The staff of A9 truly cared about the patients.

On another note - I was really impressed with their attitude and understanding of Dementia and the little things they are doing to prepare for patients with signs of Dementia.

Excellent service from start to finish

I have just been discharged after a double hernia repair, from first seeing the consultant, to the surgeon the service and treatment I received was first class. Please pass on my sincere thanks to all concerned with my treatment, especially the very considerate nursing staff on ward a4 who went above and beyond what I expected.

Great experience

No one wants to go into hospital for surgery but Ward B4 at Halton was as good as I could have wished for. All the staff from cleaners to surgeons were approachable and communicated well and were very happy to help. They made you feel that they enjoyed their jobs and were happy to help. I would recommend the hospital to anyone.

Excellent care in the day case unit

I attended the day case unit (Halton) yesterday in the afternoon for an endometrial ablation. From the moment I arrived to when I left, the care and service was absolutely excellent. I can't praise highly enough the staff on

the ward from when I was met at reception to when I left in the early evening. They were all polite, helpful, knowledgeable and very caring. Thank you all very much indeed.

Excellent treatment and aftercare

I was admitted (CMTC) with Cauda Equina symptoms one day and had emergency discectomy and decompression surgery the following day. Now just over a year later I am almost fully recovered and able to enjoy life to the maximum once again.

Lumber Decompression

I was admitted into the facility (CMTC) on 15th March 2014 for a Lumber Decompression, my operation and aftercare were second to none, during my stay the staff were caring attentive and professional. I have never been very good with hospitals, I get very nauseas and uncomfortable but must congratulate the staff for allaying most of my fears.

Before I retired, my company provided me with BUPA and I have had occasion to be admitted to the Spires Hospital at Stretton Warrington, I can assure you that your facility far outstrips them on patient care and efficiency. Fantastic, keep up the good work. As I said, I`m not good with hospitals, but I would not hesitate to have medical treatment at your hospital, Thank you to all the staff concerned.

1.4 Compliments

The Trust received 13 formal compliments through letters sent directly to the Chief Executive. The new Trust website provides a new email address, Patient.ExperienceTeam@whh.nhs.uk for people wishing to make a complaint, comment or compliment. This has a less negative impression than the "complaints" inbox and people visiting the website are beginning to use this. Leaflets and posters are being updated to include new information for contacting the Patient Experience Team.

Table 6: Compliments by division, April – June 2014

Division	Letters
Scheduled	5
Unscheduled	8
WCSS	0
Total	13

Excerpts from compliment letters

I would like to take this opportunity to thank ALL the staff on the Urgent Care Centre who looked after my mum during her stay on the unit. The care she received was excellent as was the dedication, commitment and hard work of everyone concerned. Mum is now settling into the home, but I am sure she would rather have stayed with you, which says everything. I hope the powers that be can support you in keeping the unit open as it definitely plays an important part in the discharge of patients. Good luck to you all for the future.

I would like to pass on my sincere thanks to you and your outstanding nursing team for the excellent care that you gave to my wife during her recent stay on your ward… Your ward is a great example for best

*practise nursing and care, and you should be very, very proud of your team and the trust executive should be very proud of you. Once again a huge thanks from me and our 8 year old daughter. (*Ward A7)

There are many superlative words that can be used to describe the level of service, together with patient care your staff on ward A9 offered to my father, here are five examples which immediately come to my mind: caring, committed, dedicated, positive attitude, professional.

I attended the CMTC and I was extremely impresses with the standard of care that I experienced. I found the professionalism and friendly understanding of the staff who dealt with me most reassuring.

I am writing this letter in praise of all the staff on ward A2/B12. My wife was an inpatient on these wards and her care under Matron and her staff was of the highest standard. Their dedication and care was a credit to the hospital.

2. Formal Complaints

2.1. Data collection and analysis

As described in the recent annual complaints report, the Datix complaints module has been reviewed and we are able to better categorise complaints issues by subject. This will provide wards, departments and divisions with better information about trends and the ability to generate reports on specific areas of concerns, to initiate or support remedial or development work.

