WHH Board of Directors Meeting Part 1

Supplementary Pack

Wednesday 27th July 2022
10.00am-12.30pm
Trust Conference Room/Via MS Teams

Appendices to Papers
BM/22/07/90 iv – Maternity Update (Ockenden – Appendix 1)
BM/22/07/95 ii – Board Assurance Framework (Appendix 1)

Agenda Papers
BM/22/07/96 - Cycle of Business – Strategic People Committee
BM/22/07/97 - EPRR Annual Report
BM/22/07/98 - Charities Commission Checklist
BM/22/07/99 - Infection Prevention Control Annual Report
BM/22/07/100 - Infection Prevention Control – Board Assurance Framework
BM/22/07/101 – Digital Board Report
BM/22/07/102 – Clinical Recovery Oversight Committee – Chairs Annual Report
BM/22/07/103 – Complaints Annual Report
BM/22/07/104 – Medicines Management & Controlled Drugs Licence Annual Report
BM/22/07/105 – Workforce Race Equality Standards (WRES)
BM/22/07/106 – Workforce Disability Equality Standards (WDES)

SUPPLEMENTARY PAPERS

TRUST BOARD MEETING – PART 1 *(Held in Public)*
Wednesday 27 July 2022, 10.00am – 12.30pm
Trust Conference Room/Via MS Teams

AGENDA ITEM	TIME	AGENDA ITEM		OBJECTIVE/DESIRED OUTCOME	PROCESS	PRESENTER
APPENDICES						
BM/22/07/90 iv PAGE 4		Maternity Update – Ockenden (Appendix 1)	***To note for assurance***	n/a	***Paper***	John Culshaw Trust Secretary
FOR APPROVAL						
BM/22/07/95 PAGE 91		Board Assurance Framework	***To note for assurance***	n/a	***Report***	John Culshaw Trust Secretary
BM/22/07/96 PAGE 123		Cycle of Business Strategic People Committee	***For approval***	Committee: Strategic People Committee Date of Meeting: 20/07/22 Agenda Ref: SPC/07/73 Outcome: Supported	***Paper***	John Culshaw Trust Secretary
TO NOTE FOR ASSURANCE						
BM/22/07/97 PAGE 126		EPRR Annual Report	***To note for assurance***	Committee: Finance & Sustainability Committee Date of Meeting: 20 July 2022 *Meeting cancelled due to operational pressures*	***Paper***	Dan Moore, Chief Operating Officer
BM/22/07/98 PAGE 139		Charities Commission Checklist (Annual Review)	***To note for assurance***	Committee: Charitable Funds Committee Date of Meeting: 27.06.22 Agenda Ref: CFC/22/06/10(b) Outcome: Approved	***Paper***	Pat McLaren, Director of Communications & Engagement
BM/22/07/99 PAGE 144		Infection Prevention and Control Annual Report	***To note for assurance***	Committee: Quality Assurance Committee Date of Meeting: 7 July 2022 Agenda Ref: QAC/22/07/180	***Paper***	Kimberley Salmon-Jamieson, Chief Nurse & Deputy CEO
BM/22/07/100 PAGE 189		Infection Prevention and Control - Board Assurance Framework	***To note for assurance***	Committee: Quality Assurance Committee Date of Meeting: 7 July 2022 Agenda Ref: QAC/22/07/181 Outcome: Noted for assurance	***Paper***	Kimberley Salmon-Jamieson, Chief Nurse & Deputy CEO
BM/22/07/101 PAGE 244		Digital Board Report	***To note for assurance***	Committee: Finance & Sustainability Committee Date of Meeting: 20 July 2022 *Meeting cancelled due to operational pressures*	***Paper***	Paul Fitzsimmons Executive Medical Director
BM/22/07/102 PAGE 251		Clinical Recovery Oversight Committee – Chairs Annual Report	***To note for assurance***	Committee: Clinical Recovery Oversight Committee Date of Meeting: 19 July 2022 Meeting cancelled due to operational pressures – approved by Chair's Action	***Paper***	Terry Atherton, Committee Chair
BM/22/07/103 PAGE 259		Complaints Annual Report	***To note for assurance***	Committee: Quality Assurance Committee Date of Meeting: 7 June 2022 Agenda Ref: QAC/22/06/152 Outcome: Approved	***Paper***	Kimberley Salmon-Jamieson, Chief Nurse & Deputy CEO
BM/22/07/104 PAGE 271		Medicines Management & Controlled Drugs Annual Report	***To note for assurance***	Committee: Quality Assurance Committee Date of Meeting: 7 June 2022 Agenda Ref: QAC/22/06/157 Outcome: Noted for assurance	***Paper***	Paul Fitzsimmons, Executive Medical Director

BM/22/07/105 **PAGE 296**		Workforce Race Equality Standards (WRES)	***To note for assurance***	Committee: Strategic People Committee Date of Meeting: 20/07/22 Agenda Ref: SPC/07/77 Outcome: Supported	***Paper***	Michelle Cloney, Chief People Officer
BM/22/07/106 **PAGE 309**		Workforce Disability Equality Standards (WDES)	***To note for assurance***	Committee: Strategic People Committee Date of Meeting: 20/07/22 Agenda Ref: SPC/07/78 Outcome: Supported	***Paper***	Michelle Cloney, Chief People Officer
Date of next meeting – Wednesday 28 September 2022						

Appendix 1
Ockenden Part 1 Action Plan

MATERNITY ACTION PLAN 2021

Purple	Action not initiated
Red	Action initiated but risk to achieving completion date
Amber	On track to achieve completion date
Green	Complete but assurance embedded not received
Blue	Complete, assurance evidence embedded received and passed to CBU for monitoring

No	Recommendation	Action Required	Current Position	Lead	Name	Completion Date	How do we know it will be effective	Action Completion Status	RAG status	Risk ID and Grading
O01a	Trusts should use the National Perinatal Mortality Review Tool to review deaths to the required standard	(a) To continue to work with the network to ensure we have an obstetrician and a midwife from another unit for all reviews and for neonatologists for neonatal deaths.	We have at least one external reviewer for each panel. Q3 PMRT review undertaken using C&M PMRT tool and with external representative within C&M	Clinical Lead for Labour Ward	Rita Arya / Debbie Yates	15/07/2021	We will have an obstetrician and a midwife from another unit for all reviews and for neonatologists for neonatal deaths.	Compliant		

O01b	Trusts should use the National Perinatal Mortality Review Tool to review deaths to the required standard	(b)Consider buddying up with another unit.	We are currently exploring options. All PMRT reviews are undertaken using the C&M template and undertaken with C& external partner External representation from C&M provider sought rather than buddying with one trust	Clinical Lead for Labour Ward	Rita Arya	09/03/2022	We will have an agreement in place with another unit or a rationale why this is not suitable.	Compliant		
O01c	Trusts should use the National Perinatal Mortality Review Tool to review deaths to the required standard	(c) Improve MSDSv2 data capture for reporting of SBLCBv2 to both NHSX and NHSE Establish a manual process where electronic data is not available to ensure a full submission until new EPR in place	At least two people are registered to submit MSDS data to SDCS Cloud and Staff have participated in MSDSv2 webinars. Maternity Informatics Team has made a monthly MSDS data submission from August 2020 – November 2020 containing the required data fields outlined in Safety Action 2. November data submission was fully compliant with the following fields: births, bookings, estimated date of delivery, presentation at delivery, Continuity of Carer, Personalised Care Plans and ethnicity and postcode. MSDS reporting difficulties for Smoking, Complex Social care, BMI and CoC PCP a Data quality compliance targets were achieved in all the required data tables. December 2020 MSDS data was submitted by 28th February 2021 deadline. NHS Digital issue a monthly MSDS data quality scorecard to data submitters (Trusts) that is presented to the Board as part of the QAC Maternity Safety Champion Report. The scorecard is included in the Women's Health Governance Group Agenda.	Payment By Results Midwife	Wendy Mawdsley	30/09/2022	Our MSDSv2 data quality will be complete. MIAA internal audit of SA1 (PMRT) completed in 13th 14th May 2022	Amended date agreed		1079 Grade 16

			The trust has a Digital Maternity Group Weekly Checkpoint to support information quality improvements. 14% manual collation of data that is validated for submission. New EPR will remove this requirement.							
O01d	Trusts should use the National Perinatal Mortality Review Tool to review deaths to the required standard	(d) The Trust Board must confirm to NHS Resolution that they have fully conformed to the MSDSv2 Information Standards Notice, DCB1513 and 10/2018, by 15th May or that a locally funded plan is in place to do this and agreed with the maternity safety champion and the LMS.	A submission has been made to NHSR advising of position.	Project Director	Deborah Carter / Catherine Owens	15/05/2021	The Trust Board will have completed the submission.	Compliant		
O01e	Trusts should use the National Perinatal Mortality Review Tool to review deaths to the required standard	(e) Procurement of a maternity specific electronic patient record which will capture all elements of MSDSv2 as part of the clinical care episode	Procurement process on-going to purchase Maternity Specific EPR system which will incorporate all elements of MSDS2, this is now at contract award stage. Product selection completed 23/3/2021 and moving towards implementation plan. Aim for implementation by 30/03/22	Project Director	Kerry Jones/ Catherine Owens	31/05/2022	We will have a maternity specific patient record system.	Compliant		

O01f	Trusts should use the National Perinatal Mortality Review Tool to review deaths to the required standard	(f) Continue to report 100% of qualifying cases to HSIB and NHSR (Evidence is NHSR form) Moving forward, all HSIB investigations will be reported as a serious incident, submitted to StEIS as per HSIB response to Ockenden (letter as evidence)	100% of qualifying cases have and continue to be reported to HSIB and NHSR (Evidence is NHSR form)	Governance Midwife/ Governance Clinical Lead	Chris Bentham / Lorraine Millward	Ongoing	We are consistently compliant with this action.	Compliant		
O01g	Trusts should use the National Perinatal Mortality Review Tool to review deaths to the required standard	(g) Further refinement of the clinical dashboard is required and the Moving to Outstanding group will ensure this is done with the review by the maternity safety champions and CCG	WHH is committed to using the Perinatal Clinical Quality Surveillance Model. We have a plan to implement the PCQSM and are already compliant with reports to HSIB, MBRRACE, complete regional dashboard, submit to SBL2 quarterly reports, SUIs, service user feedback and GMC trainee feedback. We have developed a SBL dashboard to ensure appropriate monitoring and surveillance is in place across the service.	Director of Midwifery	Catherine Owens	30/01/2022	We will have a more effective maternity dashboard.	Compliant		

O01h	Trusts should use the National Perinatal Mortality Review Tool to review deaths to the required standard	(h) Continue to be rigorous in the identification and classification of incidents.	Maternity SI's are already shared with the Trust Board by the Executive led Quality Assurance Committee. Going forward this will be done directly to the Trust Board. Maternity SI's sharing with LMS has commenced in December 2020 and will continue a quarterly basis.	Director of Midwifery	Catherine Owens	31/12/2021	Audits of levels of harm will consistently identify rigorous classification of incidents.	Compliant		
O02a	Maternity services must ensure that women and their families are listened to with their voices heard	(a) Ensure we have external reviewers to keep the PMRT process transparent and objective through sharing dates in advance with the regional maternity support manager from the LMS.	We have at least one external reviewer for each panel.	Clinical Lead for Labour Ward	Debbie Yates	15/11/2021	We will have an obstetrician and a midwife from another unit for all reviews and for neonatologists for neonatal deaths.	Compliant		
O02b	Maternity services must ensure that women and their families are listened to with their voices heard	(9) Advertise the dates for the Maternity Champion Safety Walkaround outlining reason for the Walkarounds	There are bi-monthly meetings in place and planned throughout the year with the 4 Maternity Safety Champions.	Director of Midwifery	Catherine Owens	14/01/2021	The dates for the Maternity Champion Safety Walkaround will be available.	On Track		
O02c	Maternity services must ensure that women and their families are listened to with their voices heard	(9) Build on the existing Maternity Safety Champion Walkaround with Board level Champions and continue to embed and	Virtual walkarounds are being completed with non-exec directors	Director of Midwifery	Catherine Owens	21/12/2020	Board level Champions will participate in Safety Champion Walkarounds	Compliant		

		develop new actions								
O02d	Maternity services must ensure that women and their families are listened to with their voices heard	(9) Trust to create an independent senior advocate role which reports to both the Trust and the LMS Boards and appoint to that role. (Awaiting national guidance).	Awaiting national directive but in the interim has Exec and non-Exec Board leads who advocate within the Trust.	Director of Midwifery	Catherine Owens	02/08/2022	There will be a senior advocate role. This is being developed nationally			
O02e	Maternity services must ensure that women and their families are listened to with their voices heard	(a) Agreement reached on funding of role for MVP chair – progress to recruitment	We have an MVP Chair and agree funding.	Director of Midwifery	Catherine Owens	14/02/2021	Funding will be agreed for an MVP Chair	Compliant		
O02f	Maternity services must ensure that women and their families are listened to with their voices heard	(b) To continue to develop the Safety Champion roles including exploring email signoff to promote the role and dedicated email inbox	Email addresses are on the posters. Email signatures contain the title maternity safety champion –dedicated email allocated and will be active by end May 2021.	Director of Midwifery	Catherine Owens	31/06/2021	Email signoff will be visible for all staff supporting the Safety Champion Role	On Track		
O03a	Staff training and working together: Staff who work together must train together.	(4) Auditing of compliance with recording on attendance sheets	Audits are completed on a monthly basis.	Practice Development Midwife	Catherine Owens	31/12/2021	Compliance audits will demonstrate completed attendance sheets	Compliant		

O03b	Staff training and working together: Staff who work together must train together.	(4) Routine operational monitoring of the staffing/rotas, and monitoring of activity and turnover.	Robust processes are in place for operational monitoring. Gaps in the rota are mitigated with locum, bank and agency usage evidence by Safer Staffing reports. Birth suite use the Birth rate plus acuity tool 2 hourly to monitor activity. All rotas are compliant. Midwifery staffing meetings happen daily, and staff are redeployed as required. The Continuity of Carer teams are making it easier to redeploy staff. Staff turnover is monitored closely with a dedicated matron. Vacancy rate is very low circa 1.5 WTE midwives prior to the 500 K recurrent investment in midwifery staffing of 6 band 7 midwives and an additional 1.38 WTE midwives which we are currently out to advert for.	Director of Midwifery Matron for Neonatology Rota Master	Catherine Owens Jackie Gifford	09/03/2022	There is routine monitoring of staffing/rotas, and monitoring of activity and turnover. Safer Staffing report provides assurance of staffing rota compliance.	Compliant		
O03c	Staff training and working together: Staff who work together must train together.	(4) For safety action 4, evidence needs to be presented to Trust board once action plan created for Obstetric staffing, ACSA standards satisfied regarding anaesthetic workforce, and neonatal workforce	An action plan is in place and presented to board for obstetric staffing. ACSA accreditation has been applied for by the Trust and is currently being assessed.	Consultant Obstetrician Consultant Anaesthesiologist	Rita Arya / Gemma Roberts	31/10/2021	Evidence will be presented to Trust Board and demonstrated in board minutes	Compliant		