2.2 *Formal complaints by division and by subject for Quarter 1*

Figure 2: Graph showing all complaints by subject

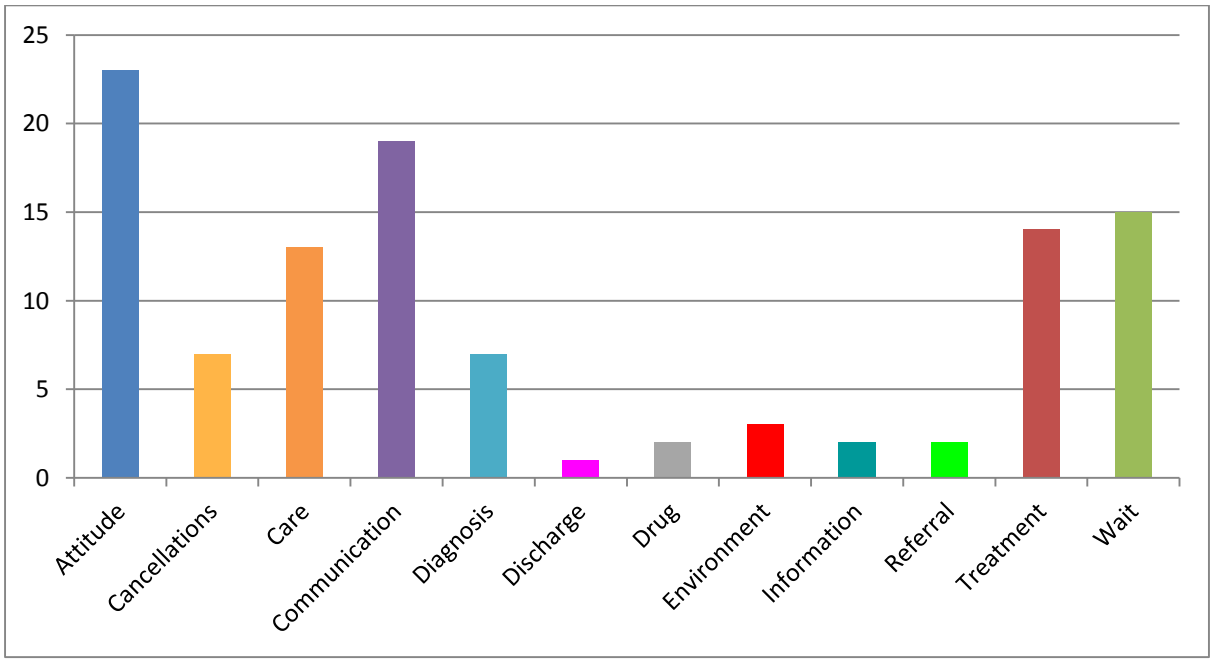


Figure 3: Graph showing top 5 subjects for Unscheduled Care, Quarter 1

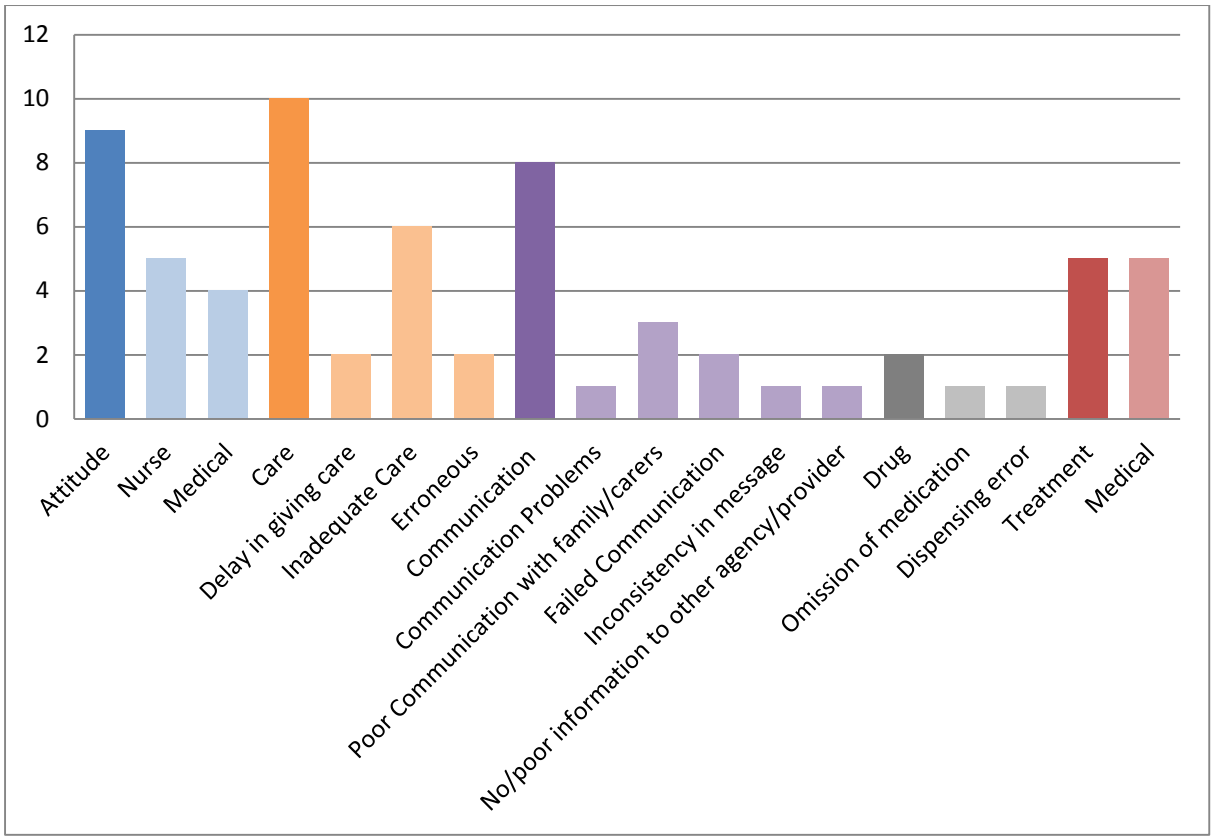


Figure 4: Graph showing top 5 subjects for Scheduled Care, Quarter 1

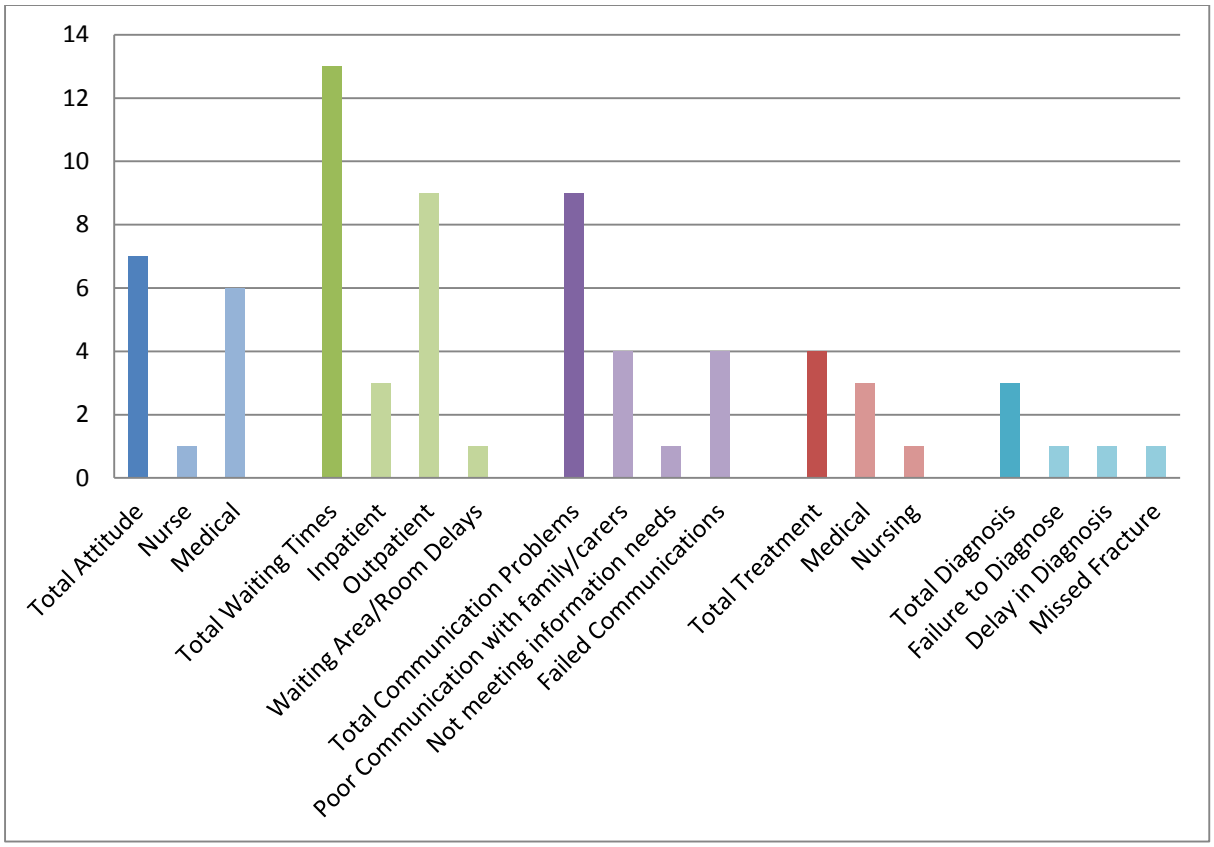
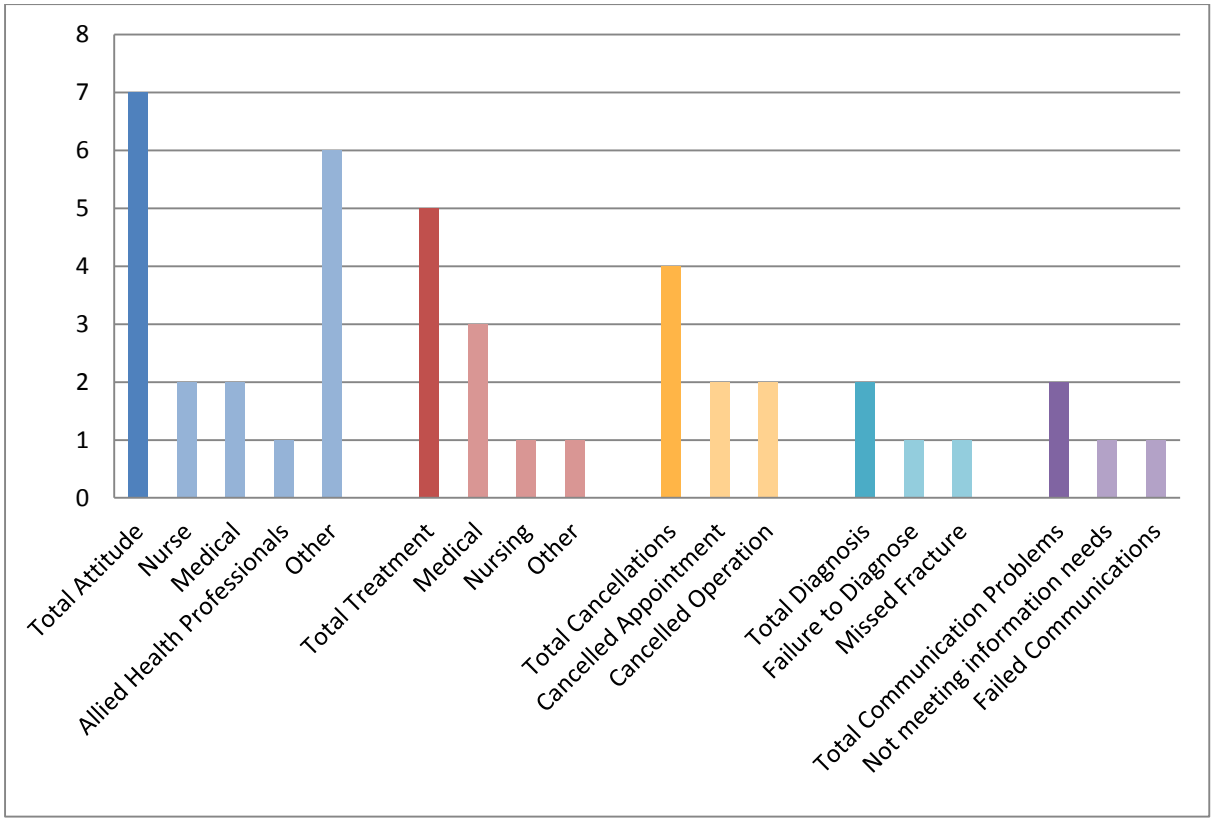


Figure 5: Graph showing top 5 subjects for WCSS, Quarter 1



2.3 Concerns raised in Quarter 1

Some patients prefer to raise a concern rather than a formal complaint. Due to the way the Patient Experience Team now works, Patient Experience Officers provide cover for the PALS Officer. This has seen some "blurring" of PALS and concerns and lower numbers of concerns are reported. The team is establishing specific working definitions to ensure that concerns, complaints and PALS contacts are appropriately categorised and answered. Please note that since April 2014, any withdrawn complaints will be re-categorised as concerns.

A total of 9 issues have been logged as concerns for Quarter 1. Four of these were withdrawn complaints.

Figure 3: Concerns by division for Quarter 1

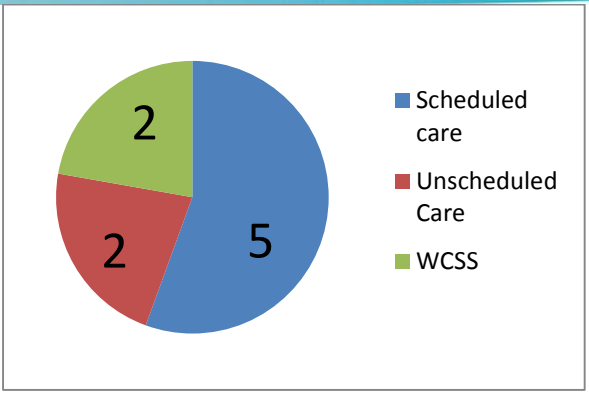


Table 7: Examples of the themes from concerns in Quarter 1:

Themes	Number received
Waiting times	5
Diagnosis	1
Treatment	1
Care	1
Other	1
Total	9

2.4 *Responding to people who want to tell us about their experience in a timely manner*

In Quarter 1 we responded to 96.51% of our complaints within agreed timescales. Provision of high quality, well investigated and thorough responses is equally important to both patients and the Trust. This has been a year long process of improvement and is an ongoing challenge for divisional and corporate teams.