O03d	Staff training and working together: Staff who work together must train together.	(8) Targeted action for outstanding training in place.	Training has continued and plan to move to face to face in November	Practice Development Midwife	Jeanette Carter	31/11/2021	Training will be completed.	Compliant		
O03e	Staff training and working together: Staff who work together must train together.	(8) Strengthening of compliance for Agency/Bank staff	Meeting completed with NHSP, and this is fully in place	Practice Development Midwife	Jeanette Carter	30/06/2021	Compliance for Agency/Bank staff will be strengthened.	Compliant		
O03f	Staff training and working together: Staff who work together must train together.	(a) Audit of ward rounds and effectiveness	Consultant led labour ward rounds twice daily (over 24) hours) and 7 days per week have been implemented. Audits are scheduled	Obstetric Governance Lead	Chris Bentham	30/06/2021	Ward rounds audits will demonstrate their effectiveness.	Compliant		
O03g	Staff training and working together: Staff who work together must train together.	(b) The following staff groups are being allocated to the available training - MSW's (0) Obstetricians (14) Anaesthetists (3) Midwives (7) ODP's (12) Recovery Nurses (1).	Staff have been allocated to the training including PROMPT	Practice Development Midwife	Jeanette Carter	30/06/2021	Staff groups will be allocated to available training.	Compliant		
O03h	Staff training and working together: Staff who work together must train together.	(b) Strengthening of compliance for Agency/Bank staff	Meeting completed with NHSP, and this is fully in place	Practice Development Midwife	Jeanette Carter	30/06/2021	Compliance for Agency/Bank staff will be strengthened.	Compliant		
O04a	Managing Complex Pregnancy There must be robust pathways in place for managing	(6) Improve MSDS data capture for reporting of SBLCBv2 to both NHSX and also	The trust is compliant with full submission in relation to SBLCBv2	Project Director	Anne Goodwin	12/02/2021	MDS data capture for SBLCBv2 has improved.	Compliant		

	women with complex pregnancies	C&M SCN Dashboard.								
O04b	Managing Complex Pregnancy There must be robust pathways in place for managing women with complex pregnancies	(6) Participation in the Mat NeoSIP QI project for Prevention of Preterm Births commencing spring 2021	Signed up to Mat Neo Programme to commence September 2022. WHH is compliant with C&M Complex pregnancy pathway	Director of Midwifery	Catherine Owens / Vacancy	30/092022	To ensure compliance and participation with all actions			
O04c	Managing Complex Pregnancy There must be robust pathways in place for managing women with complex pregnancies	(6) Participation in the Mat NeoSIP QI project for Reduction of Smoking in Pregnancy commencing spring 2021	Signed up to Mat Neo Programme to commence September 2022. WHH is compliant with C&M Complex pregnancy pathway	Director of Midwifery	Sarah Currell	30/092022	To ensure compliance and participation with all actions			
O04d	Managing Complex Pregnancy There must be robust pathways in place for managing women with complex pregnancies	(6) Consider feasibility of recording named clinic/service lead consultant for each complex pregnancy case in the health records/ Lorenzo	This information is already recorded in our electronic records system and on handheld notes	Complex Care Matron	Lisa Davies	14/02/2021	The named clinic/service lead will be recorded in health records for each complex pregnancy case.			
O04e	Managing Complex Pregnancy There must be robust pathways in place for managing women with	(a) A bespoke maternity EPR will be in place from Summer 2021 which will enable more robust	The system has been agreed and the implementation phase has commenced.	Project Director/ Associate CD	Kerry Jones / Rita Arya	31/05/2022	A bespoke maternity EPR system will be in place.	On Track		

	complex pregnancies	compliance with this action								
O04f	Managing Complex Pregnancy There must be robust pathways in place for managing women with complex pregnancies	(b) Review any incidents where women with complex medical problems were not reviewed by the appropriate specialist.	All incidents are reviewed and discussed with relevant staff to ensure risk is mitigated and learning is shared.	Governance Manager	Lorraine Millward	14/02/2021	All incidents where women with complex medical problems will be reviewed by the appropriate specialist	Compliant		
O04g	Managing Complex Pregnancy There must be robust pathways in place for managing women with complex pregnancies	(b) To establish a network of fetal medicine centres	Fetal medicine centres are a nationally led piece of work that we are participating in.	Clinical Lead for Labour Ward	Rita Arya	30/09/2022	A network of fetal medicine centres will be established. Deadline to be extended until 30/09/2022	On Track		
O05a	Risk Assessment Throughout Pregnancy Staff must ensure that women undergo a risk assessment at each contact throughout the pregnancy pathway	(6) Continue to improve MSDS data capture for reporting of SBLCBv2 to both NHSX and also C&M SCN Dashboard.	The trust is compliant with full submission in relation to SBLCBv2	Project Director	Ailsa Gaskill-Jones / Wendy Mawdsley	12/02/2021	The MSDS data capture will have improved.	Compliant		

O05b	Risk Assessment Throughout Pregnancy Staff must ensure that women undergo a risk assessment at each contact throughout the pregnancy pathway	Ensure that these are consistently in use	To ensure that all actions are implemented and monitored	Director of Midwifery	Rita Arya	30/09/2022	All actions will be implemented, and improvements made. Deadline to be extended until 30/09/2022	On Track		
O05c	Risk Assessment Throughout Pregnancy Staff must ensure that women undergo a risk assessment at each contact throughout the pregnancy pathway	(a) Production of guidelines and pathways to support the final roll out of Continuity of Care Teams and development of Personalised Care Pathways by March 2021.	Guideline for Risk Assessment in the Antenatal Period in place. Perinatal Institute Pregnancy Notes contains specific risk assessment sections for: Medical History, Family History, Obstetric History, Social History, Substance Use, Mental Health, VTE, Screening for Antenatal Anomalies, and Intention to Accept of Blood Products. The individual risk assessments are used to record a booking risk assessment. The booking risk assessment is also recorded on Lorenzo along with maternity payment pathway. Risk assessment is updated on every antenatal contact and documented in the Perinatal Institute Pregnancy Notes using the section at the end of each assessment to confirm the management plan has been reviewed and revised. Guideline for Planning Place of Birth: Antenatal and Intrapartum Risk	Deputy Head of Midwifery	Ailsa Gaskill-Jones	30/09/2022	Guidelines and pathways to support the final roll out of Continuity of Care Teams and development of Personalised Care Pathways will be in place.			

			Assessment is in place Proforma to support women with choice of place of birth is competed at 36 weeks and recorded in the hand held records. Risks affecting choice of place of birth are reviewed during the initial labour assessment. Development of and roll out of Continuity of Care Teams underway with an action plan for implementations monitored through the governance & QAC meetings. Organisation is working to achieve COC and PCP NHSE targets. Compliance figures are submitted to LMS. Women have opportunity for labour and birth in; Birth Suite, Nest or Home Birth settings, depending on their individual risks and preferences.							
O05d	Risk Assessment Throughout Pregnancy Staff must ensure that women undergo a risk assessment at each contact throughout the pregnancy pathway	(a) Develop a process to capture and record conversations, decisions and outcomes developed between women and health professionals.	This is in place within the medical records.	Deputy Head of Midwifery	Ailsa Gaskill-Jones	31/10/2021	A process to capture and record conversations, decisions and outcomes developed between women and health professionals will be in place.			

O05e	Risk Assessment Throughout Pregnancy Staff must ensure that women undergo a risk assessment at each contact throughout the pregnancy pathway	(a) Develop an IT system to capture care planning as described above.	The system has been agreed and the implementation phase has commenced.	Project Director	Kerry Jones	30/03/2021	A bespoke maternity EPR system will be in place.			
O05f	Risk Assessment Throughout Pregnancy Staff must ensure that women undergo a risk assessment at each contact throughout the pregnancy pathway	(a) Resolve maternity IT data capture issues to support reporting of PCSP to external organisations.	This is recorded within handwritten and electronic records.	Deputy Head of Midwifery	Wendy Mawdsley	30/09/2022	Data capture issues will be resolved for reporting of PCSP to external organisations. Deadline to be extended until 30/09/2022	On Track		
O05g	Risk Assessment Throughout Pregnancy Staff must ensure that women undergo a risk assessment at each contact throughout the pregnancy pathway	(a) Formalisation of monthly process to monitor PCSP compliance.	This is in place and audited.	Deputy Head of Midwifery	Ailsa Gaskill-Jones	30/09/2022	PCSP compliance will be audited.			

O06a	Monitoring Fetal Wellbeing All maternity services must appoint a dedicated Lead Midwife and Lead Obstetrician both with demonstrated expertise to focus on and champion best practice in fetal monitoring.	(a) Continue to embed new posts	Staff members are in post.	Project Director	Rita Arya / Sarah David	14/02/2021	Staff in post	Compliant		
O06b	Monitoring Fetal Wellbeing All maternity services must appoint a dedicated Lead Midwife and Lead Obstetrician both with demonstrated expertise to focus on and champion best practice in fetal monitoring.	(b) Adopt RCOG/RCM e-learning package when available.	This action was superseded with MIS year 3 Fetal Monitoring specification. Training schedule with MIS core competency framework implemented in to mandatory training. The initial eLearning package was never progressed nationally	Clinical Lead for Labour Ward	Rita Arya / Sarah David	19/07/2022		Compliant		
O06c	Monitoring Fetal Wellbeing All maternity services must appoint a dedicated Lead Midwife and Lead Obstetrician both with demonstrated expertise to focus on	(c) Implement SBL e-learning package	This action was superseded with MIS year 3 Fetal Monitoring specification. Training schedule with MIS core competency framework implemented in to mandatory training. The initial eLearning package was never progressed nationally	Clinical Lead for Labour Ward	Jeanette Carter	19/07/2022		Compliant		

	and champion best practice in fetal monitoring.									
O06d	Monitoring Fetal Wellbeing All maternity services must appoint a dedicated Lead Midwife and Lead Obstetrician both with demonstrated expertise to focus on and champion best practice in fetal monitoring.	(d) Implement SBL e-learning package	This action was superseded with MIS year 3 Fetal Monitoring specification. Training schedule with MIS core competency framework implemented in to mandatory training. The initial eLearning package was never progressed nationally	Clinical Lead for Labour Ward	Jeanette Carter	19/07/2022		Compliant		
O06e	Monitoring Fetal Wellbeing All maternity services must appoint a dedicated Lead Midwife and Lead Obstetrician both with demonstrated expertise to focus on and champion best practice in fetal monitoring.	(e) Update TNA to support additional training requirements.	This is complete and is reviewed on a monthly basis.	Practice Development Midwife	Sarah David	31/03/2021	An effective TNA is in place.	Compliant		

O06f	Monitoring Fetal Wellbeing All maternity services must appoint a dedicated Lead Midwife and Lead Obstetrician both with demonstrated expertise to focus on and champion best practice in fetal monitoring.	(f) Publish process for competency assessment to include actions to be taken for those who do not pass the assessment criteria.	There is a process in place. Work is in hand to ensure the process for those not passing competency assessments is published.	Practice Development Midwife	Sarah David	30/04/2021	Competency assessment will be published.	Compliant		
O06g	Monitoring Fetal Wellbeing All maternity services must appoint a dedicated Lead Midwife and Lead Obstetrician both with demonstrated expertise to focus on and champion best practice in fetal monitoring.	(g) Following recognition by HSIB that issues with equipment used in fetal monitoring, WHH have been reviewed all equipment and a Business Case has been approved for the purchase of new equipment.	Equipment purchased and delivered. Training package in place and equipment in process of being commissioned.	Fetal surveillance Midwife	Sarah David	30/06/2021	Equipment commissioned and training undertaken	Compliant		
O06h	Monitoring Fetal Wellbeing All maternity services must appoint a dedicated Lead Midwife and Lead Obstetrician both with demonstrated expertise to focus on	(h) The Lead Midwife will provide updates on developments in practices related to fetal surveillance at the Women's Health Governance meeting. Here she	The midwife has identified all relevant updates and attended the Women's Health Meeting	Fetal Surveillance Midwife	Sarah David	31/03/2021	Updates on developments in practices related to fetal surveillance provided by the fetal Surveillance Midwife at the Women's Health Governance	Compliant		

	and champion best practice in fetal monitoring.	will present audit findings and give progress reports on current quality improvement projects.					meeting evidenced by governance meeting minutes.			
O06i	Monitoring Fetal Wellbeing All maternity services must appoint a dedicated Lead Midwife and Lead Obstetrician both with demonstrated expertise to focus on and champion best practice in fetal monitoring.	(i) The % of staff compliant in their mandatory fetal monitoring training will be expected to increase to demonstrate effective communication with staff of the required training needs.	An action plan is in place and is monitored at Women's Health Governance Meeting.	Fetal Surveillance Midwife	Sarah David	30/06/2021	Monitoring of action plan at Women's Health Governance Meeting will provide assurance of staff compliance in their mandatory fetal monitoring training.	Compliant		
O06j	Monitoring Fetal Wellbeing All maternity services must appoint a dedicated Lead Midwife and Lead Obstetrician both with demonstrated expertise to focus on and champion best practice in fetal monitoring.	(a) Compliance with all elements of the SBL 2 care bundle will be achieved by remediation actions following structured audit.	This is in place	CNST Midwife	Anne Goodwin	14/02/2021	The audit will demonstrate compliance with all elements of SBL2	Compliant		

O07a	Informed Consent All Trusts must ensure women have ready access to accurate information to enable their informed choice of intended place of birth and mode of birth, including maternal choice for caesarean delivery	(a) Continue with plan to further develop MVP and appointment of chair	We have an MVP Chair and agree funding.	Director of Midwifery	Catherine Owens	14/02/2021	An MVP Chair will be appointed	Compliant		
O07b	Informed Consent All Trusts must ensure women have ready access to accurate information to enable their informed choice of intended place of birth and mode of birth, including maternal choice for caesarean delivery	(b) Action plan agreed to support information quality to be improved	This is complete	Deputy Head of Midwifery	Ailsa Gaskill-Jones	14/02/2021	The action plan is completed with evidence demonstrating information quality improvement.	Compliant		
O08a	Providers asked to undertake a maternity work-force gap analysis, to have a plan in place to meet the Birthrate Plus (BR+) (or equivalent) standard by the 31st of January 2020 and	(a) routine operational monitoring of the staffing/rotas, and monitoring of activity and turnover.	Birth rate plus full review is due to commence on 12/04/2021 and tabletop exercise completed Jan 2021.	Deputy Head of Midwifery	Ailsa Gaskill-Jones	31/10/2021	Full review of Birth rate plus will be undertaken, and action plan developed	Compliant		

	to confirm timescales for implementation.									
O08b	Providers asked to undertake a maternity work-force gap analysis, to have a plan in place to meet the Birthrate Plus (BR+) (or equivalent) standard by the 31st of January 2020 and to confirm timescales for implementation.	(5) Complete the planned BR plus workforce desktop review and report findings through CBU Quality and Improvements meeting	Completed Jan 2021	Head of Midwifery	Catherine Owens	14/02/2021	The BR plus workforce desktop review will be completed.	Compliant		
O08C	Providers asked to undertake a maternity work-force gap analysis, to have a plan in place to meet the Birthrate Plus (BR+) (or equivalent) standard by the 31st of January 2020 and to confirm timescales for implementation.	(b) Obtain funding for the full Birth Rate Plus Assessment via the LMS/SCN	Completed March 2021	Head of Midwifery	Catherine Owens	31/03/2021	Funding obtained for the full Birth Rate Plus Assessment via the LMS/SCN.	Compliant		

O08d	Providers asked to undertake a maternity work-force gap analysis, to have a plan in place to meet the Birthrate Plus (BR+) (or equivalent) standard by the 31st of January 2020 and to confirm timescales for implementation.	(c) Monitor progress against the outcomes of the desktop review and access the funding for the wider BR+ review.	Completed March 2021	Head of Midwifery	Catherine Owens	31/03/2021	Progress against the outcomes of the desktop review monitored and funding for the wider BR+ review obtained.	Compliant		
O09a	The trust is asked to review its approach to NICE guidelines in maternity and provide assurance that these are assessed and implemented where appropriate. Where non-evidenced based guidelines are utilised, the trust must undertake a robust assessment process before implementation and ensure that the decision is clinically justified.	(a) Ensure the co-ordinated approach to review all maternity guidelines against NICE recommendations continues	We have a robust process in place.	Head of Midwifery/ Consultant Lead for Labour Ward	Catherine Owens / Rita Arya	14/02/2021	Process embedded and maternity guidelines reviewed against NICE recommendations with relevant Clinical staff.	Compliant		

O09b	The trust is asked to review its approach to NICE guidelines in maternity and provide assurance that these are assessed and implemented where appropriate. Where non-evidenced based guidelines are utilised, the trust must undertake a robust assessment process before implementation and ensure that the decision is clinically justified.	(b) Develop proforma for clinical staff to sign off clinical guideline during review and in development to highlight areas where NICE guidance has not been followed	In place	Governance Manager	Lorraine Millward	30/06/2021	Proforma for clinical staff to sign off clinical guideline to highlight areas where NICE guidance has not been followed will be available.	Compliant	

Appendix 2
Ockenden Part 1 phase 2 Action Plan

MATERNITY ACTION PLAN 2021

Purple	Action not initiated
Red	Action initiated but risk to achieving completion date
Amber	On track to achieve completion date
Green	Complete but assurance embedded not received
Blue	Complete, assurance evidence embedded received and passed to CBU for monitoring

IEA	Question	Action	Evidence Required	CSU Assessment	Provider	LMNS	Provider Reassessment 20/07/2022	Lead	Name	Completion Date	RAG Rated
IEA1	Q1	Maternity Dashboard to LMS every 3 months	SOP required which demonstrates how the trust reports this both internally and externally through the LMS.	Yes	WARRINGTON AND HALTON NHS FOUNDATION TRUST	Cheshire and Merseyside LMNS	Yes	Digital Midwife/PBR Lead		Jul-21	
IEA1	Q1	Maternity Dashboard to LMS every 3 months	Submission of minutes and organogram, that shows how this takes place.	Yes	WARRINGTON AND HALTON NHS FOUNDATION TRUST	Cheshire and Merseyside LMNS	Yes			Jul-21	

IEA1	Q1	Maternity Dashboard to LMS every 3 months	Minutes and agendas to identify regular review and use of common data dashboards and the response / actions taken.	Yes	WARRINGTON AND HALTON NHS FOUNDATION TRUST	Cheshire and Merseyside LMNS	Yes				
IEA1	Q1	Maternity Dashboard to LMS every 3 months	Dashboard to be shared as evidence.	Yes	WARRINGTON AND HALTON NHS FOUNDATION TRUST	Cheshire and Merseyside LMNS	Yes				
IEA2	Q11	Non-executive director who has oversight of maternity services	Evidence of how all voices are represented:	No	WARRINGTON AND HALTON NHS FOUNDATION TRUST	Cheshire and Merseyside LMNS	No	Project Director	Deborah Carter	Jul-21	
IEA2	Q11	Non-executive director who has oversight of maternity services	Name of NED and date of appointment	No	WARRINGTON AND HALTON NHS FOUNDATION TRUST	Cheshire and Merseyside LMNS	Yes	Project Director	Deborah Carter	Jul-21	
IEA2	Q11	Non-executive director who has oversight of maternity services	Evidence of ward to board and board to ward activities e.g. NED walk arounds and subsequent actions	No	WARRINGTON AND HALTON NHS FOUNDATION TRUST	Cheshire and Merseyside LMNS	Yes	Project Director	Deborah Carter	Jul-21	
IEA2	Q11	Non-executive director who has oversight of maternity services	Evidence of NED sitting at trust board meetings, minutes of trust board where NED has contributed	Yes	WARRINGTON AND HALTON NHS FOUNDATION TRUST	Cheshire and Merseyside LMNS	Yes	Project Director	Deborah Carter	Jul-21	
IEA2	Q11	Non-executive director who has oversight of maternity services	Evidence of link in to MVP; any other mechanisms	Yes	WARRINGTON AND HALTON NHS FOUNDATION TRUST	Cheshire and Merseyside LMNS	Yes				