Table 8: Complaints closed in agreed timescales for Quarter 1

	April	May	June
Number of complaints closed in month, resolved within the required timescale	34	20	29
Number of complaints closed in month, not resolved within the required timescale	2	1	0
Number of complaints closed in the month	36	21	29
% complaints closed in month, resolved within required timescale	94.44%	95.24%	100.00%

2.5 Complaints withdrawn

During the period from April – June 2014 a total of four complaints were withdrawn. Complaints can be withdrawn for a variety of reasons, but generally it is because the service user had the opportunity to discuss their issues with a member of the service or a member of staff from the divisional team had contacted them to discuss their concerns and they had been resolved, for example this could be an appointment confirmed, or clarity of information provided satisfactorily. Sometimes complainants do not return completed consent forms and the complaint may be withdrawn, after providing the complainant with a final date for sending the consent. As already explained since 1 April 2014 we

have logged withdrawn complaints as a 'concern' in order that we capture any themes and learning from the complaint whether or not it results in a formal letter response.

2.6 Returned complaints

During Quarter 1, 11 people were unhappy with their initial complaint responses and wrote to/contacted us asking for further information, to meet with us, or to provide clarification. These previously closed complaints, where the complainant has raised further questions with us we refer to as a 'return complaint'.

At the time of reporting, there are 15 outstanding return complaints from 2013/2014 and meetings are being held and further responses prepared.

Table 9 - Returned Complaints by division for Quarter 1 and whether upheld

Division	Not upheld	Partially upheld	Upheld
Unscheduled Care	2	1	1
Scheduled Care	2	4	0
WCSS	0	1	0
Corporate	0	0	0
Total	4	6	1

2.7 Complaints linked to serious untoward incidents

During Quarter 1, no complaints had been the subject of a serious untoward incident investigation. A total of 14 complaints were linked to reported incidents that included falls and other patient safety incidents already reported and acted upon.

2.8 Formal meetings organised

In the new complaints policy it has been agreed that there is benefit in having appropriate staff meeting with complainants early if it is possible. This helps complainants to clarify concerns, to develop a relationship with and "humanise" the people involved in the services they have concerns about.

During the period a total of 26 meetings were held with complainants. Of these only 6 were return meetings, i.e. the complainant has received a final response letter but is unhappy with it and asks for a meeting to discuss ongoing issues.

3. Lessons learned

The following table provides examples of closed complaints and actions taken by the divisions who are responsible for implementing and monitoring lessons learned. Each division has specific systems in place to feedback learning from complaints, firstly during/after the investigations and then through divisional groups, e.g. Divisional Integrated Governance Groups (DIGG, senior nurse/ward manager meetings.

Examples of complaints, action taken and learning

Description of Complaint	Actions	Learning
WCSS: **Breast Screening** Patient raised concerns in relation to the attitude of the member of staff and the fact that staff said she was late for her appointment, having arrived at 16:36 hours due to being stuck in traffic.	Apologies provided for poor experience. Member of staff interviewed regarding incident and attitude. This to be monitored by senior radiographer. All staff informed not to shut down at 16:30, but wait 15 minutes for any late arrivals.	Individual learning for member of staff regarding attitude and professional manner. All team to provide some additional time at the end of the session in case of patients being unavoidably delayed.
CT Scan Patient not happy with the waiting times in the CT scan department. Also unhappy with the seating and space in the department.	Apologies for delays in CT on the date the patient attended. Caused by acute requests, superseding routine appointments. Apologies regarding facilities. Informed of new project to improve the radiology department. Review of appointment systems.	Feedback to team on patient concerns. This is an ongoing issue that staff are very aware of, but patient feedback can be useful when considering changes to the department/ways of working.
Scheduled Care: **Trauma & Orthopaedics** Patient was not satisfied with process of getting a bed so that he could have emergency orthopaedic surgery and feels that the admission criteria, process and number of beds are poor. Patient also felt that communication very poor throughout. He was very happy with care once he was admitted – described as "commendable".	Timeline of patient experience was mapped. Showed he waited 6 days and communication could be improved. Matron spoke to patient during his recovery period apologised for the delays and asked him if he would be willing to tell his story. Patient provided story and was thanked for his feedback, including the positive comments about his care. The story has been heard at the *Senior Nurse Divisional Away Day* and at Board. Solutions are being discussed.	Individual experience of delays and poor communication has been shared with clinical nursing staff. Divisionally there has been discussion about these issues and better patient flow.
Ophthalmology		

Patient asked for an explanation as to why the hospital had failed to book him a field test examination. He was not happy to have attended to find that his test hadn't been booked and he wanted remuneration for parking costs. He was also unhappy that this had happened in the past, he had complained then and been assured that action would be taken to prevent this happening again.	Investigation showed human error. The test required had not been recorded on the clinic outcome slip. When the patient attended the clinic was fully booked so he had to be given another appointment. Apologies were given and patient informed that changes had been implemented after the last complaint. It was explained that this was a human error/omission and feedback had been given. Free parking for the return appointment was provided.	The Ophthalmic team have now discussed and agreed how to avoid this recent error occurring again including as much as possible human factors. The team are now in the process of changing the clinical pathway to include in this the need for booking a field test for all routine glaucoma follow up patients. The team have now discussed and agreed how to avoid this recent error occurring again including, as much as possible, human factors. The team are now in the process of changing the clinical pathway to include in this the need for booking a field test for all routine glaucoma follow up patients.
Unscheduled Care: **Accident & Emergency** Daughter of elderly male patient complained about the attitude and care of two members of nursing staff in AED; agency staff nurse and carer. Also very unhappy with wait in AED and pain control. Father on trolley the whole time in distress, very sick. Also poor communication about blood transfusion.	Apologies made for long wait and for not getting a proper hospital bed so patient could rest more comfortably. Nursing agency informed of complaint against staff nurse and asked for a statement. Decision made not to use this nurse in future. An action plan to support the carer in learning from this incident and to improve her future performance in delivering patient care. Carer has worked alongside the AED Practice Based Educator to improve her communication skills. She is also currently working through the Trust *Care and Compassion* booklet, which is a workbook that ensures the individual reflects on their performance and is supervised by a senior member of staff.	Whole team learning through feedback asking staff to consider: • Comfort of patients, i.e. provision of a bed where a frail and elderly patient has to wait for a bed on a ward. • Wearing of ID bands • Professional and respectful communications with patients and families. • Regular updates to patients who are waiting and clarity/ consistency of message. Individual learning for carer and development objectives/monitoring.
Urgent Care/escalation		

Patient's son was very unhappy that his mother was transferred from UCC to a nursing home when he had clearly told staff that should a nursing home become available he would want to be there to settle her in. There were issues about the nursing home choice that the complainant raised separately with social services.	Miscommunication regarding son's availability. Also miscommunications about nursing home selection. Early meeting by Associate Director of Nursing to discuss concerns and apologise for poor communication. Assured patient's son that discharge procedures had been safe. Action plan: • Safety briefing re. communication with family 2 days prior to discharge. • Documentation of all communication with family re. discharge. • 3 x weekly audits of documentation for completeness and accuracy. • MDT records in discharge planning folder to be completed. This is a return and a large meeting with representatives of all services is being held 17 July 2014.	Team learning and monitoring of effective discharge planning and need for updates/communication with family.

4. Actions

Having set up a new team and new systems, we are now focusing on not only ensuring that the new systems are becoming embedded in the culture, but that all staff involved in complaints are able to contribute in an effective and timely way. Divisional teams need to establish the governance around complaints handling to ensure that where there are lessons to learn this is done and all evidence is correctly recorded, shared and archived.

Following on from the annual complaints report in May 2014, the following identifies any progress on actions/improvements identified:

- Developing this skills and knowledge of the new Patient Experience Team
  Patient Experience team PDRs will be completed by 31 July 2014. Each patient experience officer is taking the lead for one aspect of operations (safeguarding/equality & diversity, information governance and information management) and will attend appropriate training and meetings to support their learning. More one to one training by Patient Experience Matron will also be introduced around the standard of complaint responses/letter writing.

- Developing a responsive, combined service – making it easy.
- Work will continue on improving systems. A meeting is planned with the Senior Learning & Development Officer to formulate regular complaints training for all staff. More tailored

support for staff is available on request. Training sessions to all grades of staff will be delivered in a practical way with interactive sessions drawing on anonymised and completed patient complaints.

- Monitoring and performance management in place.
  Policy audit is next due in October 2014.

- Focus on return complaints to understand underlying root causes and better identification of outcome.
  A thirty day deadline for returns has been identified. This should be manageable, given a previous investigation has taken place and in some cases, there will nothing to add to the first response and a prompt reply should be easily achieved.