IEA2	Q11	Non-executive director who has oversight of maternity services	NED JD	Yes	WARRINGTON AND HALTON NHS FOUNDATION TRUST	Cheshire and Merseyside LMNS	Yes				
IEA2	Q13	Demonstrate mechanism for gathering service user feedback, and work with service users through Maternity Voices Partnership to coproduce local maternity services	Please upload your CNST evidence of co-production. If utilised then upload completed templates for providers to successfully achieve maternity safety action 7. CNST templates to be signed off by the MVP.	No	WARRINGTON AND HALTON NHS FOUNDATION TRUST	Cheshire and Merseyside LMNS	Yes	DOM	Catherine Owens	Feb-22	
IEA2	Q13	Demonstrate mechanism for gathering service user feedback, and work with service users through Maternity Voices Partnership to coproduce local maternity services	Evidence of service user feedback being used to support improvement in maternity services (E.G you said, we did, FFT, 15 Steps)	Yes	WARRINGTON AND HALTON NHS FOUNDATION TRUST	Cheshire and Merseyside LMNS	Yes	Project Director	Deborah Carter	Jul-21	
IEA2	Q13	Demonstrate mechanism for gathering service user feedback, and work with service users through Maternity Voices Partnership to coproduce local maternity services	Clear co-produced plan, with MVP's that demonstrate that co-production and co-design of service improvements, changes and developments will be in place and will be embedded by December 2021.	Yes	WARRINGTON AND HALTON NHS FOUNDATION TRUST	Cheshire and Merseyside LMNS	Yes	Project Director	Deborah Carter	Jul-21	
IEA2	Q14	Trust safety champions meeting bimonthly with Board level champions	Minutes of the meeting and minutes of the LMS meeting where this is discussed.	No	WARRINGTON AND HALTON NHS FOUNDATION TRUST	Cheshire and Merseyside LMNS	No	DOM	Catherine Owens	Sep-22	

IEA2	Q14	Trust safety champions meeting bimonthly with Board level champions	SOP that includes role descriptors for all key members who attend by-monthly safety meetings.	No	WARRINGTON AND HALTON NHS FOUNDATION TRUST	Cheshire and Merseyside LMNS	yes	DOM	Catherine Owens	Dec-21	
IEA2	Q14	Trust safety champions meeting bimonthly with Board level champions	Log of attendees and core membership.	Yes	WARRINGTON AND HALTON NHS FOUNDATION TRUST	Cheshire and Merseyside LMNS	Yes	Project Director	Deborah Carter	Jul-21	
IEA2	Q14	Trust safety champions meeting bimonthly with Board level champions	Action log and actions taken.	Yes	WARRINGTON AND HALTON NHS FOUNDATION TRUST	Cheshire and Merseyside LMNS	Yes	Project Director	Deborah Carter	Jul-21	
IEA2	Q15	Evidence that you have a robust mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services.	Clear co-produced plan, with MVP's that demonstrate that co-production and co-design of all service improvements, changes and developments will be in place and will be embedded by December 2021.	Yes	WARRINGTON AND HALTON NHS FOUNDATION TRUST	Cheshire and Merseyside LMNS	Yes	Project Director	Deborah Carter	Jul-21	
IEA2	Q16	Non-executive director supports the Board maternity safety champion	Name of ED and date of appointment	Yes	WARRINGTON AND HALTON NHS FOUNDATION TRUST	Cheshire and Merseyside LMNS	Yes	Project Director	Deborah Carter	Jul-21	

IEA2	Q16	Non-executive director supports the Board maternity safety champion	Evidence of participation and collaboration between ED, NED and Maternity Safety Champion, e.g. evidence of raising issues at trust board, minutes of trust board and evidence of actions taken	Yes	WARRINGTON AND HALTON NHS FOUNDATION TRUST	Cheshire and Merseyside LMNS	Yes	Project Director	Deborah Carter	Jul-21	
IEA2	Q16	Non-executive director supports the Board maternity safety champion	Role descriptors	Yes	WARRINGTON AND HALTON NHS FOUNDATION TRUST	Cheshire and Merseyside LMNS	Yes	Project Director	Deborah Carter	Jul-21	
IEA3	Q17	Multidisciplinary training and working occurs. Evidence must be externally validated through the LMS, 3 times a year.	Submit training needs analysis (TNA) that clearly articulates the expectation of all professional groups in attendance at all MDT training and core competency training. Also aligned to NHSR requirements.	Yes	WARRINGTON AND HALTON NHS FOUNDATION TRUST	Cheshire and Merseyside LMNS	Yes	Project Director	Deborah Carter	Jul-21	
IEA3	Q17	Multidisciplinary training and working occurs. Evidence must be externally validated through the LMS, 3 times a year.	Submit evidence of training sessions being attended, with clear evidence that all MDT members are represented for each session.	Yes	WARRINGTON AND HALTON NHS FOUNDATION TRUST	Cheshire and Merseyside LMNS	Yes	Project Director	Deborah Carter	Jul-21	
IEA3	Q17	Multidisciplinary training and working occurs. Evidence must be externally validated through the LMS, 3 times a year.	LMS reports showing regular review of training data (attendance, compliance coverage) and training needs assessment that demonstrates validation describes as checking the accuracy of the data.	Yes	WARRINGTON AND HALTON NHS FOUNDATION TRUST	Cheshire and Merseyside LMNS	Yes	Project Director	Deborah Carter	Jul-21	

IEA3	Q17	Multidisciplinary training and working occurs. Evidence must be externally validated through the LMS, 3 times a year.	Where inaccurate or not meeting planned target what actions and what risk reduction mitigations have been put in place.	Yes	WARRINGTON AND HALTON NHS FOUNDATION TRUST	Cheshire and Merseyside LMNS	Yes	Project Director	Deborah Carter	Jul-21	
IEA3	Q17	Multidisciplinary training and working occurs. Evidence must be externally validated through the LMS, 3 times a year.	A clear trajectory in place to meet and maintain compliance as articulated in the TNA.	Yes	WARRINGTON AND HALTON NHS FOUNDATION TRUST	Cheshire and Merseyside LMNS	Yes	Project Director	Deborah Carter	Jul-21	
IEA3	Q18	Twice daily consultant-led and present multidisciplinary ward rounds on the labour ward.	SOP created for consultant led ward rounds.	Yes	WARRINGTON AND HALTON NHS FOUNDATION TRUST	Cheshire and Merseyside LMNS	Yes	Project Director	Deborah Carter	Jul-21	
IEA3	Q18	Twice daily consultant-led and present multidisciplinary ward rounds on the labour ward.	Evidence of scheduled MDT ward rounds taking place since December, twice a day, day & night. 7 days a week (e.g. audit of compliance with SOP)	Yes	WARRINGTON AND HALTON NHS FOUNDATION TRUST	Cheshire and Merseyside LMNS	Yes	Project Director	Deborah Carter	Jul-21	
IEA3	Q19	External funding allocated for the training of maternity staff, is ring-fenced and used for this purpose only	Evidence that additional external funding has been spent on funding including staff can attend training in work time.	No	WARRINGTON AND HALTON NHS FOUNDATION TRUST	Cheshire and Merseyside LMNS	No	Director of Finance	Louisa Taylor	Sep-22	
IEA3	Q19	External funding allocated for the training of maternity staff, is ring-fenced and used for this purpose only	Confirmation from Directors of Finance	No	WARRINGTON AND HALTON NHS FOUNDATION TRUST	Cheshire and Merseyside LMNS	No	DOF	Louisa Taylor	Sep-22	

IEA3	Q19	External funding allocated for the training of maternity staff, is ring-fenced and used for this purpose only	Evidence from Budget statements.	No	WARRINGTON AND HALTON NHS FOUNDATION TRUST	Cheshire and Merseyside LMNS	No	DoF	Louisa Taylor	Sep-22	
IEA3	Q19	External funding allocated for the training of maternity staff, is ring-fenced and used for this purpose only	MTP spend reports to LMS	No	WARRINGTON AND HALTON NHS FOUNDATION TRUST	Cheshire and Merseyside LMNS	No	DoF	Louisa Taylor	Sep-22	
IEA3	Q19	External funding allocated for the training of maternity staff, is ring-fenced and used for this purpose only	Evidence of funding received and spent.	Yes	WARRINGTON AND HALTON NHS FOUNDATION TRUST	Cheshire and Merseyside LMNS	Yes	Project Director	Deborah Carter	Jul-22	
IEA1	Q2	External clinical specialist opinion for cases of intrapartum fetal death, maternal death, neonatal brain injury and neonatal death	Policy or SOP which is in place for involving external clinical specialists in reviews.	Yes	WARRINGTON AND HALTON NHS FOUNDATION TRUST	Cheshire and Merseyside LMNS	Yes				
IEA1	Q2	External clinical specialist opinion for cases of intrapartum fetal death, maternal death, neonatal brain injury and neonatal death	Audit to demonstrate this takes place - MIAA audit completed which reviewed SA1 - compliant with standards.	Yes	WARRINGTON AND HALTON NHS FOUNDATION TRUST	Cheshire and Merseyside LMNS	Yes				

IEA3	Q21	90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session	LMS reports showing regular review of training data (attendance, compliance coverage) and training needs assessment that demonstrates validation describes as checking the accuracy of the data. Where inaccurate or not meeting planned target what actions and what risk reduction mitigations have been put in place.	Yes	WARRINGTON AND HALTON NHS FOUNDATION TRUST	Cheshire and Merseyside LMNS	Yes	Project Director	Deborah Carter	Jul-21	
IEA3	Q21	90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session	A clear trajectory in place to meet and maintain compliance as articulated in the TNA.	Yes	WARRINGTON AND HALTON NHS FOUNDATION TRUST	Cheshire and Merseyside LMNS	Yes	Project Director	Deborah Carter	Jul-21	
IEA3	Q21	90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session	Attendance records - summarised	Yes	WARRINGTON AND HALTON NHS FOUNDATION TRUST	Cheshire and Merseyside LMNS	Yes	Project Director	Deborah Carter	Jul-21	
IEA3	Q22	Implement consultant led labour ward rounds twice daily (over 24 hours) and 7 days per week.	Evidence of scheduled MDT ward rounds taking place since December 2020 twice a day, day & night; 7 days a week (E.G audit of compliance with SOP)	Yes	WARRINGTON AND HALTON NHS FOUNDATION TRUST	Cheshire and Merseyside LMNS	Yes	Project Director	Deborah Carter	Jul-21	

IEA3	Q23	The report is clear that joint multi-disciplinary training is vital, and therefore we will be publishing further guidance shortly which must be implemented. In the meantime, we are seeking assurance that a MDT training schedule is in place	LMS reports showing regular review of training data (attendance, compliance coverage) and training needs assessment that demonstrates validation described as checking the accuracy of the data.	Yes	WARRINGTON AND HALTON NHS FOUNDATION TRUST	Cheshire and Merseyside LMNS	Yes	Project Director	Deborah Carter	Jul-21	
IEA3	Q23	The report is clear that joint multi-disciplinary training is vital, and therefore we will be publishing further guidance shortly which must be implemented. In the meantime, we are seeking assurance that a MDT training schedule is in place	A clear trajectory in place to meet and maintain compliance as articulated in the TNA.	Yes	WARRINGTON AND HALTON NHS FOUNDATION TRUST	Cheshire and Merseyside LMNS	Yes	Project Director	Deborah Carter	Jul-21	
IEA4	Q24	Links with the tertiary level Maternal Medicine Centre & agreement reached on the criteria for those cases to be discussed and /or referred to a maternal medicine specialist centre	SOP that clearly demonstrates the current maternal medicine pathways that includes agreed criteria for referral to the maternal medicine centre pathway.	No	WARRINGTON AND HALTON NHS FOUNDATION TRUST	Cheshire and Merseyside LMNS	No	Associate Clinical Director	Rita Arya	Mar-22	
IEA4	Q24	Links with the tertiary level Maternal Medicine Centre & agreement reached on the criteria for those cases to be discussed and /or referred to a maternal medicine specialist centre	Audit that demonstrates referral against criteria has been implemented that there is a named consultant lead, and early specialist involvement and that a management plan that has been agreed between the women and clinicians	Yes	WARRINGTON AND HALTON NHS FOUNDATION TRUST	Cheshire and Merseyside LMNS	Yes	Project Director	Deborah Carter	Jul-21	

IEA4	Q25	Women with complex pregnancies must have a named consultant lead	SOP that states that both women with complex pregnancies who require referral to maternal medicine networks and women with complex pregnancies but who do not require referral to maternal medicine network must have a named consultant lead.	No	WARRINGTON AND HALTON NHS FOUNDATION TRUST	Cheshire and Merseyside LMNS	No	Associate Clinical Director	Rita Arya	Mar-22	
IEA4	Q25	Women with complex pregnancies must have a named consultant lead	Audit of 1% of notes, where all women have complex pregnancies to demonstrate the woman has a named consultant lead.	Yes	WARRINGTON AND HALTON NHS FOUNDATION TRUST	Cheshire and Merseyside LMNS	Yes	Project Director	Deborah Carter	Jul-21	
IEA4	Q26	Complex pregnancies have early specialist involvement and management plans agreed	SOP that identifies where a complex pregnancy is identified, there must be early specialist involvement and management plans agreed between the woman and the teams.	No	WARRINGTON AND HALTON NHS FOUNDATION TRUST	Cheshire and Merseyside LMNS	Yes	Associate Clinical Director	Rita Arya	Mar-22	
IEA4	Q26	Complex pregnancies have early specialist involvement and management plans agreed	Audit of 1% of notes, where women have complex pregnancies to ensure women have early specialist involvement and management plans are developed by the clinical team in consultation with the woman.	Yes	WARRINGTON AND HALTON NHS FOUNDATION TRUST	Cheshire and Merseyside LMNS	Yes	Project Director	Deborah Carter	Jul-21	
IEA4	Q27	Compliance with all five elements of the Saving Babies' Lives care bundle Version 2	SOP's	No	WARRINGTON AND HALTON NHS FOUNDATION TRUST	Cheshire and Merseyside LMNS	yes	MIS lead midwife	Anne Goodwin	Sep-22	
IEA4	Q27	Compliance with all five elements of the Saving Babies' Lives care bundle Version 2	Audits for each element.	Yes	WARRINGTON AND HALTON NHS	Cheshire and Merseyside LMNS	Yes	Project Director	Deborah Carter	Jul-21	

					FOUNDATION TRUST						
IEA4	Q27	Compliance with all five elements of the Saving Babies' Lives care bundle Version 2	Guidelines with evidence for each pathway	Yes	WARRINGTON AND HALTON NHS FOUNDATION TRUST	Cheshire and Merseyside LMNS	Yes	Project Director	Deborah Carter	Jul-21	
IEA4	Q28	All women with complex pregnancy must have a named consultant lead, and mechanisms to regularly audit compliance must be in place.	SOP that states women with complex pregnancies must have a named consultant lead.	Yes	WARRINGTON AND HALTON NHS FOUNDATION TRUST	Cheshire and Merseyside LMNS	Yes	Project Director	Deborah Carter	Jul-21	
IEA4	Q28	All women with complex pregnancy must have a named consultant lead, and mechanisms to regularly audit compliance must be in place.	Submission of an audit plan to regularly audit compliance	No	WARRINGTON AND HALTON NHS FOUNDATION TRUST	Cheshire and Merseyside LMNS	yes	Audits Lead	Claire Darling	Jul-22	
IEA4	Q29	Understand what further steps are required by your organisation to support the development of maternal medicine specialist centres	The maternity services involved in the establishment of maternal medicine networks evidenced by notes of meetings, agendas, action logs.	Yes	WARRINGTON AND HALTON NHS FOUNDATION TRUST	Cheshire and Merseyside LMNS	Yes	Project Director	Deborah Carter	Jul-21	
IEA4	Q29	Understand what further steps are required by your organisation to support the development of maternal medicine specialist centres	Criteria for referrals to MMC	No	WARRINGTON AND HALTON NHS FOUNDATION TRUST	Cheshire and Merseyside LMNS	Yes		Rita Arya	Sep-22	
IEA4	Q29	Understand what further steps are required by your organisation to support the development of maternal medicine specialist centres	Agreed pathways	No	WARRINGTON AND HALTON NHS FOUNDATION TRUST	Cheshire and Merseyside LMNS	Yes	Project Director	Deborah Carter	Jul-21	

IEA1	Q3	Maternity SI's to Trust Board & LMS every 3 months	Submit SOP	Yes	WARRINGTON AND HALTON NHS FOUNDATION TRUST	Cheshire and Merseyside LMNS	Yes				
IEA1	Q3	Maternity SI's to Trust Board & LMS every 3 months	Submission of private trust board minutes as a minimum every three months with highlighted areas where SI's discussed	Yes	WARRINGTON AND HALTON NHS FOUNDATION TRUST	Cheshire and Merseyside LMNS	Yes				
IEA1	Q3	Maternity SI's to Trust Board & LMS every 3 months	Individual SI's, overall summary of case, key learning, recommendations made, and actions taken to address with clear timescales for completion	Yes	WARRINGTON AND HALTON NHS FOUNDATION TRUST	Cheshire and Merseyside LMNS	Yes				
IEA5	Q30	All women must be formally risk assessed at every antenatal contact so that they have continued access to care provision by the most appropriately trained professional	SOP that includes definition of antenatal risk assessment as per NICE guidance.	Yes	WARRINGTON AND HALTON NHS FOUNDATION TRUST	Cheshire and Merseyside LMNS	Yes	Project Director	Deborah Carter	Jul-21	
IEA5	Q30	All women must be formally risk assessed at every antenatal contact so that they have continued access to care provision by the most appropriately trained professional	How this is achieved within the organisation.	No	WARRINGTON AND HALTON NHS FOUNDATION TRUST	Cheshire and Merseyside LMNS	Yes		Rita Arya	Jul-22	
IEA5	Q30	All women must be formally risk assessed at every antenatal contact so that they have continued access to care provision by	What is being risk assessed.	Yes	WARRINGTON AND HALTON NHS FOUNDATION TRUST	Cheshire and Merseyside LMNS	Yes	Project Director	Deborah Carter	Jul-21	

		the most appropriately trained professional									
IEA5	Q30	All women must be formally risk assessed at every antenatal contact so that they have continued access to care provision by the most appropriately trained professional	Review and discussed and documented intended place of birth at every visit.	Yes	WARRINGTON AND HALTON NHS FOUNDATION TRUST	Cheshire and Merseyside LMNS	Yes	Project Director	Deborah Carter	Jul-21	
IEA5	Q30	All women must be formally risk assessed at every antenatal contact so that they have continued access to care provision by the most appropriately trained professional	Personal Care and Support plans are in place and an ongoing audit of 1% of records that demonstrates compliance of the above.	Yes	WARRINGTON AND HALTON NHS FOUNDATION TRUST	Cheshire and Merseyside LMNS	Yes	Project Director	Deborah Carter	Jul-21	
IEA5	Q31	Risk assessment must include ongoing review of the intended place of birth, based on the developing clinical picture.	SOP that includes review of intended place of birth.	Yes	WARRINGTON AND HALTON NHS FOUNDATION TRUST	Cheshire and Merseyside LMNS	Yes	Project Director	Deborah Carter	Jul-21	
IEA5	Q31	Risk assessment must include ongoing review of the intended place of birth, based on the developing clinical picture.	Personal Care and Support plans are in place and an ongoing audit of 1% of records that demonstrates compliance of the above.	Yes	WARRINGTON AND HALTON NHS FOUNDATION TRUST	Cheshire and Merseyside LMNS	Yes	Project Director	Deborah Carter	Jul-21	
IEA5	Q31	Risk assessment must include ongoing review of the intended place of birth, based on the developing clinical picture.	Out with guidance pathway.	No	WARRINGTON AND HALTON NHS FOUNDATION TRUST	Cheshire and Merseyside LMNS	Yes	Consultant Midwife	Claire Darling	Jul-22	
IEA5	Q31	Risk assessment must include ongoing review of the intended place of birth, based on the developing clinical picture.	Evidence of referral to birth options clinics	No	WARRINGTON AND HALTON NHS FOUNDATION TRUST	Cheshire and Merseyside LMNS	yes	Consultant Midwife	Claire Darling	Jul-22	

IEA5	Q33	A risk assessment at every contact. Include ongoing review and discussion of intended place of birth. This is a key element of the Personalised Care and Support Plan (PCSP). Regular audit mechanisms are in place to assess PCSP compliance.	SOP to describe risk assessment being undertaken at every contact.	Yes	WARRINGTON AND HALTON NHS FOUNDATION TRUST	Cheshire and Merseyside LMNS	Yes	Project Director	Deborah Carter	Jul-21	
IEA5	Q33	A risk assessment at every contact. Include ongoing review and discussion of intended place of birth. This is a key element of the Personalised Care and Support Plan (PCSP). Regular audit mechanisms are in place to assess PCSP compliance.	What is being risk assessed.	Yes	WARRINGTON AND HALTON NHS FOUNDATION TRUST	Cheshire and Merseyside LMNS	Yes	Project Director	Deborah Carter	Jul-21	
IEA5	Q33	A risk assessment at every contact. Include ongoing review and discussion of intended place of birth. This is a key element of the Personalised Care and Support Plan (PCSP). Regular audit mechanisms are in place to assess PCSP compliance.	How this is achieved in the organisation	No	WARRINGTON AND HALTON NHS FOUNDATION TRUST	Cheshire and Merseyside LMNS	Yes	Deputy Head of Midwifery	Ailsa Gaskill Jones	Jul-22	
IEA5	Q33	A risk assessment at every contact. Include ongoing review and discussion of intended place of birth. This is a key element of the Personalised Care and	Review and discussed and documented intended place of birth at every visit.	Yes	WARRINGTON AND HALTON NHS FOUNDATION TRUST	Cheshire and Merseyside LMNS	Yes	Project Director	Deborah Carter	Jul-21	

		Support Plan (PCSP). Regular audit mechanisms are in place to assess PCSP compliance.									
IEA5	Q33	A risk assessment at every contact. Include ongoing review and discussion of intended place of birth. This is a key element of the Personalised Care and Support Plan (PCSP). Regular audit mechanisms are in place to assess PCSP compliance.	Personal Care and Support plans are in place and an ongoing audit of 5% of records that demonstrates compliance of the above.	Yes	WARRINGTON AND HALTON NHS FOUNDATION TRUST	Cheshire and Merseyside LMNS	Yes	Project Director	Deborah Carter	Jul-21	
IEA5	Q33	A risk assessment at every contact. Include ongoing review and discussion of intended place of birth. This is a key element of the Personalised Care and Support Plan (PCSP). Regular audit mechanisms are in place to assess PCSP compliance.	Example submission of a Personalised Care and Support Plan (It is important that we recognise that PCSP will be variable in how they are presented from each trust)	Yes	WARRINGTON AND HALTON NHS FOUNDATION TRUST	Cheshire and Merseyside LMNS	Yes	Project Director	Deborah Carter	Jul-21	
IEA6	Q34	Appoint a dedicated Lead Midwife and Lead Obstetrician both with demonstrated expertise to focus on and champion best practice in fetal monitoring	Name of dedicated Lead Midwife and Lead Obstetrician	No	WARRINGTON AND HALTON NHS FOUNDATION TRUST	Cheshire and Merseyside LMNS	No	Associate Clinical Director	Rita Arya	Sep-22	
IEA6	Q34	Appoint a dedicated Lead Midwife and Lead Obstetrician both with demonstrated expertise to focus on and champion	Copies of rotas / off duties to demonstrate they are given dedicated time.	Yes	WARRINGTON AND HALTON NHS FOUNDATION TRUST	Cheshire and Merseyside LMNS	Yes	Project Director	Deborah Carter	Jul-21	

		best practice in fetal monitoring									
IEA6	Q34	Appoint a dedicated Lead Midwife and Lead Obstetrician both with demonstrated expertise to focus on and champion best practice in fetal monitoring	Examples of what the leads do with the dedicated time E.G attendance at external fetal wellbeing event, involvement with training, meeting minutes and action logs.	Yes	WARRINGTON AND HALTON NHS FOUNDATION TRUST	Cheshire and Merseyside LMNS	Yes	Project Director	Deborah Carter	Jul-21	
IEA6	Q34	Appoint a dedicated Lead Midwife and Lead Obstetrician both with demonstrated expertise to focus on and champion best practice in fetal monitoring	Incident investigations and reviews	Yes	WARRINGTON AND HALTON NHS FOUNDATION TRUST	Cheshire and Merseyside LMNS	Yes	Project Director	Deborah Carter	Jul-21	
IEA6	Q35	The Leads must be of sufficient seniority and demonstrated expertise to ensure they are able to effectively lead on elements of fetal health	Job Description which has in the criteria as a minimum for both roles and confirmation that roles are in post	Yes	WARRINGTON AND HALTON NHS FOUNDATION TRUST	Cheshire and Merseyside LMNS	Yes	Project Director	Deborah Carter	Jul-21	
IEA6	Q35	The Leads must be of sufficient seniority and demonstrated expertise to ensure they are able to effectively lead on elements of fetal health	Improving the practice & raising the profile of fetal wellbeing monitoring	Yes	WARRINGTON AND HALTON NHS FOUNDATION TRUST	Cheshire and Merseyside LMNS	Yes	Project Director	Deborah Carter	Jul-21	
IEA6	Q35	The Leads must be of sufficient seniority and demonstrated expertise to ensure they are able to effectively lead on elements of fetal health	Consolidating existing knowledge of monitoring fetal wellbeing	No	WARRINGTON AND HALTON NHS FOUNDATION TRUST	Cheshire and Merseyside LMNS	yes	Fetal Surveillance Midwife	Sarah David	Sep-22	

IEA6	Q35	The Leads must be of sufficient seniority and demonstrated expertise to ensure they are able to effectively lead on elements of fetal health	Keeping abreast of developments in the field	No	WARRINGTON AND HALTON NHS FOUNDATION TRUST	Cheshire and Merseyside LMNS	yes	Fetal Surveillance Midwife	Sarah David	Mar-22	
IEA6	Q35	The Leads must be of sufficient seniority and demonstrated expertise to ensure they are able to effectively lead on elements of fetal health	Ensuring that colleagues engaged in fetal wellbeing monitoring are adequately supported e.g. clinical supervision	Yes	WARRINGTON AND HALTON NHS FOUNDATION TRUST	Cheshire and Merseyside LMNS	Yes	Project Director	Deborah Carter	Jul-21	
IEA6	Q35	The Leads must be of sufficient seniority and demonstrated expertise to ensure they are able to effectively lead on elements of fetal health	Interface with external units and agencies to learn about and keep abreast of developments in the field, and to track and introduce best practice.	No	WARRINGTON AND HALTON NHS FOUNDATION TRUST	Cheshire and Merseyside LMNS	yes	Fetal Surveillance Midwife	Sarah David	Jul-22	
IEA6	Q35	The Leads must be of sufficient seniority and demonstrated expertise to ensure they are able to effectively lead on elements of fetal health	Plan and run regular departmental fetal heart rate (FHR) monitoring meetings and training.	Yes	WARRINGTON AND HALTON NHS FOUNDATION TRUST	Cheshire and Merseyside LMNS	Yes	Project Director	Deborah Carter	Jul-21	
IEA6	Q35	The Leads must be of sufficient seniority and demonstrated expertise to ensure they are able to effectively lead on elements of fetal health	Lead on the review of cases of adverse outcome involving poor FHR interpretation and practice.	Yes	WARRINGTON AND HALTON NHS FOUNDATION TRUST	Cheshire and Merseyside LMNS	Yes	Project Director	Deborah Carter	Jul-21	
IEA6	Q36	Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2?	SOP's	No	WARRINGTON AND HALTON NHS FOUNDATION TRUST	Cheshire and Merseyside LMNS	No	Associate Clinical Director	Rita Arya	Sep-22	

IEA6	Q36	Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2?	Audits for each element	Yes	WARRINGTON AND HALTON NHS FOUNDATION TRUST	Cheshire and Merseyside LMNS	Yes	Project Director	Deborah Carter	Jul-21	
IEA6	Q36	Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2?	Guidelines with evidence for each pathway	Yes	WARRINGTON AND HALTON NHS FOUNDATION TRUST	Cheshire and Merseyside LMNS	Yes	Project Director	Deborah Carter	Jul-21	
IEA6	Q37	Can you evidence that at least 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session since the launch of MIS year three in December 2019?	Submit training needs analysis (TNA) that clearly articulates the expectation of all professional groups in attendance at all MDT training and core competency training. Also aligned to NHSR requirements.	Yes	WARRINGTON AND HALTON NHS FOUNDATION TRUST	Cheshire and Merseyside LMNS	Yes	Project Director	Deborah Carter	Jul-21	
IEA6	Q37	Can you evidence that at least 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session since the launch of MIS year three in December 2019?	A clear trajectory in place to meet and maintain compliance as articulated in the TNA.	Yes	WARRINGTON AND HALTON NHS FOUNDATION TRUST	Cheshire and Merseyside LMNS	Yes	Project Director	Deborah Carter	Jul-21	
IEA6	Q37	Can you evidence that at least 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session since the	Attendance records - summarised	Yes	WARRINGTON AND HALTON NHS FOUNDATION TRUST	Cheshire and Merseyside LMNS	Yes	Project Director	Deborah Carter	Jul-21	

		launch of MIS year three in December 2019?									
IEA7	Q39	Trusts ensure women have ready access to accurate information to enable their informed choice of intended place of birth and mode of birth, including maternal choice for caesarean delivery	Submission from MVP chair rating trust information in terms of accessibility (navigation, language etc) quality of info (clear language, all/minimum topic covered) other evidence could include patient information leaflets, apps, websites.	No	WARRINGTON AND HALTON NHS FOUNDATION TRUST	Cheshire and Merseyside LMNS	No	Consultant Nurse	Claire Darling	Aug-22	
IEA7	Q39	Trusts ensure women have ready access to accurate information to enable their informed choice of intended place of birth and mode of birth, including maternal choice for caesarean delivery	Information on maternal choice including choice for caesarean delivery.	Yes	WARRINGTON AND HALTON NHS FOUNDATION TRUST	Cheshire and Merseyside LMNS	Yes	Project Director	Deborah Carter	Jul-21	
IEA1	Q4	Using the National Perinatal Mortality Review Tool to review perinatal deaths	Local PMRT report. PMRT trust board report. Submission of a SOP that describes how parents and women are involved in the PMRT process as per the PMRT guidance.	Yes	WARRINGTON AND HALTON NHS FOUNDATION TRUST	Cheshire and Merseyside LMNS	Yes				
IEA1	Q4	Using the National Perinatal Mortality Review Tool to review perinatal deaths	Audit of 100% of PMRT completed demonstrating meeting the required standard including parents notified as a minimum and external review.	Yes	WARRINGTON AND HALTON NHS FOUNDATION TRUST	Cheshire and Merseyside LMNS	Yes				

IEA7	Q41	Women must be enabled to participate equally in all decision-making processes	An audit of 1% of notes demonstrating compliance.	No	WARRINGTON AND HALTON NHS FOUNDATION TRUST	Cheshire and Merseyside LMNS	No	Digital Midwife.	Kerry Jones	Aug-22	
IEA7	Q41	Women must be enabled to participate equally in all decision-making processes	CQC survey and associated action plans	Yes	WARRINGTON AND HALTON NHS FOUNDATION TRUST	Cheshire and Merseyside LMNS	No	Project Director	Deborah Carter	Sep-22	
IEA7	Q41	Women must be enabled to participate equally in all decision-making processes	SOP which shows how women are enabled to participate equally in all decision-making processes and to make informed choices about their care. And where that is recorded.	No	WARRINGTON AND HALTON NHS FOUNDATION TRUST	Cheshire and Merseyside LMNS	Yes	Deputy Head of Midwifery	Ailsa Gaskill Jones	Jul-22	
IEA7	Q42	Women's choices following a shared and informed decision-making process must be respected	An audit of 5% of notes demonstrating compliance, this should include women who have specifically requested a care pathway which may differ from that recommended by the clinician during the antenatal period, and also a selection of women who request a caesarean section during labour or induction.	No	WARRINGTON AND HALTON NHS FOUNDATION TRUST	Cheshire and Merseyside LMNS	No	Consultant Midwife	Claire Darling	Sep-22	
IEA7	Q42	Women's choices following a shared and informed decision-making process must be respected	SOP to demonstrate how women's choices are respected and how this is evidenced following a shared and informed decision-making process, and where that is recorded.	Yes	WARRINGTON AND HALTON NHS FOUNDATION TRUST	Cheshire and Merseyside LMNS	Yes	Project Director	Deborah Carter	Jul-21	

IEA7	Q43	Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership to coproduce local maternity services?	Please upload your CNST evidence of co-production. If utilised, then upload completed templates for providers to successfully achieve maternity safety action 7. CNST templates to be signed off by the MVP.	No	WARRINGTON AND HALTON NHS FOUNDATION TRUST	Cheshire and Merseyside LMNS	No	consultant midwife	Claire Darling	Mar-22	
IEA7	Q43	Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership to coproduce local maternity services?	Evidence of service user feedback being used to support improvement in maternity services (E.G you said, we did, FFT, 15 Steps)	Yes	WARRINGTON AND HALTON NHS FOUNDATION TRUST	Cheshire and Merseyside LMNS	Yes	Project Director	Deborah Carter	Jul-21	
IEA7	Q43	Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership to coproduce local maternity services?	Clear co-produced plan, with MVP's that demonstrate that co-production and co-design of all service improvements, changes and developments will be in place and will be embedded by December 2021.	Yes	WARRINGTON AND HALTON NHS FOUNDATION TRUST	Cheshire and Merseyside LMNS	Yes	Project Director	Deborah Carter	Jul-21	
IEA7	Q44	Pathways of care clearly described, in written information in formats consistent with NHS policy and posted on the trust website.	Submission from MVP chair rating trust information in terms of accessibility (navigation, language etc) quality of info (clear language, all/minimum topic covered) other evidence could include patient information leaflets, apps, websites.	No	WARRINGTON AND HALTON NHS FOUNDATION TRUST	Cheshire and Merseyside LMNS	No	consultant midwife	Claire Darling	Jul-22	