- Improved complaints monitoring through updating complaint category information collected – making data meaningful.
  All new Datix categories have been added to the complaints module. As time goes on there may be more additions. In addition, the PALS module of Datix will be reviewed to provide more information.

- Updating the complaints information for patients and visitors, electronic as well as paper based.
  Updated posters and leaflets are being developed and will be completed and ready for printing in August 2014.

- Completion and assurance for action plans developed as a result of complaints.
  The CIRIS system provides a repository for governance, risk and compliance information and it was agreed that the action plans for complaints would be recorded on the system to facilitate reporting and monitoring of action plans generated by upheld and partially upheld complaints. The divisions have each identified clear processes for ensuring that all action plans developed as a part of the investigation and response to a complaint are recorded on CIRIS and these will be reported locally within divisions, at the appropriate sub-committees and at Board. The six monthly policy audit in October 2014 will monitor how effective these systems are.

5. Recommendations

The Board is asked to note the contents of this report, which describe the progress in the monitoring of complaints and to approve the actions as documented above.

Warrington and Halton Hospitals NHS
NHS Foundation Trust

W&HHFT/TB/14/124

BOARD OF DIRECTORS

Paper Title	July 2014 publication of the CQC Intelligent Monitoring for WHHFT
Date of Meeting	July 2014
Director Responsible	Karen Dawber, Executive Director of Governance and Workforce
Author(s)	Millie Bradshaw, Associate Director of Governance
Purpose	To inform the Board to the results Intelligent Monitoring published 24th July 2014

Paper previously considered (state Board and/or Committee and dates)	**Committee**	**Date**
	Going to Clinical Governance, Audit and Quality meeting	July 2014

Relates to which Trust objectives	√ **appropriate**
• Ensure all our patients are safe in our care	√
• To be the employer of choice for healthcare we deliver	√
• To give our patients the best possible experience	√
• To provide sustainable local healthcare services	√

Key points arising from the Report/Paper:

Summary Findings within the February QRP Profile	Page/Paragraph Reference
Please see attached Briefing paper for review and comment	

Recommendation(s) (include what you require the Board to do; approve/note/ratify etc.)

The Board is asked to note the CQC Intelligent Monitoring for the Trust

Intelligent Monitoring Report

Report on

Warrington and Halton Hospitals NHS Foundation Trust

July 2014

CQC has developed a new model for monitoring a range of key indicators about NHS acute and specialist hospitals. These indicators relate to the five key questions we will ask of all services – are they safe, effective, caring, responsive and well-led? The indicators will be used to raise questions about the quality of care. They will not be used on their own to make judgements. Our judgements will always be based on the result of an inspection, which will take into account our Intelligent Monitoring analysis alongside local information from the public, the trust and other organisations.

What does this report contain?

This report presents CQC's analysis of the key indicators (which we call 'tier one indicators') for Warrington and Halton Hospitals NHS Foundation Trust. We have analysed each indicator to identify two possible levels of risk.

We have used a number of tests to determine where the thresholds of "risk" and "elevated risk" sit for each indicator, based on our judgement of which statistical tests are most appropriate. These tests include CUSUM and z-scoring techniques. Where an indicator has 'no evidence of risk' this refers to where our statistical analysis has not deemed there to be a "risk" or "elevated risk". For some data sources these thresholds are determined by a rules-based approach - for example concerns raised by staff to CQC (and validated by CQC) are always flagged in the model.

NHS Trusts that have had an inspection at the time of producing this update of Intelligent Monitoring have not been assigned a banding; all other indicator analysis results are shown in their report. "Recently inspected" is stated for these trusts. This is to reflect the fact that CQC's new comprehensive inspections will provide its definitive judgements for each organisation.

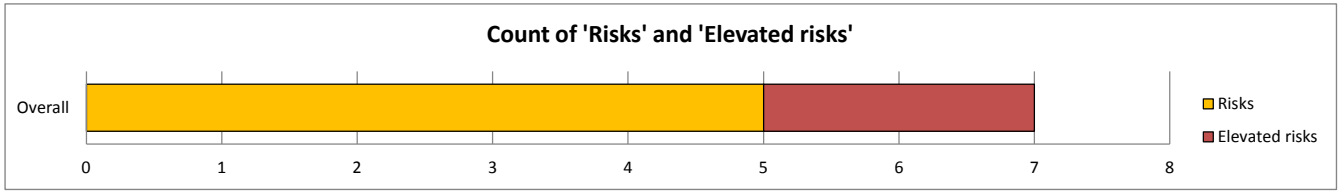
Further details of the analysis applied are explained in the accompanying guidance document.

What guidance is available?

We have published a document setting out the definition and full methodology for each indicator. If you have any queries or need more information, please email enquiries@cqc.org.uk or use the contact details at www.cqc.org.uk/contact-us

Warrington and Halton Hospitals NHS Foundation Trust

Trust Summary



Priority banding for inspection	3
Number of 'Risks'	5
Number of 'Elevated risks'	2
Overall Risk Score	9
Number of Applicable Indicators	96
Percentage Score	4.69%
Maximum Possible Risk Score	192

Elevated risk	SSNAP Domain 2: overall team-centred rating score for key stroke unit indicator (01-Oct-13 to 31-Dec-13)
Elevated risk	Whistleblowing alerts (22-Mar-13 to 02-Jun-14)
Risk	Never Event incidence (01-May-13 to 30-Apr-14)
Risk	Composite indicator: In-hospital mortality - Haematological conditions
Risk	Maternity Survey C1 "At the very start of your labour, did you feel that you were given appropriate advice and support when you contacted a midwife or the hospital?" (Score out of 10) (01-Feb-13 to 28-Feb-13)
Risk	Monitor - Continuity of service rating (27-May-14 to 27-May-14)
Risk	NHS Staff Survey - KF10. The proportion of staff receiving health and safety training in last 12 months (01-Sep-13 to 31-Dec-13)

Tier One Indicators

Section	ID	Indicators	Observed	Expected	Risk?
Never Events	STEISNE	Never Event incidence (01-May-13 to 30-Apr-14)	2	-	Risk
Avoidable infections	CDIFF	Incidence of Clostridium difficile (C.difficile) (01-Apr-13 to 31-Mar-14)	31	28.05	No evidence of risk
	MRSA	Incidence of Meticillin-resistant Staphylococcus aureus (MRSA) (01-Apr-13 to 31-Mar-14)	4	2.26	No evidence of risk
Deaths in low risk diagnosis groups	MORTLOWR	Dr Foster Intelligence: Mortality rates for conditions normally associated with a very low rate of mortality (01-Oct-12 to 30-Sep-13)	Within expected range	-	No evidence of risk
Patient safety incidents	NRLSL03	Proportion of reported patient safety incidents that are harmful (01-Feb-13 to 31-Jan-14)	0.39	0.29	No evidence of risk
	NRLSL04	Potential under-reporting of patient safety incidents resulting in death or severe harm (01-Feb-13 to 31-Jan-14)	20	33.74	No evidence of risk
	NRLSL05	Potential under-reporting of patient safety incidents (01-Feb-13 to 31-Jan-14)	7554	5666.25	No evidence of risk
Central Alerting System	COM_CASIM	Composite of Central Alerting System (CAS) safety alerts indicators (01-Apr-04 to 30-Apr-14)	-	-	No evidence of risk
	CASIM01A01	*The number of alerts which CAS stipulated should have been closed by trusts during the preceding 12 months, but which were still open on the date CQC extracted data from the CAS system (01-May-13 to 30-Apr-14)*	*0 alerts still open*	-	*No evidence of risk*
	CASIM01B01	*The number of alerts which CAS stipulated should have been closed by trusts more than 12 months before, but which were still open on the date CQC extracted data from the CAS system (01-Apr-04 to 30-Apr-13)*	*0 alerts still open*	-	*No evidence of risk*
	CASIM01C01	*Percentage of CAS alerts with closing dates during the preceding 12 months which the trust has closed late (01-May-13 to 30-Apr-14)*	*< 25% of alerts closed late*	-	*No evidence of risk*
Venous Thromboembolism	VTERA03	Proportion of patients risk assessed for Venous Thromboembolism (VTE) (01-Oct-13 to 31-Dec-13)	0.96	0.95	No evidence of risk
Mortality: Trust Level	SHMI01	Summary Hospital-level Mortality Indicator (01-Oct-12 to 30-Sep-13)	Trust's mortality rate is 'As Expected'	-	No evidence of risk
	COM_HSMR	Dr Foster Intelligence: Composite of Hospital Standardised Mortality Ratio indicators (01-Oct-12 to 30-Sep-13)	-	-	No evidence of risk
	HSMR	*Dr Foster Intelligence: Hospital Standardised Mortality Ratio (01-Oct-12 to 30-Sep-13)*	*Within expected range*	-	*No evidence of risk*
	HSMRWKDAY	*Dr Foster Intelligence: Hospital Standardised Mortality Ratio (Weekday) (01-Oct-12 to 30-Sep-13)*	*Within expected range*	-	*No evidence of risk*
	HSMRWKEND	*Dr Foster Intelligence: Hospital Standardised Mortality Ratio (Weekend) (01-Oct-12 to 30-Sep-13)*	*Within expected range*	-	*No evidence of risk*