IEA7	Q44	Pathways of care clearly described, in written information in formats consistent with NHS policy and posted on the trust website.	Gap analysis of website against Chelsea & Westminster conducted by the MVP	Yes	WARRINGTON AND HALTON NHS FOUNDATION TRUST	Cheshire and Merseyside LMNS	Yes	Project Director	Deborah Carter	Jul-21	
IEA7	Q44	Pathways of care clearly described, in written information in formats consistent with NHS policy and posted on the trust website.	Co-produced action plan to address gaps identified	Yes	WARRINGTON AND HALTON NHS FOUNDATION TRUST	Cheshire and Merseyside LMNS	Yes	Project Director	Deborah Carter	Jul-21	
IEA7	Q44	Pathways of care clearly described, in written information in formats consistent with NHS policy and posted on the trust website.	Information on maternal choice including choice for caesarean delivery.	Yes	WARRINGTON AND HALTON NHS FOUNDATION TRUST	Cheshire and Merseyside LMNS	Yes	Project Director	Deborah Carter	Jul-21	
WF	Q45	Demonstrate an effective system of clinical workforce planning to the required standard	Most recent BR+ report and board minutes agreeing to fund.	No	WARRINGTON AND HALTON NHS FOUNDATION TRUST	Cheshire and Merseyside LMNS	Yes	DOM	Catherine Owens	Jul-22	
WF	Q45	Demonstrate an effective system of clinical workforce planning to the required standard	Evidence of reviews 6 monthly for all staff groups and evidence considered at board level.	Yes	WARRINGTON AND HALTON NHS FOUNDATION TRUST	Cheshire and Merseyside LMNS	Yes	Project Director	Deborah Carter	Jul-21	
WF	Q45	Demonstrate an effective system of clinical workforce planning to the required standard	Consider evidence of workforce planning at LMS/ICS level given this is the direction of travel of the people plan	Yes	WARRINGTON AND HALTON NHS FOUNDATION TRUST	Cheshire and Merseyside LMNS	Yes	Project Director	Deborah Carter	Jul-21	

WF	Q46	Demonstrate an effective system of midwifery workforce planning to the required standard?	Most recent BR+ report and board minutes agreeing to fund.	No	WARRINGTON AND HALTON NHS FOUNDATION TRUST	Cheshire and Merseyside LMNS	Yes	DOM	Catherine Owens	44743	
WF	Q47	Director/Head of Midwifery is responsible and accountable to an executive director	HoM/DoM Job Description with explicit signposting to responsibility and accountability to an executive director	No	WARRINGTON AND HALTON NHS FOUNDATION TRUST	Cheshire and Merseyside LMNS	Yes	Project Director	Deborah Carter	Jul-21	
WF	Q48	Describe how your organisation meets the maternity leadership requirements set out by the Royal College of Midwives in Strengthening midwifery leadership: a manifesto for better maternity care:	Gap analysis completed against the RCM strengthening midwifery leadership: a manifesto for better maternity care	Yes	WARRINGTON AND HALTON NHS FOUNDATION TRUST	Cheshire and Merseyside LMNS	Yes	Project Director	Deborah Carter	Jul-21	
WF	Q48	Describe how your organisation meets the maternity leadership requirements set out by the Royal College of Midwives in Strengthening midwifery leadership: a manifesto for better maternity care:	Action plan where manifesto is not met	Yes	WARRINGTON AND HALTON NHS FOUNDATION TRUST	Cheshire and Merseyside LMNS	Yes	Project Director	Deborah Carter	Jul-21	
WF	Q49	Providers to review their approach to NICE guidelines in maternity and provide assurance that these are assessed and implemented where appropriate.	SOP in place for all guidelines with a demonstrable process for ongoing review.	No	WARRINGTON AND HALTON NHS FOUNDATION TRUST	Cheshire and Merseyside LMNS	Yes	Obstetric Governance Lead	Chris Bentham	Jul-22	

WF	Q49	Providers to review their approach to NICE guidelines in maternity and provide assurance that these are assessed and implemented where appropriate.	Audit to demonstrate all guidelines are in date.	No	WARRINGTON AND HALTON NHS FOUNDATION TRUST	Cheshire and Merseyside LMNS	Yes	Obstetric Governance Lead	Chris Bentham	Apr-22	
WF	Q49	Providers to review their approach to NICE guidelines in maternity and provide assurance that these are assessed and implemented where appropriate.	Evidence of risk assessment where guidance is not implemented.	No	WARRINGTON AND HALTON NHS FOUNDATION TRUST	Cheshire and Merseyside LMNS	Yes	Obstetric Governance Lead	Chris Bentham	Apr-22	
IEA1	Q5	Submitting data to the Maternity Services Dataset to the required standard	Evidence of a plan for implementing the full MSDS requirements with clear timescales aligned to NHSR requirements within MIS.	Yes	WARRINGTON AND HALTON NHS FOUNDATION TRUST	Cheshire and Merseyside LMNS	Yes				
IEA1	Q6	Reported 100% of qualifying cases to HSIB / NHS Resolution's Early Notification scheme	Audit showing compliance of 100% reporting to both HSIB and NHSR Early Notification Scheme.	Yes	WARRINGTON AND HALTON NHS FOUNDATION TRUST	Cheshire and Merseyside LMNS	Yes				
IEA1	Q7	Plan to implement the Perinatal Clinical Quality Surveillance Model	Submit SOP and minutes and organogram of organisations involved that will support the above from the trust, signed off via the trust governance structure.	no	WARRINGTON AND HALTON NHS FOUNDATION TRUST	Cheshire and Merseyside LMNS	No	MIS lead midwife	Anne Goodwin	Sep-22	
IEA1	Q7	Plan to implement the Perinatal Clinical Quality Surveillance Model	LMS SOP and minutes that describe how this is embedded in the ICS governance structure and signed off by the ICS.	no	WARRINGTON AND HALTON NHS FOUNDATION TRUST	Cheshire and Merseyside LMNS	No	MIS Lead Midwife	Anne Goodwin	Sep-22	

IEA1	Q7	Plan to implement the Perinatal Clinical Quality Surveillance Model	Full evidence of full implementation of the perinatal surveillance framework by June 2021.	Yes	WARRINGTON AND HALTON NHS FOUNDATION TRUST	Cheshire and Merseyside LMNS	Yes	MIS lead midwife	Anne Goodwin	Mar-22	

Appendix 3
Ockenden Part 2 Action Plan

RAG RATING

Purple	Action not initiated
Red	Action initiated but risk to achieving completion date
Amber	On track to achieve completion date
Green	Complete but assurance embedded not received
Blue	Complete, assurance evidence embedded received and passed to CBU for monitoring

		Ref	No	Recommendation	Action	Lead	Completion Due Date	Date due to be embedded	Action RAG Status	Commentary	Risk ID and Grading	Theme

6	Joint Provider/LMNS	IEA 1b Training	6	All NQMs must remain within the hospital setting for a minimum period of one year post qualification (to be confirmed nationally). This timeframe will ensure there is an opportunity to develop essential skills and competencies on which to advance individual clinical practice, enhance professional confidence and resilience and provide a structured period of transition from student to accountable midwife.	Awaiting further national guidance - NMQ hospital working period. Retention midwife support in place.	Deputy Head of Midwifery				Awaiting further national guidance - NMQ hospital working period. Retention midwife support in place.		

13	Provider	IEA 2 Safe Staffing	2	In Trusts with no separate consultant rotas for Obstetrics and Gynaecology there must be a risk assessment and escalation protocol for periods of competing workload. This must be agreed at Board level.	Develop a SOP with guidance on escalation for out of hours work for consultants who are covering obstetrics and gynaecology. Delete the next sentence. Monitor completed proforma's at W&C Governance Committee. Escalation to Board through escalation process to be met.	Associate Clinical Director Obstetrics and Gynaecology	28.8.22				
19	Provider	IEA 2 Safe Staffing	8	Newly appointed Band 7/8 midwives must be allocated a named and experienced mentor to support their transition into leadership and management roles.	Develop a mentorship directory. Each Band 7/8 to identify development needs and opportunities to support them in their leadership and management role. This will form part of their appraisal and CPD plan.	Deputy Head of Midwifery	30/09/2022				
21	Provider	IEA 2 Safe Staffing	10	All Trusts should follow the latest RCOG guidance on managements of locums. The RCOG encourages the use of internal locums and	Review RCOG guidance and benchmark WHH processes. Present findings in HLBP to Women's and Children's Governance meeting. Please note WHH	Associate Clinical Director Obstetrics and Gynaecology	31/12/2022				

				has developed practical guidance with NHS England on the management of locums. This includes support for locums and ensuring they comply with recommended processes such as pre-employment checks and appropriate induction	locums appointed by HR and follow trust pathway.							
29	Provider	IEA 4 Clinical Governance - Leadership	3	Every Trust must ensure they have a Patient Safety Specialist, specifically dedicated to maternity services	Awaiting national guidance for specific requirements of the role.	Associate Director of Governance	31/12/2022					
32	Provider	IEA 4 Clinical Governance - Leadership	6	All maternity services must ensure there are midwifery and obstetric co-leads for developing guidelines. The midwife co-lead must be of a senior level, such as a consultant midwife, who can drive the guideline agenda and have links with audit and research.	Monitor guideline compliance via Women's and Children's Governance Meeting. Trust Compliance manager, Consultant Midwife and Labour Ward Lead to benchmark national and regional guidelines when launched/updated Send notification of	Consultant Midwife	31/01/2023			Consultant midwife new in post and will lead this moving forward		

					new and updated guidelines via safety brief.							
1	National	IEA 1a Workforce Planning and Sustainability	1	To fund Maternity and Neonatal services appropriately requires a multi-year settlement to ensure the workforce is enabled to deliver consistent safe Maternity and Neonatal care across England.	Awaiting further national correspondence.	National				Staffing levels have been reviewed and agreed at Quality Assurance Committee based on the 'BirthRate Plus 'report. BirthRate Plus to undergo national review as per Ockenden recommendations. Ockenden funding utilised to recruit 5.0 WTE Specialist Midwives. Medical staffing for additional governance roles funded through Ockenden.		
2	Joint Provider/LMNS	IEA 1a Workforce Planning and Sustainability	2	Minimum staffing levels should be those agreed nationally, or where there are no agreed national levels, staffing levels must be locally agreed with the LMNS, with a BirthRate Plus staffing review. This must encompass the increased acuity	Undertake a full staffing review utilising BirthRate Plus. Continue to oversee daily staffing reviews to ensure safe staffing is in place with appropriate escalation processes and policy. Internal Bi-annual staffing reviews to	Director of Midwifery	30/09/2022					

				and complexity of women, vulnerable families, and additional mandatory training to ensure Trusts are able to safely meet organisational CNST and CQC requirements. This must be repeated at a minimum of every 3 years.	continue. Report weekly staffing and acuity forecast to C&M weekly sitrep meeting (Gold Command). Staffing levels reported to Quality Assurance Committee and to the Board of Directors.						
3	Joint Provider/LMNS	IEA 1a Financing a safe maternity workforce	3	Minimum staffing levels must include a calculated uplift, representative of data for the previous 3 years. This must include all absences encompassing; sickness, mandatory training, annual leave and maternity leave.	Monitor sickness and absence weekly to calculate staffing/workforce needs to facilitate safe staffing levels in real time. Gather data for the preceding 3 years to calculate accuracy in uplift required. Proactive management to influence required uplift is in place to optimise the position e.g., Welcome Back interviews. Calculate mandatory training hours and triangulate with 23% staffing uplift as per BirthRate Plus Report.	Director of Midwifery	30/09/2022				

4	National	IEA 1a Financing a safe maternity workforce	4	The feasibility and accuracy of the Birth-rate Plus tool and associated methodology must be reviewed nationally by all bodies. These bodies must include as a minimum NHSE, RCOG, RCM, RCPCH.	Awaiting further national instruction.	National					
5	Joint Provider/LMNS	IEA 1b Training	5	All Trusts must implement a robust preceptorship programme for newly qualified midwives (NQM), which supports supernumerary status during their orientation period and protected learning time for professional development as per the RCM (2017) position statement.	Review current Preceptorship Programme and update as per TNA for Maternity and Neonatal service and ensure this is aligned to the national safety agenda. Develop a TNA for each staff group to inform CBU TNA. Provide quarterly update reports to be shared with W&C governance committee and programme of education.	Consultant Midwife	01/09/2022			Awaiting national guidance. Current model is for NQMs to work in a rostered MCoC model with a preceptorship package which is being reviewed to ensure this meets their needs. No NQM will attend an intrapartum setting without assurance of competence and will be supported in the community setting. Retention Midwife is reviewing all preceptorship processes/support mechanisms alongside the Consultant Midwife.		

7	National	IEA 1b Training	7	All Trusts must ensure all midwives responsible for coordinating Labour Ward attend a fully funded and nationally recognised coordinator education module, which supports advanced decision-making, learning through training in human factors, situational awareness and psychological safety.	Awaiting national guidance.	National				Awaiting national guidance.		
8	Provider	IEA 1b Training	8	All Trusts to ensure newly appointed Labour Ward coordinators receive an orientation package which reflects their individual needs. This must encompass opportunities to be released from clinical practice to focus on their personal and professional development.	Further develop Labour Ward Coordinator Induction and Orientation Programme. Review of competency Framework for NQM. NQM feedback survey to be devised, implemented and evaluated.	Deputy Head of Midwifery	30/09/2022			All band 7s are allocated to attend band 7 leadership programme bespoke to Women's & Children's. Further develop existing Induction Programme.		

9	Provider	IEA 1b Training	9	All Trusts must develop a core team of senior midwives who are trained in the provision of High Dependency (HDU) maternity care. The core team should be large enough to ensure there is at least one HDU trained midwife on each shift, 24/7.	Identify training needs of the Birth Suite Coordinators and facilitate appropriate training with competency review for the delivery of High Dependency care. Ensure a midwife with High Dependency maternity care skills is on duty on each shift.	Practice Development Midwife	31/12/2022			Exploration of Level 6/7 Maternal Enhanced Care Module University of Salford. CPD to be allocated. Exploring single day Enhanced Maternal Care model.		
10	Provider	IEA 1b Training	10	All Trusts must develop a strategy to support a succession-planning programme for the maternity workforce to develop potential future leaders and senior managers. This must include a gap analysis of all leadership and management roles to include those held by Specialist Midwives and Obstetric Consultants. This must include supportive organisational processes and relevant practical work experience.	Develop designated Maternity Strategy which incorporates maternity workforce sustainability. Undertake a gap analysis of leadership roles amongst Specialist Midwives and Obstetric Consultants. Embed findings of gap analysis into Workforce Planning Strategy.	Director of Midwifery - Associate Chief Nurse	31/10/2022			Development of designated Midwifery Strategy underway.		

11	Multiagency	IEA 1b Training	11	There is progress around the creation of Maternal Medicine Networks nationally, which will enhance the care and safety of complex pregnancies. To address the shortfall of Maternal Medicine Physicians, a sustainable training programme across the country must be established, to ensure the appropriate workforce long term.	Awaiting national guidance.					Maternal medicine clinic embedded into service. Lead Obstetrician and Physician in place, Consultant Midwife in place. Awaiting local SOP for referral criteria and link in to North West Coast Medicine Network.		
12	Joint Provider/LMNS	IEA 2 Safe Staffing	1	When agreed staffing levels across maternity services are not achieved on a day-to-day basis this must be escalated to the services' Senior Management Team, Obstetric Leads, the Chief Nurse, Medical Director, Patient Safety Champion and LMS	Daily staffing reviews. Bi-annual staffing reviews to continue. Report weekly staffing and acuity forecast to C&M weekly sitrep meeting (Gold Command). Staffing levels reported to Quality Assurance Committee and to the Board of Directors, in addition to W&C Governance Committee. Embed C&M escalation and divert policy to facilitate safe escalation of staffing and acuity	Matron	30/09/2022			Bleep holder SoP in draft, for presentation and ratification in July 2022 Women's Governance meeting with implementation plan to support roll out by 30/9/2022. Red Flag exception reports to be produced monthly from July 2022 to Women's Governance with formal Governance report on a quarterly basis.		

					and where staffing levels cannot be increased.							
14	Provider	IEA 2 Safe Staffing	3	All Trusts must ensure the Labour Ward coordinator role is recognised as a specialist job role with an accompanying job description and person specification	Develop Labour Ward Coordinator job description to ensure the role is identified as a specialist role and ensure each coordinator has the essential and desirable skills to meet the needs of the role.	Deputy Head of Midwifery	03/08/2022			JD to be reviewed and updated in view of Ockenden recommendations		
15	Joint Provider/LMNS	IEA 2 Safe Staffing	4	All Trusts must review and suspend, if necessary, the existing provision and further roll out of Midwifery Continuity of Carer (MCoC) unless they can demonstrate staffing meets safe minimum requirements on all shifts. This will preserve the safety of all pregnant women and families, which is currently compromised by the unprecedented	Undertake review of MCoC staffing and model and develop an action plan to ensure national MCoC trajectory is met. Inform Quality Assurance Committee of MCoC plan twice yearly.	Deputy Head of Midwifery	Complete - 31/06/2022			MCoC review paper submitted to QAC June 2022. Staffing review continues.		

				pressures that MCoC models place on maternity services already under significant strain.								
16	Joint Provider/LMNS	IEA 2 Safe Staffing	5	The reinstatement of MCoC should be withheld until robust evidence is available to support its reintroduction	Not Applicable to WHH MCoC not suspended at WHH	Deputy Head of Midwifery	N/A MCoC not suspended at WHH	N/A MCoC not suspended at WHH				
17	Provider	IEA 2 Safe Staffing	6	The required additional time for maternity training for consultants and locally employed doctors must be provided in job plans. The protected time required will be in addition to that required for generic Trust mandatory training and reviewed as training requirements change	At each annual consultant appraisal mandatory training is embedded within the CPD element	Associate Clinical Director Obstetrics and Gynaecology	31/07/2022			The Majority of job plans have been completed. Awaiting reassignment of planned activity to new roles. Consultants have 6 weeks study leave and mandatory study is in addition to this and can be booked as such, through the electronic booking system, with 6 weeks' notice. Consultants allocated up to 6 weeks study leave		
18	Provider	IEA 2 Safe Staffing	7	All Trusts must ensure there are visible, supernumerary clinical skills facilitators to	Clinical skills facilitator and retention midwife already in post and are	Practice Development Midwife	31/12/2022			To explore the recruitment of an Education Midwife to sit alongside the recruitment and retention		

				support midwives in clinical practice across all settings.	supernumerary to work alongside clinicians.					midwife. Awaiting Ockenden part two funding to support creation of this role. Retention Midwife in post		
20	Provider	IEA 2 Safe Staffing	9	All Trusts must develop strategies to maintain bi-directional robust pathways between midwifery staff in the community setting and those based in the hospital setting, to ensure high quality care and communication.	Embed Trust wide Communication Strategy Facilitate quarterly team talks to update staff of current changes to practice, news events, safety trajectories, recruitment, KPIs, to improve and maintain bi-directional communication between the hospital and community setting.	Deputy Head of Midwifery	31/12/2022			Continuity of carer model facilitates bi-directional communication between the community and hospital setting.		
22	Joint Provider/LMNS	IEA 3 Escalation & Accountability	1	All Trusts must develop and maintain a conflict of clinical opinion policy to support staff members in being able to escalate their clinical concerns regarding a woman's care in case of disagreement between healthcare professionals	Policy to de developed and embedded. Policy for rotation of midwives between settings. Ensure robust mechanisms of communication.	Director of Midwifery.	30/09/2022			Internal escalation SOP in place, daily maternity bleep holder in place. Consultant on call rota and Site Manager on Call for out of hours. To further develop via roll out of bleep holder SOP and consider options for additional out of hours support.		

23	Provider	IEA 3 Escalation & Accountability	2	When a middle grade or trainee obstetrician (non-consultant) is managing the maternity service without direct consultant presence Trusts must have an assurance mechanism to ensure the middle grade or trainee is competent for this role	All specialist trainees have named educational supervisors and complete RCOG eportfolio requirements to ensure they meet the matrix objectives for their year of training. The RCOG guideline on direct consultant and indirect consultant supervision is followed and WHH has a SOP. The one SAS doctor on the rota has an annual medical appraisal and has WBA to show competence. Locum doctors have experience and references on their application to state where they are competent. Any concerns are escalated to the TPD at HENW, and the Dr is not on duty out of hours without direct consultant presence.	College Tutor Obstetrics and Gynaecology	Complete			In place, evidenced by RCOG portfolio. Only one staff grade on WHH on call rota at ST5 level.		

24	Provider	IEA 3 Escalation & Accountability	3	Trusts should aim to increase resident Consultant Obstetrician presence where this is achievable, this will help to facilitate presence on Midwifery Led Units.	WHH have 73 hours consultant residence and undertake 2 ward rounds daily.	Associate Clinical Director	28.10.22			Two consultant ward rounds in place, twelve hours apart and presence increased by 14.5 hours. Resident for 74.4 hours.		
25	Provider	IEA 3 Escalation & Accountability	4	There must be clear local guidelines for when Consultant Obstetricians' attendance is mandatory within the unit	Consultant On Call SOP to be embedded. This will be monitored.	Associate Clinical Director Obstetrics and Gynaecology	Complete			SOP in place which confirms attendance of consultant base don RCOG guidance 2021.		
26	Provider	IEA 3 Escalation & Accountability	5	There must be clear local guidelines detailing when the Consultant Obstetrician and the Midwifery Manager on-call should be informed of activity within the unit.	WHH have implemented guideline for when Consultant obstetrician is on call. Review diverts and escalations as necessary.	Director of Midwifery and Associate Chief Nurse	Complete but continual Process			NW regional escalation and divert policy rolled out across the organisation and included in the new Bleep holder SOP. Birth rate + app to be implemented. Training arranged for 5/7/2022, roll out Autumn 2022.		
27	Provider	IEA 4 Clinical Governance - Leadership	1	Trust Boards must work together with Maternity Departments to develop regular progress and exception reports, assurance reviews and regularly review the progress of any	Monthly update reports to Quality Assurance Committee-opportunity for escalation to Board if necessary. Quarterly Maternity Board updates using LMNS template.	Director of Midwifery and Associate Chief Nurse	Complete but continual Process			DoM present MTP update, and national safety agenda reports monthly to Quality Assurance Committee and bi-monthly updates to Trust board		

				maternity improvement and transformation plans								
28	Provider	IEA 4 Clinical Governance - Leadership	2	All maternity service senior leadership teams must use appreciative inquiry to complete the National Maternity Self-Assessment Tool if not previously done. A comprehensive report of their self-assessment including governance structures and any remedial plans must be shared with their Trust board	National Maternity Self-Assessment Tool to be reported to Trust Board with any exception reports -1/4 submissions.	Director of Midwifery and Associate Chief Nurse	Complete but continual Process			Maternity self-assessment tool completed, and action plan monitored through QAC and Trust Board. Submitted in January 2022. To be submitted again in August - 1/4 from this point		
30	Provider	IEA 4 Clinical Governance - Leadership	4	All clinicians with responsibility for Maternity Governance must be given sufficient time in their job plans to be able to engage effectively with their management responsibilities	Planned activity programmed within job descriptions.	Clinical Director W&C	Complete			Governance Lead for maternity has protected time/PA and specialist leads.		

31	Provider	IEA 4 Clinical Governance - Leadership	5	All Trusts must ensure that those individuals leading maternity governance teams are trained in human factors, causal analysis and family engagement.	Training to be scoped.	Director of Governance	31/12/2022			Scoping in progress		
33	Provider	IEA 4 Clinical Governance - Leadership	7	All maternity services must ensure they have midwifery and obstetric co-leads for audits	WHH have a consultant audit lead. Recruit to a midwifery audit lead.	CBU Business Manager W&C	06/07/2022			Audit leads in place in some speciality and areas. To be reviewed alongside recruitment of audit midwife.		
34	Provider	IEA 5 Clinical Governance - Incident Investigating and Complaints	1	All maternity governance teams must ensure the language used in investigation reports is easy to understand for families, for example ensuring any medical terms are explained in lay terms.	Governance Leads to continue to work alongside wider Governance Team for quality assurance as well as content.	Lead Midwife for Governance	Complete but continual Process			Process in place - Exec sign off at weekly Safety Oversight Group.		
35	Provider	IEA 5 Clinical Governance - Incident Investigating and Complaints	2	Lessons from clinical incidents must inform delivery of the local multidisciplinary training plan.	Embed lessons learned into mandatory training. Quarterly Learning from Experience Report presented at Quality Assurance Committee and Trust Board.	Obstetric Governance Lead	Complete but continual Process			Monthly meetings with Governance Lead fed into training package, audit of training through SIM and future incidents. Sharing of LFE process established.		

36	Provider	IEA 5 Clinical Governance - Incident Investigating and Complaints	3	Actions arising from a Serious Incident investigation which involve a change in practice must be audited to ensure a change in practice has occurred.	Embed action plans from SI's into clinical practice. All SI's to be discussed at Governance Meeting for completion of actions with evidence. Audit of actions to be taken as dip sample bi-monthly. All maternity SIs shared with Trust Board	Consultant Midwife	Complete but continual Process			Governance processes well established and in place		
37	Provider	IEA 5 Clinical Governance - Incident Investigating and Complaints	4	Change in practice arising from an SI investigation must be seen within 6 months after the incident occurred.	Audit as above Establish Training Faculty Task and Finish group to embed and oversee learning from SI investigations. Develop action plan and tracker to monitor trajectory and report quarterly to W&C Governance meeting.	Obstetric Governance Lead	Continual Process			Lessons learned shared and personalised development plans implemented for individuals involved in incidents as appropriate. To be part of a formal audit process once Audit Midwife in post. Education Task & Finish group set up July 2022, draft TOR to be shared and develop action plan		
38	Provider	IEA 5 Clinical Governance - Incident Investigating and Complaints	5	All Trusts must ensure that complaints which meet SI threshold must be investigated as such	All complaints are monitored through the Trusts Complaints Team. Triage process in place to identify when complaint should transfer to incident process.	Lead Midwife for Governance	Complete			Complaint / incident triage process well embedded.		

39	Provider	IEA 5 Clinical Governance - Incident Investigating and Complaints	6	All maternity services must involve service users (ideally via their MVP) in developing complaints response processes that are caring and transparent	Continue to develop MVP relationship Regular meetings with the MVP take place (monthly) regular input from the MVP such as Fifteen Steps to obtain independent feedback. Continue to receive feedback from the MVP Chair from Patients/Families contacting through their email / social media. Feedback to the Consultant Midwife. Develop link to maternity Quality/Governance themed feedback session. Fresh eyes review of complaints	Consultant Midwife	Complete but continual Process			MVP Chair ToR approved, calendar of events scheduled, quarterly MVP meetings facilitated, 15 steps undertaken and Maternity Survey action plan codeveloped with MVP. Next step to facilitate attendance at Governance meetings and input to complaints process.		
40	Provider	IEA 5 Clinical Governance - Incident Investigating and Complaints	7	Complaint's themes and trends must be monitored by the maternity governance team.	Monitored through Governance meetings. Daily review of Governance dashboard. Daily review of datix. Departmental complaints process. Bi-monthly report of themes to be provided by the governance team.	Obstetric Governance Lead	Complete but continual Process			Governance meetings in place which review themes and trends. Cases are used as part of MDT training. Governance dashboards in place.		

41	National	IEA 6 Learning from Maternal Deaths	1	NHS England and Improvement must work together with the Royal Colleges and the Chief Coroner for England and Wales to ensure that this is provided in any case of a maternal death.		National			National			
42	National	IEA 6 Learning from Maternal Deaths	2	The joint review panel/investigation must have an independent chair, must be aligned with local and regional staff and seek external clinical expert opinion where required.		National			National			
43	National	IEA 6 Learning from Maternal Deaths	3	Learning from this review (NHSE/I led as above) must be introduced into clinical practice within 6 months of the completion of the panel. The learning must also be shared across the LMS. (As in 90 below)		National			National			

44	Joint Provider/LMNS	IEA 7 Multidisciplinary Training	1	All members of the Multidisciplinary Team working within maternity should attend regular joint training, governance and audit events. Staff should have allocated time in job plans to ensure attendance, which must be monitored.	Facilitate MDT training and ensure the training faculty has MDT representation. Provide quarterly training report to W&C governance committee.	Associate Clinical Director Obstetrics and Gynaecology	30/09/2022		,	Allocation of lead roles for simulation fetal surveillance. Allocation of rota time to facilitate training/SIM. All consultants have 1.5 SPA allocation in their job plans and are compliant. Review to be completed to improve midwifery attendance.		
45	Joint Provider/LMNS	IEA 7 Multidisciplinary Training	2	Multidisciplinary training must integrate the local handover tools (such as SBAR) into the teaching programme at all Trusts.	Develop a learning directory consisting of lessons learned following incidences and investigation reports. Share single point of learning slides across the CBU using an SBAR approach.	Practice Development Midwife	Complete	31/07/2022		SBAR integrated throughout MDT training. Lessons learned shared monthly via Microsoft forms. Evidence to be collated.		
46	Joint Provider/LMNS	IEA 7 Multidisciplinary Training	3	All Trusts must mandate annual human factor training for all staff working in a maternity setting; this should include the principles of psychological safety and upholding civility in the workplace, ensuring staff are enabled to escalate clinical concerns. The content of human	Facilitate human factor training within all mandatory training programmes and ensure training is agreed with the LMS.	Practice Development Midwife	15.12.22			HF training incorporated into full day Obstetric Emergency/PROMPT training. Incorporated in maternity simulation and fetal monitoring training. Faculty of staff. Further development in relation to workplace culture and civility to be implemented		

				factor training must be agreed with the LMS.								
47	Joint Provider/LMNS	IEA 7 Multidisciplinary Training	4	There must be regular multidisciplinary skills drills and on-site training for the management of common obstetric emergencies including haemorrhage, hypertension and cardiac arrest and the deteriorating patient.	Develop annual skills drills schedule to include haemorrhage, hypertension and cardiac arrest and the deteriorating patient, and common obstetric emergencies.	Practice Development Midwife	Complete	30/07/2022		3 yearly programmes of annual skills drills developed directly linked to incidents, MIS standards/Core competencies. Insitu SIMS.		
48	Provider	IEA 7 Multidisciplinary Training	5	There must be mechanisms in place to support the emotional and psychological needs of staff, at both an individual and team level, recognising that well supported staff teams are better able to consistently deliver kind and compassionate care.	Facilitate a listening event to ascertain the emotional and psychological needs of the workforce. Develop an action plan to address themes raised and identify resources to support these. Signpost all staff to Trust established wellbeing facilities.	CBU Manager	25.11.2022			Renewed induction process in place from August 2022 alongside updated 1:1 process and staff welfare offer.		

49	Joint Provider/LMNS	IEA 7 Multidisciplinary Training	6	Systems must be in place in all Trusts to ensure that all staff are trained and up to date in CTG and emergency skills.	All clinical staff to undertake CTG training and emergency skills annually. Provide quarterly training update reports to W&C governance committee- link to any incidents/ complaints and monitor compliance.	Fetal Surveillance Lead Midwife / Practice Development Midwife	30/09/2022			Annual programme in place to deliver fetal monitoring training in line with the standards outlined in the SBL and MIS. PROMPT training delivered encompassing all recommendations from the core competency framework. Staff are rostered to attend this training and compliance is reported monthly. Where non-compliance is identified this is managed as per Trust SOP.		
50	Multiagency	IEA 7 Multidisciplinary Training	7	Clinicians must not work on Labour Wards or provide intrapartum care in any location without appropriate regular CTG training and emergency skills training. This must be mandatory.	All staff must declare if they have not undertaken appropriate CTG and emergency skills training to prioritise allocation of mandatory training. This will be reviewed on internal training database.	Fetal Surveillance Lead Midwife	Continual Process			Annual skills drills schedule and fetal monitoring action plan in place for all intrapartum care midwives to be up to date with CTG/Emergency skills training scheduled 4th & 18th July will achieve full compliance for midwives providing intrapartum care. Annual skills drills schedule and fetal monitoring action in place for obstetrics and training scheduled for all non-compliant staff. All Obstetric colleagues now booked on sessions. Escalation for noncompliance in place via Consultant Midwife.		

51	Provider	IEA 8 Complex Antenatal Care	**1**	Women with pre-existing medical disorders, including cardiac disease, epilepsy, diabetes and chronic hypertension, must have access to preconception care with a specialist familiar in managing that disorder and who understands the impact that pregnancy may have.	No further actions required as medical pathways embedded	Consultant Physician with specialist interest in maternal medicine	Complete			We cannot debrief all women with all these conditions and are not required to. We have 2 preconception services. One through the labour ward lead who has an interest in maternal medicine and the consultant physician who is an endocrinologist sees women periconceptually to optimise their health. we are part of the NW maternal medicine network and can refer to tertiary preconception services for certain conditions e.g., cardiac. Preconception clinic s are included in both job plans of both doctors		
52	Provider	IEA 8 Complex Antenatal Care	**2**	Trusts must have in place specialist antenatal clinics dedicated to accommodating women with multifetal pregnancies. They must have a dedicated consultant and have dedicated specialist midwifery staffing. These recommendations are supported by the NICE Guideline Twin and	Review multiple pregnancy pathway and amend accordingly in line with RCOG/NICE guidance.	Lead Obstetrician for Multiple Pregnancies	31/08/2022			WHH are compliant with NICE guidance 2019. Recruitment ongoing for Twin midwife. Role being covered by ultra-sonographer at present as contingency plan. We have signed up to complete the Twins Trust Audit.		

				Triplet Pregnancies 2019								
53	Provider	IEA 8 Complex Antenatal Care	**3**	NICE Diabetes and Pregnancy Guidance 2020 must be followed when managing all pregnant women with pre-existing diabetes and gestational diabetes.	Annual audit of diabetes pathway	Consultant Physician with specialist interest in maternal medicine	Complete but continual Process			WHH are compliant with NICE guidance.		
54	Provider	IEA 8 Complex Antenatal Care	**4**	When considering and planning delivery for women with diabetes, clinicians should present women with evidence-based advice as well as relevant national recommendations. Documentation of these joint discussions must be made in the woman's maternity records.	Audit shared decision making in clinical records. Quarterly audit to be undertaken in first instance. There is a joint specialist field within Badgernet EPR.	Consultant Midwife	15/9/2022 - continual Process			Badgernet capability utilised to share information and to document discussions. Audits to confirm assurance.		