Indicators displaying * represent a suppressed value between 1 and 5

Section	ID	Indicators	Observed	Expected	Risk?
	COM_CARDI	Composite indicator: In-hospital mortality - Cardiological conditions and procedures	-	-	No evidence of risk
	HESMORT24CU	*In-hospital mortality: Cardiological conditions (01-Dec-12 to 30-Nov-13)*	-	-	*No evidence of risk*
	MORTAMI	*Mortality outlier alert: Acute myocardial infarction (01-Apr-12 to 14-Jul-14)*	-	-	*No evidence of risk*
	MORTARRES	*Mortality outlier alert: Cardiac arrest and ventricular fibrillation (01-Apr-12 to 14-Jul-14)*	-	-	*No evidence of risk*
	MORTCABGI	*Mortality outlier alert: CABG (isolated first time) (01-Apr-12 to 14-Jul-14)*	*Not included*	*Not included*	*Not included*
	MORTCABGO	*Mortality outlier alert: CABG (other) (01-Apr-12 to 14-Jul-14)*	*Not included*	*Not included*	*Not included*
	MORTCASUR	*Mortality outlier alert: Adult cardiac surgery (01-Apr-12 to 14-Jul-14)*	*Not included*	*Not included*	*Not included*
	MORTCATH	*Mortality outlier alert: Coronary atherosclerosis and other heart disease (01-Apr-12 to 14-Jul-*	-	-	*No evidence of risk*
	MORTCHF	*Mortality outlier alert: Congestive heart failure; nonhypertensive (01-Apr-12 to 14-Jul-14)*	-	-	*No evidence of risk*
	MORTDYSRH	*Mortality outlier alert: Cardiac dysrhythmias (01-Apr-12 to 14-Jul-14)*	-	-	*No evidence of risk*
	MORTHVD	*Mortality outlier alert: Heart valve disorders (01-Apr-12 to 14-Jul-14)*	-	-	*No evidence of risk*
	MORTPHD	*Mortality outlier alert: Pulmonary heart disease (01-Apr-12 to 14-Jul-14)*	-	-	*No evidence of risk*
	COM_CEREB	Composite indicator: In-hospital mortality - Cerebrovascular conditions	-	-	No evidence of risk
	HESMORT21CU	*In-hospital mortality: Cerebrovascular conditions (01-Dec-12 to 30-Nov-13)*	-	-	*No evidence of risk*
	MORTACD	*Mortality outlier alert: Acute cerebrovascular disease (01-Apr-12 to 14-Jul-14)*	-	-	*No evidence of risk*
	COM_DERMA	Composite indicator: In-hospital mortality - Dermatological conditions	-	-	No evidence of risk
	HESMORT35CU	*In-hospital mortality: Dermatological conditions (01-Dec-12 to 30-Nov-13)*	-	-	*No evidence of risk*
	MORTSKINF	*Mortality outlier alert: Skin and subcutaneous tissue infections (01-Apr-12 to 14-Jul-14)*	-	-	*No evidence of risk*
	MORTSKULC	*Mortality outlier alert: Chronic ulcer of skin (01-Apr-12 to 14-Jul-14)*	-	-	*No evidence of risk*
	COM_ENDOC	Composite indicator: In-hospital mortality - Endocrinological conditions	-	-	No evidence of risk
	HESMORT29CU	*In-hospital mortality: Endocrinological conditions (01-Dec-12 to 30-Nov-13)*	-	-	*No evidence of risk*
	MORTDIABWC	*Mortality outlier alert: Diabetes mellitus with complications (01-Apr-12 to 14-Jul-14)*	-	-	*No evidence of risk*
	MORTDIABWOC	*Mortality outlier alert: Diabetes mellitus without complications (01-Apr-12 to 14-Jul-14)*	-	-	*No evidence of risk*
	MORTFLUID	*Mortality outlier alert: Fluid and electrolyte disorders (01-Apr-12 to 14-Jul-14)*	-	-	*No evidence of risk*
	COM_GASTR	Composite indicator: In-hospital mortality - Gastroenterological and hepatological conditions and procedures	-	-	No evidence of risk
	HESMORT27CU	*In-hospital mortality: Gastroenterological and hepatological conditions (01-Dec-12 to 30-Nov-*	-	-	*No evidence of risk*
	MORTALCLIV	*Mortality outlier alert: Liver disease, alcohol-related (01-Apr-12 to 14-Jul-14)*	-	-	*No evidence of risk*
	MORTBILIA	*Mortality outlier alert: Biliary tract disease (01-Apr-12 to 14-Jul-14)*	-	-	*No evidence of risk*
	MORTGASHAE	*Mortality outlier alert: Gastrointestinal haemorrhage (01-Apr-12 to 14-Jul-14)*	-	-	*No evidence of risk*
	MORTGASN	*Mortality outlier alert: Noninfectious gastroenteritis (01-Apr-12 to 14-Jul-14)*	-	-	*No evidence of risk*
	MORTINTOBS	*Mortality outlier alert: Intestinal obstruction without hernia (01-Apr-12 to 14-Jul-14)*	-	-	*No evidence of risk*
	MORTOGAS	*Mortality outlier alert: Other gastrointestinal disorders (01-Apr-12 to 14-Jul-14)*	-	-	*No evidence of risk*
	MORTOLIV	*Mortality outlier alert: Other liver diseases (01-Apr-12 to 14-Jul-14)*	-	-	*No evidence of risk*
	MORTOPJEJ	*Mortality outlier alert: Operations on jejunum (01-Apr-12 to 14-Jul-14)*	-	-	*No evidence of risk*
	MORTPERI	*Mortality outlier alert: Peritonitis and intestinal abscess (01-Apr-12 to 14-Jul-14)*	-	-	*No evidence of risk*
	MORTTEPBI	*Mortality outlier alert: Therapeutic endoscopic procedures on biliary tract (01-Apr-12 to 14-Jul-14)*	-	-	*No evidence of risk*
	MORTTEPLGI	*Mortality outlier alert: Therapeutic endoscopic procedures on lower GI tract (01-Apr-12 to 14-Jul-14)*	-	-	*No evidence of risk*
	MORTTEPUGI	*Mortality outlier alert: Therapeutic endoscopic procedures on upper GI tract (01-Apr-12 to 14-Jul-14)*	-	-	*No evidence of risk*
	MORTTOJI	*Mortality outlier alert: Therapeutic operations on jejunum and ileum (01-Apr-12 to 14-Jul-14)*	-	-	*No evidence of risk*

Section	ID	Indicators	Observed	Expected	Risk?
Mortality	COM_GENIT	Composite indicator: In-hospital mortality - Genito-urinary conditions	-	-	No evidence of risk
	HESMORT31CU	*In-hospital mortality: Genito-urinary conditions (01-Dec-12 to 30-Nov-13)*	-	-	*No evidence of risk*
	MORTUTI	*Mortality outlier alert: Urinary tract infections (01-Apr-12 to 14-Jul-14)*	-	-	*No evidence of risk*
	COM_HAEMA	Composite indicator: In-hospital mortality - Haematological conditions	-	-	Risk
	HESMORT28CU	*In-hospital mortality: Haematological conditions (01-Dec-12 to 30-Nov-13)*	-	-	*Risk*
	MORTDEFI	*Mortality outlier alert: Deficiency and other anaemia (01-Apr-12 to 14-Jul-14)*	-	-	*No evidence of risk*
	COM_INFEC	Composite indicator: In-hospital mortality - Infectious diseases	-	-	No evidence of risk
	HESMORT26CU	*In-hospital mortality: Infectious diseases (01-Dec-12 to 30-Nov-13)*	-	-	*No evidence of risk*
	MORTSEPT	*Mortality outlier alert: Septicaemia (except in labour) (01-Apr-12 to 14-Jul-14)*	-	-	*No evidence of risk*
	COM_MENTA	Composite indicator: In-hospital mortality - Conditions associated with Mental health	-	-	No evidence of risk
	HESMORT33CU	*In-hospital mortality: Conditions associated with Mental health (01-Dec-12 to 30-Nov-13)*	-	-	*No evidence of risk*
	MORTSENI	*Mortality outlier alert: Senility and organic mental disorders (01-Apr-12 to 14-Jul-14)*	-	-	*No evidence of risk*
	COM_MUSCU	Composite indicator: In-hospital mortality - Musculoskeletal conditions	-	-	No evidence of risk
	HESMORT36CU	*In-hospital mortality: Musculoskeletal conditions (01-Dec-12 to 30-Nov-13)*	-	-	*No evidence of risk*
	MORTPATH	*Mortality outlier alert: Pathological fracture (01-Apr-12 to 14-Jul-14)*	-	-	*No evidence of risk*
	COM_NEPHR	Composite indicator: In-hospital mortality - Nephrological conditions	-	-	No evidence of risk
	HESMORT30CU	*In-hospital mortality: Nephrological conditions (01-Dec-12 to 30-Nov-13)*	-	-	*No evidence of risk*
	MORTRENA	*Mortality outlier alert: Acute and unspecified renal failure (01-Apr-12 to 14-Jul-14)*	-	-	*No evidence of risk*
	MORTRENC	*Mortality outlier alert: Chronic renal failure (01-Apr-12 to 14-Jul-14)*	-	-	*No evidence of risk*
	COM_NEURO	Composite indicator: In-hospital mortality - Neurological conditions	-	-	No evidence of risk
	HESMORT34CU	*In-hospital mortality: Neurological conditions (01-Dec-12 to 30-Nov-13)*	-	-	*No evidence of risk*
	MORTEPIL	*Mortality outlier alert: Epilepsy, convulsions (01-Apr-12 to 14-Jul-14)*	-	-	*No evidence of risk*
	COM_PAEDI	Composite indicator: In-hospital mortality - Paediatric and congenital disorders and perinatal mortality	-	-	No evidence of risk
	HESMORT32CU	*In-hospital mortality: Paediatric and congenital disorders (01-Dec-12 to 30-Nov-13)*	-	-	*No evidence of risk*
	MATPERIMOR	*Maternity outlier alert: Perinatal mortality (01-Apr-12 to 14-Jul-14)*	-	-	*No evidence of risk*
	COM_RESPI	Composite indicator: In-hospital mortality - Respiratory conditions	-	-	No evidence of risk
	HESMORT25CU	*In-hospital mortality: Respiratory conditions (01-Dec-12 to 30-Nov-13)*	-	-	*No evidence of risk*
	MORTASTHM	*Mortality outlier alert: Asthma (01-Apr-12 to 14-Jul-14)*	-	-	*No evidence of risk*
	MORTBRONC	*Mortality outlier alert: Acute bronchitis (01-Apr-12 to 14-Jul-14)*	-	-	*No evidence of risk*
	MORTCOPD	*Mortality outlier alert: Chronic obstructive pulmonary disease and bronchiectasis (01-Apr-12 to 14-Jul-14)*	-	-	*No evidence of risk*
	MORTPLEU	*Mortality outlier alert: Pleurisy, pneumothorax, pulmonary collapse (01-Apr-12 to 14-Jul-14)*	-	-	*No evidence of risk*
	MORTPNEU	*Mortality outlier alert: Pneumonia (01-Apr-12 to 14-Jul-14)*	-	-	*No evidence of risk*