55	Provider	IEA 8 Complex Antenatal Care	**5**	Trusts must develop antenatal services for the care of women with chronic hypertension. Women who are identified with chronic hypertension must be seen in a specialist consultant clinic to evaluate and discuss risks and benefits to treatment. Women must be commenced on Aspirin 75-150mg daily, from 12 weeks gestation in accordance with the NICE Hypertension and Pregnancy Guideline (2019).	Undertake audit of women re compliance of Chronic Hypertension pathway every 3 years	Consultant Physician with specialist interest in maternal medicine	Complete but continual Process			WHH are compliant with NICE guidance. NICE guidance to be adhered to and audited every 3 years due to small numbers of women with chronic hypertension (Approximately 20 per year)		
56	Joint Provider/LMNS	IEA 9 Preterm Birth	**1**	Senior clinicians must be involved in counselling women at high risk of very preterm birth, especially when pregnancies are at the thresholds of viability.	Complaints and incidents to be monitored reflective of these themes alongside compliments received. To be evidenced in documentation and audited 6 monthly.	Lead Obstetrician for Preterm Birth Clinic	Complete but continual Process			.		

57	Joint Provider/LMNS	IEA 9 Preterm Birth	**2**	Women and their partners must receive expert advice about the most appropriate fetal monitoring that should be undertaken dependent on the gestation of their pregnancies and what mode of delivery should be considered.	Rita we will need to audit this. What interval would you recommend?	Lead Obstetrician for Preterm Birth Clinic	10/01/2023			WHH use the tertiary unit extreme preterm birth pathway to have the consultation with the women and families, jointly in consultation with the neonatal team, to plan care.		
58	Joint Provider/LMNS	IEA 9 Preterm Birth	**3**	Discussions must involve the local and tertiary neonatal teams, so parents understand the chances of neonatal survival and are aware of the risks of possible associated disability.	Audit maternal records 6 monthly of discussions held with women or likely to be admitted pre term labour.	Consultant Neonatal Lead	15.11.2022					
59	Multiagency	IEA 9 Preterm Birth	**4**	There must be a continuous audit process to review all in utero transfers and cases where a decision is made not to transfer to a Level 3 neonatal unit and when delivery subsequently occurs in the local unit.	Continuous audit. Present quarterly HLBP to Perinatal Morbidity and Mortality meetings	Lead Obstetrician for Preterm Birth Clinic	30.7.2022			Information reported on Activity and Demand Capacity Report to ODN and information from Badger Net. Continuous audit in process		

60	Provider	IEA 10 Labour and Birth	**1**	All women must undergo a full clinical assessment when presenting in early or established labour. This must include a review of any risk factors and consideration of whether any complicating factors have arisen which might change recommendations about place of birth. These must be shared with women to enable an informed decision re place of birth to be made	6 monthly BSOTS audit for assurance of full clinical assessment with evidence of informed decision making. Criteria of risk factors for audit to be determined with identification of place of birth. Continue to engage with National Mateo Sip project. Continue to use MEOWS system to identify deterioration.	Birth Suite Manager	15.11.2022			BSOTs system in place which includes initial and ongoing risk assessment for any presentation in early labour. This is embedded in antenatal and intrapartum records in Badgernet. Use of MEOWS system throughout labour to identify deteriorating patient. WHH are engaging national Mateo Sip project.		
61	Provider	IEA 10 Labour and Birth	**2**	Midwifery-led units must complete yearly operational risk assessments.	Risk assessments to be completed annually. To be presented at governance meetings and Quality Assurance Committee.	Consultant Midwife	Ongoing - annual. Initial assessment 10.7.22					
62	Provider	IEA 10 Labour and Birth	**3**	Midwifery-led units must undertake regular multidisciplinary team skill drills to correspond with the training needs analysis plan	Scheduled programme of MDT skill drills to be undertaken. Feedback learning to CBU with any actions for improvement.	Practice Development Midwife	30.7.2022			Schedule of skill drills planned and in place. Neonatal skill drill undertaken July 12th. Schedule planned for year		

63	Provider	IEA 10 Labour and Birth	**4**	It is mandatory that all women who choose birth outside a hospital setting are provided accurate and up to date written information about the transfer times to the consultant obstetric unit. Maternity services must prepare this information working together and in agreement with the local ambulance Trust	Homebirth team/community risk assess at the point of booking and throughout the pregnancy. Transfer times are a major part of this process. MDT working with NWAS development of Consultant Midwife WHH/NWAS to ensure seamless care plans for any complex home confinements.	Consultant Midwife	31/08/2022				
64	Provider	IEA 10 Labour and Birth	**5**	Maternity units must have pathways for induction of labour, (IOL). Trusts need a mechanism to clearly describe safe pathways for IOL if delays occur due to high activity or short staffing.	Continue to implement and evidence Induction of Labour pathway. Delays to be red flagged forming part of C&M Escalation Policy.	Deputy Head of Midwifery	Complete - process in place			Clear and accessible IOL guidelines in place. Escalation processes embedded.		
65	Provider	IEA 10 Labour and Birth	**6**	Centralised CTG monitoring systems must be made mandatory in obstetric units across England to ensure regular multi-professional review of CTGs	No further action required. WHH has completed procurement process of monitoring systems. We have implemented a centralised CTG monitoring and archiving system	Fetal Surveillance Lead Midwife/Digital Midwife	31/08/2022			The launch of the Badgernet EPR has added full central monitoring functionality. Consistency needs to be gained ensuring all CTG's are linked to the central system, there is ongoing training and education to embed this practice. An SOP supporting the functionality needs to be written to guide	

										appropriate use and escalation when concerns are identified.		
66	Provider	IEA 11 Obstetric Anaesthesia	**1**	Conditions that merit further follow-up include, but are not limited to, postural puncture headache, accidental awareness during general anaesthesia, intraoperative pain and the need for conversion to general anaesthesia during obstetric interventions, neurological injury relating to anaesthetic interventions, and significant failure of labour analgesia	WHH have a joint audit every September and therefore annual audit of these cases should be presented to the joint obstetric /anaesthetic audit meeting. Review findings of ACSA accreditation programme (recently undertaken, pending report).	Obstetric Anaesthetic Lead	ACSA completed in March 2022 - audit continual process			All women are followed up after regional or general anaesthesia (spinal/epi/ga) utilising Badgernet. Any ongoing issues are documented, also handed over on the Pando app. Clinics are available for post-natal follow up.		

67	Provider	IEA 11 Obstetric Anaesthesia	**2**	Anaesthetists must be proactive in recognising situations where an explanation of events and an opportunity for questions may improve a woman's overall experience and reduce the risk of long-term psychological consequences.	To be captured as part of anaesthetic audit and continual review of internal data intelligence (ACSA) - Completion of action plan.	Obstetric Anaesthetic Lead	28.7.2022			All women are followed up after regional or general anaesthesia (spinal/epi/ga) utilising Badgernet. Any ongoing issues are documented, also handed over on the Pando app. The maternity on call is also available 24/7 to review women who present with any post anaesthetic complications. Debriefs are available both while an inpatient or via clinics in the post-natal period.		
68	Provider	IEA 11 Obstetric Anaesthesia	**3**	All anaesthetic departments must review the adequacy of their documentation in maternity patient records and take steps to improve this where necessary as recommended in Good Medical Practice by the GMC	Present anaesthetic audit annually at Women's and Children Audit Meeting	Obstetric Anaesthetic Lead	Continual Process			Documentation was reviewed as part of ACSA assessment in March and is compliant.		
69	National	IEA 11 Obstetric Anaesthesia	**4**	Resources must be made available for anaesthetic professional bodies to determine a consensus regarding contents of core datasets and what constitutes a satisfactory		National						

				anaesthetic record in order to maximise national engagement and compliance.								
70	Provider	IEA 11 Obstetric Anaesthesia	**5**	Obstetric anaesthesia staffing guidance to include: • The role of consultants, SAS doctors and doctors-in-training in service provision, as well as the need for prospective cover, to ensure maintenance of safe services whilst allowing for staff leave. • The full range of obstetric anaesthesia workload including, elective caesarean lists, clinic work, Labour Ward cover, as well as teaching, attendance at multidisciplinary training, and governance activity. • The competency required for consultant staff who cover	Review ACSA accreditation report when received. Review of job descriptions Review of rotas Review of ward round attendance - spot checks Audit of MDT handovers	Obstetric Anaesthetic Lead	15.12.2022			WHH has an anaesthetic staffing rota covering maternity. This was reviewed at ACSA and deemed compliant. 10 consultant sessions are covered, and Speciality Anaesthetic dress cover out of hours with consultant anaesthetic cover. All those providing on call cover required to complete PROMPT yearly. The anaesthetic team attend the twice daily ward round. Obstetric Anaesthetist Lead attends governance meetings, intrapartum forum and rapid reviews etc.		

				obstetric services out of hours, but who have no regular obstetric commitments. • Participation by anaesthetists in the maternity multidisciplinary ward rounds as recommended in the first report								
71	Provider	IEA 12 Postnatal Care	**1**	All Trusts must develop a system to ensure consultant review of all postnatal readmissions, and unwell postnatal women, including those requiring care on a non-maternity ward	Continue to implement Consultant ward rounds when on call, inclusive of all postnatal readmissions. Audit compliance of consultant on call SOP.	Obstetric Governance Lead	15/10/2022 continual Process			Consultant On Call sop has been approved. To be uploaded to the hub and disseminated to the team.		

72	Provider	IEA 12 Postnatal Care	**2**	Unwell postnatal women must have timely consultant involvement in their care and be seen daily as a minimum	Case notes review and audit - quarterly Rita How often do you recommend we audit this?	Obstetric Governance Lead	15/10/2022 continual Process			Ward round and handover SOP has been approved through Governance in March 2022. Uploaded to the Hub		
73	Provider	IEA 12 Postnatal Care	**3**	Postnatal readmissions must be seen within 14 hours of readmission or urgently if necessary	Case notes review and audit quarterly. Audit compliance of consultant on call SOP. How often?	Obstetric Governance Lead	15/10/2022 continual Process			Ward round and handover SOP has been approved through Governance in March 2022. Uploaded to the Hub		
74	Provider	IEA 12 Postnatal Care	**4**	Staffing levels must be appropriate for both the activity and acuity of care required on the postnatal ward both day and night, for both mothers and babies.	Implement Bitrate Plus acuity tool for postnatal and intrapartum areas. Train staff on use of tool.	Deputy Head of Midwifery	01/11/2022			Daily walkaround completes alongside daily review of future staffing across the inpatient areas. Daily bleep holder rota to provide support decision-making around redeployment requirements. New BR+ App to be installed. Staff trained on 5th July. Pending implementation Autumn		
75	Provider	IEA 13 Bereavement Care	**1**	Trusts must provide bereavement care services for women and families who suffer pregnancy loss. This must be available daily, not just Monday to Friday.	Bereavement midwife to be in place. Scope expansion of Bereavement Service to extend further.	Bereavement Midwife	31/10/2022			Full time specialist bereavement post in establishment. We have 1 WTE - 2 posts National guidelines in place to support staff out of hours. Bereavement training included in mandatory training. Next steps to explore link midwives/MSWs and ensure training compliancy.		

										Explore additional service cover.		
76	Provider	IEA 13 Bereavement Care	**2**	All Trusts must ensure adequate numbers of staff are trained to take post-mortem consent, so that families can be counselled about post-mortem within 48 hours of birth. They should have been trained in dealing with bereavement and in the purpose and procedures of post-mortem examinations.	Gap analysis to be undertaken for assurance of current position. Training trajectory to be in place with reporting through Quality Assurance Committee. Training analysis required for both bereavement and consent.	Bereavement Midwife	20/10/2022			All Obstetric Specialists have regional training and consultants have Advanced Skills Training in line with RCOG requirements.		
77	Provider	IEA 13 Bereavement Care	**3**	All Trusts must develop a system to ensure that all families are offered follow-up appointments after perinatal loss or poor serious neonatal outcome	WHH have implemented this service Quarterly PMRT reports shared with Quality Assurance Committee and Trust Board.	Bereavement Midwife	Complete - ongoing process			All families are offered follow up appts as part of the national bereavement care pathway. Bereavement Support coordinator collaborates with Obstetric consultant to deliver all clinical results and support family in the post-natal period.		

78	Provider	IEA 13 Bereavement Care	**4**	Compassionate, individualised, high quality bereavement care must be delivered for all families who have experienced a perinatal loss, with reference to guidance such as the National Bereavement Care Pathway	WHH have implemented this pathway and audit Quarterly PMRT reports shared with Quality Assurance Committee and Trust Board.	Bereavement Midwife	Complete - ongoing process			All families are offered follow up appts as part of the national bereavement care pathway. Bereavement Support coordinator collaborates with Obstetric consultant to deliver all clinical results and support family in the post-natal period.		
79	Multiagency	IEA 14 Neonatal Care	**1**	Neonatal and maternity care providers, commissioners and networks must agree on pathways of care including the designation of each unit and on the level of neonatal care that is provided.		LMNS/ODN						
80	Multiagency	IEA 14 Neonatal Care	**2**	Care that is outside this agreed pathway must be monitored by exception reporting (at least quarterly) and reviewed by providers and the network. The activity and results of the reviews must be reported to commissioners and the Local Maternity Neonatal Systems (LMS/LMNS) quarterly.		LMNS/ODN						

81	Multiagency	IEA 14 Neonatal Care	**3**	Maternity and Neonatal services must continue to work towards a position of at least 85% of births at less than 27 weeks gestation taking place at a maternity unit with an onsite NICU.	Review ODN Neonatal reports and develop necessary action plans. All singleton pregnancies with <27-week gestation and <28 weeks for multiple pregnancies to be delivered at tertiary hospital as per the network guidelines. Any attendance with threatened labour is transferred in utero to tertiary hospitals if safe to do so. If any emergencies and needs delivering imminently, babies are stabilised and transferred with the support of regional transport team Connect Northwest. Exception reporting to be completed and maintained.	Consultant Neonatal Lead	Complete	31/08/2022		All singleton pregnancies with <27-week gestation and <28 weeks for multiple pregnancies are delivered at tertiary hospital as per the network guidelines. Any attendance with threatened labour is transferred in utero to tertiary hospitals if safe to do so. If any emergencies and needs delivering imminently, babies are stabilised and transferred with the support of regional transport team Connect Northwest. Exception reporting completed and maintained network have them and keeps the data.		

82	Multiagency	IEA 14 Neonatal Care	**4**	Neonatal Operational Delivery Networks must ensure that staff within provider units have the opportunity to share best practice and education to ensure units do not operate in isolation from their local clinical support network. For example, senior medical, ANNP and nursing staff must have the opportunity for secondment to attend other appropriate network units on an occasional basis to maintain clinical expertise and avoid working in isolation.		ODN				guideline		
83	Multiagency	IEA 14 Neonatal Care	**5**	Each network must report to commissioners annually what measures are in place to prevent units from working in isolation.		LMNS						

84	Multiagency	IEA 14 Neonatal Care	**6**	Neonatal providers must ensure that processes are defined which enable telephone advice and instructions to be given, where appropriate, during the course of neonatal resuscitations. When it is anticipated that the consultant is not immediately available (for example out of hours), there must be a mechanism that allows a real-time dialogue to take place directly between the consultant and the resuscitating team if required	Consultant to provide resident on call. All discussions to be recorded in notes and audited (dip sample). All Registrar and Consultant discussions to be documented in clinical record. Processes to be clearly defined and communicated to ensure all standards of recommendation are met.	Consultant Neonatal Lead	Complete	31/08/2022		Consultant provides resident on call until 2130 weekdays, until 1700 hrs weekends and bank holidays. All discussions regarding births/resuscitations are recorded on notes. If any births outside these hrs, registrar discusses with consultant who attends the birth, and all gets documented with timelines.		
85	Multiagency	IEA 14 Neonatal Care	**7**	Neonatal Practitioners must ensure that once an airway is established and other reversible causes have been excluded, appropriate early consideration is given to increasing inflation pressures to achieve adequate chest rise. Pressures above 30cmH2O in term babies, or above	Ensure compliance with Resuscitation Council UK Newborn Life Support requirements.	Consultant Neonatal Lead	Complete	31/08/2022		We practice this on all resuscitations and its part of NLS. Also discussed at inductions for juniors and mandatory training.		