Indicators displaying * represent a suppressed value between 1 and 5

Section	ID	Indicators	Observed	Expected	Risk?
	COM_TRAUM	Composite indicator: In-hospital mortality - Trauma and orthopaedic conditions and procedures	-	-	No evidence of risk
	HESMORT37CU	*In-hospital mortality: Trauma and orthopaedic conditions (01-Dec-12 to 30-Nov-13)*	-	-	*No evidence of risk*
	MORTCRAN	*Mortality outlier alert: Craniotomy for trauma (01-Apr-12 to 14-Jul-14)*	-	-	*No evidence of risk*
	MORTFNOF	*Mortality outlier alert: Fracture of neck of femur (hip) (01-Apr-12 to 14-Jul-14)*	-	-	*No evidence of risk*
	MORTHFREP	*Mortality outlier alert: Head of femur replacement (01-Apr-12 to 14-Jul-14)*	-	-	*No evidence of risk*
	MORTHIPREP	*Mortality outlier alert: Hip replacement (01-Apr-12 to 14-Jul-14)*	-	-	*No evidence of risk*
	MORTINTINJ	*Mortality outlier alert: Intracranial injury (01-Apr-12 to 14-Jul-14)*	-	-	*No evidence of risk*
	MORTOFRA	*Mortality outlier alert: Other fractures (01-Apr-12 to 14-Jul-14)*	-	-	*No evidence of risk*
	MORTREDFB	*Mortality outlier alert: Reduction of fracture of bone (01-Apr-12 to 14-Jul-14)*	-	-	*No evidence of risk*
	MORTREDFBL	*Mortality outlier alert: Reduction of fracture of bone (upper/lower limb) (01-Apr-12 to 14-Jul-14)*	-	-	*No evidence of risk*
	MORTREDFNOF	*Mortality outlier alert: Reduction of fracture of neck of femur (01-Apr-12 to 14-Jul-14)*	-	-	*No evidence of risk*
	MORTSHUN	*Mortality outlier alert: Shunting for hydrocephalus (01-Apr-12 to 14-Jul-14)*	-	-	*No evidence of risk*
	COM_VASCU	Composite indicator: In-hospital mortality - Vascular conditions and procedures	-	-	No evidence of risk
	HESMORT23CU	*In-hospital mortality: Vascular conditions (01-Dec-12 to 30-Nov-13)*	-	-	*No evidence of risk*
	MORTAMPUT	*Mortality outlier alert: Amputation of leg (01-Apr-12 to 14-Jul-14)*	-	-	*No evidence of risk*
	MORTANEUR	*Mortality outlier alert: Aortic, peripheral, and visceral artery aneurysms (01-Apr-12 to 14-Jul-14)*	-	-	*No evidence of risk*
	MORTCLIP	*Mortality outlier alert: Clip and coil aneurysms (01-Apr-12 to 14-Jul-14)*	-	-	*No evidence of risk*
	MORTOFB	*Mortality outlier alert: Other femoral bypass (01-Apr-12 to 14-Jul-14)*	-	-	*No evidence of risk*
	MORTPVA	*Mortality outlier alert: Peripheral and visceral atherosclerosis (01-Apr-12 to 14-Jul-14)*	-	-	*No evidence of risk*
	MORTREPAAA	*Mortality outlier alert: Repair of abdominal aortic aneurysm (AAA) (01-Apr-12 to 14-Jul-14)*	-	-	*No evidence of risk*
	MORTTOFA	*Mortality outlier alert: Transluminal operations on the femoral artery (01-Apr-12 to 14-Jul-14)*	-	-	*No evidence of risk*
Maternity and women's health	MATELECCS	Maternity outlier alert: Elective Caesarean section (01-Apr-12 to 11-Jul-14)	-	-	No evidence of risk
	MATEMERCS	Maternity outlier alert: Emergency Caesarean section (01-Apr-12 to 11-Jul-14)	-	-	No evidence of risk
	MATSEPSIS	Maternity outlier alert: Puerperal sepsis and other puerperal infections (01-Apr-12 to 11-Jul-14)	-	-	No evidence of risk
Re-admissions	MATMATRE	Maternity outlier alert: Maternal readmissions (01-Apr-12 to 11-Jul-14)	-	-	No evidence of risk
	MATNEORE	Maternity outlier alert: Neonatal readmissions (01-Apr-12 to 11-Jul-14)	-	-	No evidence of risk
	COM_ELRE_ON	Composite indicator: Emergency readmissions with an overnight stay following an elective admission (01-Nov-12 to 31-Oct-13)	-	-	No evidence of risk
	HESELRE_ON	*Emergency readmissions with an overnight stay following an elective admission (Cross sectional) (01-Nov-12 to 31-Oct-13)*	*476*	*454.41*	*No evidence of risk*
	HESELRECU_ON	*Emergency readmissions with an overnight stay following an elective admission (CUSUM) (01-Jul-13 to 31-Oct-13)*	-	-	*No evidence of risk*
	COM_EMRE_ON	Composite indicator: Emergency readmissions with an overnight stay following an emergency admission (01-Nov-12 to 31-Oct-13)	-	-	No evidence of risk
	HESEMRE_ON	*Emergency readmissions with an overnight stay following an emergency admission (Cross sectional) (01-Nov-12 to 31-Oct-13)*	*2694*	*2757.45*	*No evidence of risk*
	HESEMRECU_ON	*Emergency readmissions with an overnight stay following an emergency admission (CUSUM) (01-Jul-13 to 31-Oct-13)*	-	-	*No evidence of risk*

Section	ID	Indicators	Observed	Expected	Risk?
PROMs	PROMS52	PROMs EQ-5D score: Groin Hernia Surgery (01-Apr-13 to 31-Dec-13)	Nil significance	-	No evidence of risk
	PROMS_HIP	Composite of hip related PROMS indicators (01-Apr-13 to 31-Dec-13)	-	-	No evidence of risk
	PROMS53	*PROMs EQ-5D score: Hip Replacement (PRIMARY) (01-Apr-13 to 31-Dec-13)*	*Nil significance*	*-*	*No evidence of risk*
	PROMS54	*PROMs Oxford score: Hip Replacement (PRIMARY) (01-Apr-13 to 31-Dec-13)*	*Nil significance*	*-*	*No evidence of risk*
	PROMS_KNEE	Composite of knee related PROMS indicators (01-Apr-13 to 31-Dec-13)	-	-	No evidence of risk
	PROMS55	*PROMs EQ-5D score: Knee Replacement (PRIMARY) (01-Apr-13 to 31-Dec-13)*	*Nil significance*	*-*	*No evidence of risk*
	PROMS56	*PROMs Oxford score: Knee Replacement (PRIMARY) (01-Apr-13 to 31-Dec-13)*	*Nil significance*	*-*	*No evidence of risk*
Audit	MINAP22	Proportion of patients who received all the secondary prevention medications for which they were eligible (01-Apr-12 to 31-Mar-13)	0.97	0.90	No evidence of risk
	NHFD01	The proportion of cases assessed as achieving compliance with all nine standards of care measured within the National Hip Fracture Database. (01-Apr-12 to 31-Mar-13)	0.44	0.6	No evidence of risk
	SSNAPD02	SSNAP Domain 2: overall team-centred rating score for key stroke unit indicator (01-Oct-13 to 31-Dec-13)	Level E	-	Elevated risk
Compassionate care	IPSURTALKWOR	Inpatient Survey Q34 "Did you find someone on the hospital staff to talk to about your worries and fears?" (Score out of 10) (01-Jun-13 to 31-Aug-13)	5.86	-	No evidence of risk
	IPSURSUPEMOT	Inpatient Survey Q35 "Do you feel you got enough emotional support from hospital staff during your stay?" (Score out of 10) (01-Jun-13 to 31-Aug-13)	7.07	-	No evidence of risk
Meeting physical needs	IPSURHELPEAT	Inpatient Survey Q23 "Did you get enough help from staff to eat your meals?" (Score out of 10) (01-Jun-13 to 31-Aug-13)	7.26	-	No evidence of risk
	IPSURINVDECI	Inpatient Survey Q32 "Were you involved as much as you wanted to be in decisions about your care and treatment?" (Score out of 10) (01-Jun-13 to 31-Aug-13)	7.39	-	No evidence of risk
	IPSURCNTPAIN	Inpatient Survey Q39 "Do you think the hospital staff did everything they could to help control your pain?" (Score out of 10) (01-Jun-13 to 31-Aug-13)	7.78	-	No evidence of risk
Overall experience	IPSUROVERALL	Inpatient Survey Q68 "Overall…" (I had a very poor/good experience) (Score out of 10) (01-Jun-13 to 31-Aug-13)	7.8	-	No evidence of risk
	FFTNHSESCORE	NHS England inpatients score from Friends and Family Test (Score out of 100) (01-Apr-13 to 31-Mar-14)	77.54	-	No evidence of risk
Treatment with dignity and respect	IPSURRSPDIGN	Inpatient Survey Q67 "Overall, did you feel you were treated with respect and dignity while you were in the hospital?" (Score out of 10) (01-Jun-13 to 31-Aug-13)	8.47	-	No evidence of risk
Trusting relationships	IPSURCONFDOC	Inpatient Survey Q25 "Did you have confidence and trust in the doctors treating you?" (Score out of 10) (01-Jun-13 to 31-Aug-13)	8.85	-	No evidence of risk
	IPSURCONFNUR	Inpatient Survey Q28 "Did you have confidence and trust in the nurses treating you?" (Score out of 10) (01-Jun-13 to 31-Aug-13)	8.73	-	No evidence of risk

Section	ID	Indicators	Observed	Expected	Risk?
Maternity Survey	MATSVBIRADV	Maternity Survey C1 "At the very start of your labour, did you feel that you were given appropriate advice and support when you contacted a midwife or the hospital?" (Score out of 10) (01-Feb-13 to 28-Feb-13)	7.54	-	Risk
	MATSVBIRCOM	Maternity Survey C2 "During your labour, were you able to move around and choose the position that made you most comfortable?" (Score out of 10) (01-Feb-13 to 28-Feb-13)	8.36	-	No evidence of risk
	MATSVCARBAT	Maternity Survey D6 "Thinking about your stay in hospital, how clean were the toilets and bathrooms you used?" (Score out of 10) (01-Feb-13 to 28-Feb-13)	8.27	-	No evidence of risk
	MATSVCARINF	Maternity Survey D3 "Thinking about the care you received in hospital after the birth of your baby, were you given the information or explanations you needed?" (Score out of 10) (01-Feb-13 to 28-Feb-13)	7.64	-	No evidence of risk
	MATSVSFINT	Maternity Survey C12 "Did the staff treating and examining you introduce themselves?" (Score out of 10) (01-Feb-13 to 28-Feb-13)	9.26	-	No evidence of risk
	MATSVSTAFCON	Maternity Survey C14 "If you raised a concern during labour and birth, did you feel that it was taken seriously?" (Score out of 10) (01-Feb-13 to 28-Feb-13)	7.38	-	No evidence of risk
	MATSVSTFDIG	Maternity Survey C18 "Thinking about your care during labour and birth, were you treated with respect and dignity?" (Score out of 10) (01-Feb-13 to 28-Feb-13)	9.09	-	No evidence of risk
	MATSVSTFWOR	Maternity Survey C13 "Were you and/or your partner or a companion left alone by midwives or doctors at a time when it worried you?" (Score out of 10) (01-Feb-13 to 28-Feb-13)	6.84	-	No evidence of risk
Access measures	COM_AD_A&E	Composite indicator: A&E waiting times more than 4 hours (05-Jan-14 to 30-Mar-14)	-	-	No evidence of risk
	AD_A&E13	*Proportion of patients spending more than 4 hours in Type 1 only A&E departments from arrival to discharge, transfer or admission (05-Jan-14 to 30-Mar-14)*	*0.05*	*0.05*	*No evidence of risk*
	AD_A&E14	*Proportion of patients spending more than 4 hours in Type 2 only A&E departments from arrival to discharge, transfer or admission (05-Jan-14 to 30-Mar-14)*	*Not included*	*Not included*	*Not included*
	AD_A&E15	*Proportion of patients spending more than 4 hours in Type 3 only A&E departments from arrival to discharge, transfer or admission (05-Jan-14 to 30-Mar-14)*	*0*	*0.05*	*No evidence of risk*
	COM_RTT	Composite indicator: Referral to treatment (01-Mar-14 to 31-Mar-14)	-	-	No evidence of risk
	RTT_01	*Monthly Referral to Treatment (RTT) waiting times for completed admitted pathways (on an adjusted basis): percentage within 18 weeks (01-Mar-14 to 31-Mar-14)*	*93.4%*	*90.0%*	*No evidence of risk*
	RTT_02	*Monthly Referral to Treatment (RTT) waiting times for completed non-admitted pathways: percentage within 18 weeks (01-Mar-14 to 31-Mar-14)*	*97.9%*	*95.0%*	*No evidence of risk*
	RTT_03	*Monthly Referral to Treatment (RTT) waiting times for incomplete pathways: percentage within 18 weeks (01-Mar-14 to 31-Mar-14)*	*94.7%*	*92.0%*	*No evidence of risk*
	DIAG6WK01	Diagnostics waiting times: patients waiting over 6 weeks for a diagnostic test (01-Mar-14 to 31-Mar-14)	0	0.016	No evidence of risk
	WT_CAN26	All cancers: 62 day wait for first treatment from urgent GP referral (01-Jan-14 to 31-Mar-14)	0.88	0.85	No evidence of risk
	WT_CAN27	All cancers: 62 day wait for first treatment from NHS cancer screening referral (01-Jan-14 to 31-Mar-14)	1	0.9	No evidence of risk
	WT_CAN22	All cancers: 31 day wait from diagnosis (01-Jan-14 to 31-Mar-14)	0.99	0.96	No evidence of risk
	CND_OPS02	The proportion of patients whose operation was cancelled (01-Jan-14 to 31-Mar-14)	0.017	0.009	No evidence of risk
	CND_OPS01	The number of patients not treated within 28 days of last minute cancellation due to non-clinical reason (01-Jan-14 to 31-Mar-14)	0.006	0.047	No evidence of risk
	AMBTURN06	Proportion of ambulance journeys where the ambulance vehicle remained at hospital for more than 60 minutes (01-Apr-14 to 30-Apr-14)	0.009	0.024	No evidence of risk

Section	ID	Indicators	Observed	Expected	Risk?
Discharge and Integration	DTC40	Ratio of the total number of days delay in transfer from hospital to the total number of occupied beds (01-Jan-14 to 31-Mar-14)	0.028	0.023	No evidence of risk
Patient-led assessments of the care environment	COM_PLACE	Composite of PLACE indicators (01-Apr-13 to 30-Jun-13)	-	-	No evidence of risk
	PLACE01	*PLACE score for cleanliness of environment (01-Apr-13 to 30-Jun-13)*	*0.97*	*0.96*	*No evidence of risk*
	PLACE02	*PLACE score for food (01-Apr-13 to 30-Jun-13)*	*0.87*	*0.84*	*No evidence of risk*
	PLACE03	*PLACE score for privacy, dignity and well being (01-Apr-13 to 30-Jun-13)*	*0.89*	*0.88*	*No evidence of risk*
	PLACE04	*PLACE score for facilities (01-Apr-13 to 30-Jun-13)*	*0.87*	*0.89*	*No evidence of risk*
Reporting culture	NRLS14	Consistency of reporting to the National Reporting and Learning System (NRLS) (01-Apr-13 to 30-Sep-13)	6 months of reporting	-	No evidence of risk
	COM_SUSDQ	Data quality of trust returns to the HSCIC (01-Apr-13 to 28-Feb-14)	-	-	No evidence of risk
	SUSA&E02	*Percentage of Secondary Uses Service (SUS) records for Accident and Emergency care with valid entries in mandatory fields. (01-Apr-13 to 28-Feb-14)*	*99.8%*	*96.6%*	*No evidence of risk*
	SUSAPC02	*Percentage of Secondary Uses Service (SUS) records for inpatient care with correct entries in mandatory fields. (01-Apr-13 to 28-Feb-14)*	*99.9%*	*97.3%*	*No evidence of risk*
	SUSOP02	*Percentage of Secondary Uses Service (SUS) records for outpatient care with valid entries in mandatory fields. (01-Apr-13 to 28-Feb-14)*	*100.0%*	*97.6%*	*No evidence of risk*
	FFTRESP02	Inpatients response percentage rate from NHS England Friends and Family Test (01-Apr-13 to 31-Mar-14)	27.1%	29.1%	No evidence of risk
Partners	MONITOR01	Monitor - Governance risk rating (27-May-14 to 27-May-14)	Monitor risk rating: No evident concerns	-	No evidence of risk
	MONITOR02	Monitor - Continuity of service rating (27-May-14 to 27-May-14)	2: material risk	-	Risk
	TDA01	TDA - Escalation score (01-Mar-14 to 31-Mar-14)	Not included	Not included	Not included
	NTS12	GMC National Training Survey – trainee's overall satisfaction (26-Mar-14 to 08-May-14)	Within the middle quartile (Q2/IQR)	-	No evidence of risk
Staff survey	STASURBG01	NHS Staff Survey - The proportion of staff who would recommend the trust as a place to work or receive treatment (01-Sep-13 to 31-Dec-13)	0.67	0.65	No evidence of risk
	NHSSTAFF04	NHS Staff Survey - KF7. The proportion of staff who were appraised in last 12 months (01-Sep-13 to 31-Dec-13)	0.88	0.83	No evidence of risk
	NHSSTAFF06	NHS Staff Survey - KF9. The proportion of staff reported receiving support from immediate managers (01-Sep-13 to 31-Dec-13)	0.70	0.65	No evidence of risk
	NHSSTAFF07	NHS Staff Survey - KF10. The proportion of staff receiving health and safety training in last 12 months (01-Sep-13 to 31-Dec-13)	0.60	0.75	Risk
	NHSSTAFF11	NHS Staff Survey - KF15. The proportion of staff who stated that the incident reporting procedure was fair and effective (01-Sep-13 to 31-Dec-13)	0.66	0.62	No evidence of risk
	NHSSTAFF16	NHS Staff Survey - KF21. The proportion of staff reporting good communication between senior management and staff (01-Sep-13 to 31-Dec-13)	0.30	0.29	No evidence of risk

Section	ID	Indicators	Observed	Expected	Risk?
Staffing	ESRSIC	Composite risk rating of ESR items relating to staff sickness rates (01-Apr-13 to 31-Mar-14)	-	-	No evidence of risk
	ESRSIC01	*Proportion of days sick due to back problems in the last 12 months (01-Apr-13 to 31-Mar-14)*	*0.002*	*0.002*	*No evidence of risk*
	ESRSIC02	*Proportion of days sick due to stress in the last 12 months (01-Apr-13 to 31-Mar-14)*	*0.01*	*0.007*	*No evidence of risk*
	ESRSIC03	*Proportion of days sick in the last 12 months for Medical and Dental staff (01-Apr-13 to 31-Mar-14)*	*0.018*	*0.035*	*No evidence of risk*
	ESRSIC04	*Proportion of days sick in the last 12 months for Nursing and Midwifery staff (01-Apr-13 to 31-Mar-14)*	*0.048*	*0.042*	*No evidence of risk*
	ESRSIC05	*Proportion of days sick in the last 12 months for other clinical staff (01-Apr-13 to 31-Mar-14)*	*0.044*	*0.045*	*No evidence of risk*
	ESRSIC06	*Proportion of days sick in the last 12 months for non-clinical staff (01-Apr-13 to 31-Mar-14)*	*0.039*	*0.039*	*No evidence of risk*
	ESRReg	Composite risk rating of ESR items relating to staff registration (31-Mar-14 to 31-Mar-14)	-	-	No evidence of risk
	ESRREG01	*Proportion of Medical and Dental staff that hold an active professional registration (31-Mar-14 to 31-Mar-14)*	*1*	*0.99*	*No evidence of risk*
	ESRREG02	*Proportion of Nursing and Midwifery staff that hold an active professional registration (31-Mar-14 to 31-Mar-14)*	*1*	*0.99*	*No evidence of risk*
	ESRTO	Composite risk rating of ESR items relating to staff turnover (01-Apr-13 to 31-Mar-14)	-	-	No evidence of risk
	ESRTUR01	*Turnover rate (leavers) for Medical and Dental staff (01-Apr-13 to 31-Mar-14)*	*0.09*	*0.1*	*No evidence of risk*
	ESRTUR02	*Turnover rate (leavers) for Nursing and Midwifery staff (01-Apr-13 to 31-Mar-14)*	*0.1*	*0.11*	*No evidence of risk*
	ESRTUR03	*Turnover rate (leavers) for other clinical staff (01-Apr-13 to 31-Mar-14)*	*0.1*	*0.12*	*No evidence of risk*
	ESRTUR04	*Turnover rate (leavers) for all other staff (01-Apr-13 to 31-Mar-14)*	*0.09*	*0.11*	*No evidence of risk*
	ESRSTAB	Composite risk rating of ESR items relating to staff stability (01-Apr-13 to 31-Mar-14)	-	-	No evidence of risk
	ESRSTA01	*Stability Index for Medical and Dental staff (01-Apr-13 to 31-Mar-14)*	*0.95*	*0.94*	*No evidence of risk*
	ESRSTA02	*Stability Index for Nursing and Midwifery staff (01-Apr-13 to 31-Mar-14)*	*0.9*	*0.91*	*No evidence of risk*
	ESRSTA03	*Stability Index for other clinical staff (01-Apr-13 to 31-Mar-14)*	*0.92*	*0.9*	*No evidence of risk*
	ESRSTA04	*Stability Index for non clinical staff (01-Apr-13 to 31-Mar-14)*	*0.93*	*0.91*	*No evidence of risk*
	ESRSUP	Composite risk rating of ESR items relating to staff support/ supervision (31-Mar-14 to 31-Mar-14)	-	-	No evidence of risk
	ESRSUP01	*Ratio of Band 6 Nurses to Band 5 Nurses (31-Mar-14 to 31-Mar-14)*	*0.34*	*0.4*	*No evidence of risk*
	ESRSUP02	*Ratio of Charge Nurse/ Ward Sister (Band 7) to Band 5/6 Nurses (31-Mar-14 to 31-Mar-14)*	*0.23*	*0.18*	*No evidence of risk*
	ESRSUP03	*Proportion of all ward staff who are registered nurses (31-Mar-14 to 31-Mar-14)*	*0.65*	*0.68*	*No evidence of risk*
	ESRSUP04	*Ratio of consultant doctors to non-consultant doctors (31-Mar-14 to 31-Mar-14)*	*0.54*	*0.67*	*No evidence of risk*
	ESRSUP05	*Ratio of band 7 Midwives to band 5/6 Midwives (31-Mar-14 to 31-Mar-14)*	*0.25*	*0.25*	*No evidence of risk*
	ESRSTAFF	Composite risk rating of ESR items relating to ratio: Staff vs bed occupancy (31-Mar-14 to 31-Mar-14)	-	-	No evidence of risk
	ESRRAT01	*Ratio of all medical and dental staff to occupied beds (31-Mar-14 to 31-Mar-14)*	*5.98*	*4.53*	*No evidence of risk*
	ESRRAT02	*Ratio of all nursing staff to occupied beds (31-Mar-14 to 31-Mar-14)*	*2.83*	*2.18*	*No evidence of risk*
	ESRRAT03	*Ratio of all other clinical staff to occupied beds (31-Mar-14 to 31-Mar-14)*	*2.24*	*2.02*	*No evidence of risk*
	ESRRAT04	*Ratio of all midwifery staff to births (31-Mar-14 to 31-Mar-14)*	*30.66*	*28.56*	*No evidence of risk*
	FLUVAC01	Healthcare Worker Flu vaccination uptake (01-Sep-13 to 31-Dec-13)	0.77	0.58	No evidence of risk

Section	ID	Indicators	Observed	Expected	Risk?
Qualitative intelligence	WHISTLEBLOW	Whistleblowing alerts (22-Mar-13 to 02-Jun-14)	1 or more	-	Elevated risk
	GMC	GMC - Enhanced monitoring (01-Mar-09 to 21-Apr-14)	-	-	No evidence of risk
	SAFEGUARDING	Safeguarding concerns (23-May-13 to 22-May-14)	-	-	No evidence of risk
	SYE	CQC Share Your Experience - the number of negative comments is high relative to positive comments (01-Feb-13 to 31-Jan-14)	4	6.4	No evidence of risk
	NHSCHOICES	NHS Choices - the number of negative comments is high relative to positive comments (31-Jan-13 to 30-Jan-14)	7	13.57	No evidence of risk
	P_OPINION	Patient Opinion - the number of negative comments is high relative to positive comments (22-Feb-13 to 21-Feb-14)	4	3.14	No evidence of risk
	CQC_COM	CQC complaints (23-May-13 to 22-May-14)	18	24.8	No evidence of risk
	PROV_COM	Provider complaints (01-Apr-12 to 31-Mar-13)	574	435.89	No evidence of risk

Indicators displaying * represent a suppressed value between 1 and 5