				25cmH2O in preterm babies may be required. The Resuscitation Council UK Newburn Life Support (NLS) Course must consider highlighting this treatment point more clearly in the NLS algorithm.								
86	Provider	IEA 14 Neonatal Care	**8**	Neonatal providers must ensure sufficient numbers of appropriately trained Consultants, Tier 2 staff (middle grade doctors or ANNPs) and nurses are available in every type of Neonatal Unit (NICU, LNU and SCBU) to deliver safe care 24/7 in line with national service specifications.	Daily staffing review to be undertaken. Continue to report to Neonatal SITREP network. Escalation policy in place. Ensure recruitment is in accordance with BAPM Standards and any further staffing reviews.	Clinical Director W&C	29/11/2022			Recently recruited to two Neonatal consultants, awaiting start date. One post will support middle grade rota.		
87	Provider	IEA 15 Supporting Families	**1**	There must be robust mechanisms for the identification of psychological distress, and clear pathways for women and their families to access emotional support and specialist psychological support as appropriate.	Ensure Perinatal Mental Health provision. Ensure Bereavement Midwife Support. Develop pathways to support access to Perinatal Mental Health Services in the community.	Obstetrician PNMH Lead	30/10/2022			PMH pathway embedded, dedicated consultant with specialist interest in place with established link with the wider support and referral networks. Funding in place for PMH Midwife, recruitment ongoing. Consultant Midwife to support and ensure appropriate care planning		

										as part of MDT approach. Some process improvement to be implemented.		
88	Provider	IEA 15 Supporting Families	**2**	Access to timely emotional and psychological support should be without the need for formal mental health diagnosis, as psychological distress can be a normal reaction to adverse experiences.	Continue to implement Continuity of Carer, midwifery model. Ensure Perinatal Mental Health provision Ensure Bereavement Midwife Support. Develop pathways to support access to Perinatal Mental Health Services in the community.	Obstetrician PNMH Lead	30/10/2022			Robust care pathways in place, strong relationship with external support services. Consultant midwife offering debrief and referral service. Direct access to emergency psychological services and to longer term support services. Some process improvement to be implemented.		
89	Provider	IEA 15 Supporting Families	**3**	Psychological support for the most complex levels of need should be delivered by psychological practitioners who have specialist expertise and experience in the area of maternity care	Ensure Perinatal Mental Health provision. Ensure Bereavement Midwife Support. Develop pathways to support access to Perinatal Mental Health Services in the community.	Obstetrician PNMH Lead	30/09/2022			Local and perinatal mental health pathways embedded within the service. Experienced Obstetric lead in post and areas for development identified particularly in relation to acute inpatient services/Mother and baby unit admissions. Some process improvement to be implemented.		

Appendix 1

Board Assurance Framework

Board Assurance Framework

The Board Assurance Framework (BAF) focusses on the key strategic risks i.e. those that may affect the achievement of the Trust's Strategic Objectives

Risk ID	Executive Lead	Risk Description	Strategic Objective at Risk	Current Rating	Target Rating	Risk Appetite	Monitoring Committee
224	Daniel Moore	Failure to meet the four hour emergency access standard and incur recordable 12 hour Decision to Admit (DTA) breaches, caused by capacity constraints in the Local Authority, Private Provider and Primary Care capacity resulting in potential risks to the quality of care and safety to patient, staff health and wellbeing, Trust reputation, financial impact and below expected patient experience.	1	25 (5x5)	8 (2x4)	TBC	Clinical Recovery Oversight Committee
1215	Daniel Moore	Failure to deliver the capacity required caused by the ongoing COVID-19 pandemic and potential environmental constraints resulting in delayed appointments, treatments and potential harm	1	25 (5x5)	6 (3x2)	TBC	Quality Assurance Committee
1273	Daniel Moore	Failure to provide timely patient discharge caused by system-wide Covid-19 pressures, resulting in potential reduced capacity to admit patients safely.	1	25 (5x5)	5 (5x1)	TBC	Quality Assurance Committee
1275	Kimberley Salmon-Jamieson	If we do not prevent nosocomial Covid-19 infection, then we may cause harm to our patients, staff and visitors, which can result in extending length of inpatient stay, staff absence, additional treatment costs and potential litigation.	1	20 (4x5)	5 (5x1)	TBC	Quality Assurance Committee
1289	Daniel Moore	Failure to deliver planned elective procedures caused by the Trust not having sufficient capacity (Theatres, Outpatients, Diagnostics) resulting in potential delays to treatment and possible subsequent risk of clinical harm	1	20 (4x5)	5 (5x1)	TBC	Quality Assurance Committee
134	Andrea McGee	Financial Sustainability a) Failure to sustain financial viability, caused by internal and external factors, resulted in potential impact to patient safety, staff morale and enforcement/regulatory action being taken. b) Failure to deliver the financial position and a surplus places doubt over the future sustainability of the Trust. There is a risk that current and future loans cannot be repaid and this puts into question if the Trust is a going concern.	3	20 (5x4)	10 (5x2)	TBC	Finance & Sustainability Committee
1134	Michelle Cloney	Failure to provide adequate staffing caused by absence relating to COVID-19 resulting in resource challenges and an increase within the temporary staffing domain	2	20 (4x5)	8 (4x2)	TBC	Strategic People Committee

Board Assurance Framework

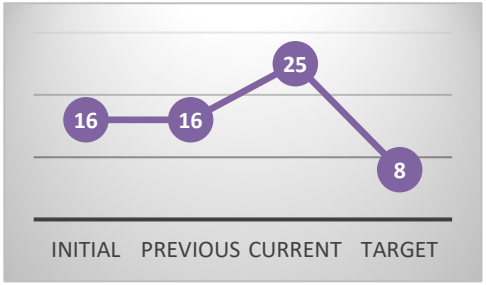
1114	Paul Fitzsimmons	FAILURE TO provide essential and effective Digital Services CAUSED BY increasing demands upon resources (e.g. cyber defences), new technology skillsets (e.g. Cloud), unfit solutions (e.g. Maternity), end-of-life solutions (e.g. Telephony), poor performance (e.g. Lorenzo EPR) RESULTING in a potentially reduced quality of care, data quality, a potential failure to meet statutory obligations (e.g. Civil Contingency measures) and subsequent reputational damage.	1	20 (5x4)	8 (2x4)	TBC	Finance & Sustainability Committee
1125	Daniel Moore	Failure to achieve constitutional access standards caused by the global COVID-19 Pandemic resulting in high attendances and occupancy, non-compliance for RTT, Diagnostics, Cancer and ED Performance	1	20 (5x4)	8 (2x4)	TBC	Clinical Recovery Oversight Committee
1079	Kimberley Salmon-Jamieson	If we do not provide an electronic patient record (EPR) system that can accurately monitor, record, track and archive antenatal (including booking information, intrapartum and postnatal care episodes because we have an IT system (Lorenzo) which is not maternity specific and does not have a robust internet connectivity, with inadequate support to cleanse data and no intra-operability between services, then we will be unable to capture all required data accurately, have a robust electronic documentation process in cases of litigation or adverse clinical outcome and poor data quality. In addition, inadequate communication with allied services, such as health visitors will be uninformed of women within the system requiring antenatal assessment. This can also result in women being allocated to the wrong pathway and the wrong payment tariff.	1	20(4x5)	2 (1x2)	TBC	Quality Assurance Committee
115	Kimberley Salmon-Jamieson	If we cannot provide minimal staffing levels in some clinical areas due to vacancies, staff sickness, patient acuity and dependency then this may impact the delivery of basic patient care.	1	16 (4x4)	12 (4x3)	TBC	Quality Assurance Committee
1372	Paul Fitzsimmons	If the Trust is unable complete a successful EPR strategic procurement project in line with the Trust's time, budget and quality requirements, due to: • An inability to develop an affordable business case due to, baseline costs, strong existing benefits & lack of new cash releasing benefits • An inability to garner ICS and NHSE support to progress the EPR business case • An inability to deliver Managed Convergence in line with emergent national policy and the ICS Convergence strategy (currently poorly defined and in development)	3	16 (4x4)	8 (2x4)	TBC	Finance & Sustainability Committee

Board Assurance Framework

		Then the Trust will be unable deliver a future Electronic Patient Record Solution Resulting (sequentially) • A continuation of the Trust's challenges with the incumbent EPR, Lorenzo (as identified in the Strategic Outline Case) • Potential for a costly extension to the existing Lorenzo contract or the highly retrograde step of returning to paper systems as Lorenzo will be at end of life at (or before) the end of the tactical contract extension					
1579	Daniel Moore	Failure of the Trusts ability to transfer patients with time critical urgent care needs to specialist units able to deliver time critical specialist interventions (Primary PCI, Hyperacute Stroke Intervention, Emergency Vascular Surgery, Major Trauma services etc) CAUSED BY an inability of the North West Ambulance Service, to provide the expected response times for critical transfers due to overwhelming demand on ambulance services, RESULTING IN a delay in transfer and thus potential severe patient harm due to the inability to access time critical specialist interventions without undue delay	1	16 (4x4)	8 (2x4)	TBC	Quality Assurance Committee
1233	Paul Fitzsimmons	If we bed the Combined Assessment Unit (CAU) then we will not have a suitable environment to review surgical patients in a timely manner resulting in a lack of surgical assessment bed capacity, poor patient experience, delays in treating surgical patients and increased admissions to the surgical bed base.	1	16 (4x4)	6 (2x3)	TBC	Quality Assurance Committee
125	Daniel Moore	Failure to maintain an old estate caused by restriction, reduction or unavailability of resources resulting in staff and patient safety issues, increased estates costs and unsuitable accommodation.	1	15 (3x5)	4 (4x1)	TBC	Executive Management Team
145	Simon Constable	If the Trust does not deliver our strategic vision, including two new hospitals and influence sufficiently within the Cheshire & Merseyside Integrated Care System (ICS) and beyond, the then Trust may not be able to provide high quality sustainable services resulting in a potential inability to provide the best outcome for our patient population, possible negative impacts on patient care, reputation and financial position.	3	12 (3x4)	8 (4x2)	TBC	Executive Management Team

Strategic Objective 1: We will… Always put our patients first delivering safe and effective care and an excellent patient experience.
Strategic Objective 2: We will… Be the best place to work with a diverse and engaged workforce that is fit for now and the future
Strategic Objective 3: We will...Work in partnership with others to achieve social and economic wellbeing in our communities.

Board Assurance Framework

Risk ID:	224	**Executive Lead:**	Moore, Daniel	**Rating**	
Strategic Objective:	Strategic Objective 1: We will… Always put our patients first delivering safe and effective care and an excellent patient experience.				
Risk Description:	Failure to meet the four hour emergency access standard and incur recordable 12 hour Decision to Admit (DTA) breaches, caused by capacity constraints in the Local Authority, Private Provider and Primary Care capacity resulting in potential risks to the quality of care and safety to patient, staff health and wellbeing, Trust reputation, financial impact and below expected patient experience.			**Initial:**	16(4x4)
				Current:	25(5x5)
				Target:	8 (2 x 4)
Assurance Details:	•Regular Trust Wide Capacity meetings led by the Senior Site Manager for the day •Systemwide relationships including social care, community, mental health and CCGs •Discharge Lounge/Patient Flow Team/Silver Command •ED Escalation Tool/2 Hourly Board Rounds ED Medical and Nursing •Controller •Private Ambulance Transport to complement patient providers out of hours •FAU/Hub operational from June 2018 - Now operating 5 days per week. •Discharge Lounge opened 26th November 2018 •Enhanced Paediatric ED opened in May 2021 that encompasses a larger footprint & more cubicle space. This supports compliance with RCEM guidance. •System actions agreed supporting the Winter Plan •Further development of Rapid Response to avoid admission •Increase IMC provided by the system such as the opening of the Lilycross site •Increase IMC at home •Regular monitored at the Mid Mersey A&E Board •Integrated Discharge Team – Daily huddle between hospital discharge team and the hospital social care team now in place. •Integrated Discharge Team – Daily huddle between hospital discharge team and the hospital social care team now in place. •The Trust participates at the system & regional UEC improvement meeting on each Wednesday •Redeveloped ED ‘at a glance’ dashboard •Trust implemented NHS 111 first successfully in August 2020 allowing for directly bookable ED appointments •Board approval of capital plan to build new £5m purpose built acute Medical Ambulatory Care area aka ED Plaza •Monitoring of utilisation of internal UC system i.e. GPAU, ED Ambulatory throughput. Reports monitored via Unplanned Care Group, ED & KPI Meetings •Integrated discharge Team now in place •Re-defined sections of ED to manage COVID-19 requirements and have the ability to segregate hot and cold COVID patients •ED Plan developed to manage surge in attendances should a further COVID-19 peak be realised. •Respiratory Ambulatory Care Facility agreed by CCG •Royal College Emergency Medicine Resetting ED Care guidance received, acted upon and achieved •Collaborative working with Orthopaedics in management ok MSK Minor injuries via Minor’s Stream •Reinstated CAU 24/7 •Upgrade to Minor’s resulting in Oxygen points in all cubicles •Non-Elective flow activity now above 2019/20 activity levels for type 1 & 3 •Meetings with senior leaders from the CCG and Local Authority to review and discharge taking place weekly. •Monthly Focus on Flow weeks scheduled every month until July 2022 • Additional Senior Manager on call support a weekends • Successful bid for c£618k to support urgent care pressure in H2 • Same Day Emergency Care Centre (SDEC) planned opening July 2022 • Command & Control initiative in place since 8th December 2022 and ongoing to support pathway 0 and pathway 1 discharges. This is creating necessary capacity to support wave 5. This is in line with national guidance.				

Board Assurance Framework

	• w/c 3rd January 2022 Ward B4 at Halton converted to provide additional G&A capacity (additional 27 beds) and flow in ED • To support capacity for Wave 5, elective activity moved to CSTM Halton facility to protect elective programme • Senior Dr at Triage Function. • Extended Minor Injuries and Minor Illness functions • Plan being worked up to utilise what will be the be old CAU as an additional area to support urgent care and decompression of A&E • Plans being progresses to procure and install a new CT scanner co-located in the main body of the ED department.. This will support increases urgent care pathway efficiency in the ED • Phlebotomy business case approved (5th May) to support earlier decision making and flow in AMU to support flow out of the ED for acute medical patients. • Plans to co-locate ED Minors in the SDEC building to enhance patient pathways being worked up for Winter 2022/23 • Revenue bid submitted to the ICS to open additional urgent care capacity (CAU) over Q3/4 2022/23	
Assurance Gaps:	•Staffing pressure created as a direct result of COVID-19 Global pandemic. •Confirmed exponential growth in types 1 & 3 as a result of population nedd and lack of access to Primary Care	

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Continued Escalation of Breaches and Patients Requiring Admission	Escalation of 4 hours quality standard and 12 hour decision to admit emergency access standard.	Escalation per ed safety escalation via Bed Meeting, Silver Command and SMOC (out of hours) and Executive on Call.	Field-Delaney, Sheila	30/09/2022	
Ongoing Monitoring of the Emergency Access Standard	ED Insight report daily SITREP report National report and benchmarking outcome UEC north dashboard Robust ongoing monitoring	Ongoing monitoring of risk via daily report SITREP, Daily Capacity and Demand report from 4* daily bed meetings. Weekly PRG	Field-Delaney, Sheila	30/09/2022	

Board Assurance Framework

Risk ID:	1215	**Executive Lead:**	Dan Moore	**Rating**
Strategic Objective:	Strategic Objective 1: We will… Always put our patients first delivering safe and effective care and an excellent patient experience.			
Risk Description:	Failure to deliver the capacity required caused by the on-going COVID-19 pandemic and potential environmental constraints resulting in delayed appointments, treatments and potential harm			**Initial:** 25 (5x5) **Current:** 25 (5x5) **Target:** 6 (3x2)

Assurance Details:

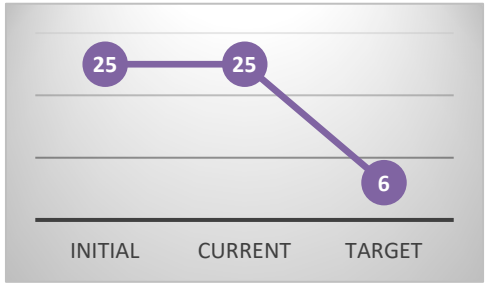
- Live dashboards and weekly activity reporting in place to ensure oversight and transparency of Trust recovery
- Operational planning to be monitored by Cheshire & Merseyside on a daily basis, by Cheshire & Merseyside elective restoration meeting weekly and the Clinical Recovery Oversight Committee (CROC) & Clinical Services Oversight Group (CSOG). This relates to elective surgical activity.
- Reviewing workforce pay incentives to create additional capacity in non-contracted work time e.g. evening and weekends. This links to the MIAA WLI Review & recent review of the rate card payments

Radiology

- New working arrangements are in place to maximise capacity whilst operating in line with IPC guidance.
- Department has been supported by the Trust through £380K recurrent funding to recruit additional staff. Advert out 11th June 2020. Recruiting 4 Radiographers, 2 Sonographers, 2 Healthcare Assistants.
- Additional staff will support additional capacity through extended working days across all scanners – currently unable to achieve this due to Covid-19 demands.
- All outstanding requests are clinically reviewed by Senior Consultant Radiologists as per local SOP. Exams are deferred in line with clinical priority. Cancer and Urgent patients are being imaged as per pre-Covid-19 as per national guidance.
- Those deferred patients are sent a letter informing of delay, and to contact their Doctor if any concern. The referrer of delayed patients are also sent a letter informing of delay, but this referrer letter includes a direct telephone number to the Senior Radiology Consultants, and also an email address should there be a concern with delaying. Any exams that are highlighted from referrers as not suitable for delay are appointed on the next available appointment.
- This delay process has been discussed via Medical Cabinet and agreed as most appropriate process.
- This clinical review and delay process is ongoing daily.
- Improvement against all modalities for numbers waiting more than 6 weeks noted.

Unplanned care

- The emergency department has been reconfigured to provide hot and cold areas to minimise nosocomial transmission – adults and paediatrics in line with Royal College of Emergency Medicine (RCEM) guidance.
- Minor injuries is provided in an area in close proximity but separate to the main emergency department. This has provided an opportunity to use the old minors department as Majors 2 to support management of surge demand and avoidance of corridor care.
- New working arrangements are in place to maximise capacity whilst operating in line with IPC guidance.
- In patient capacity is reviewed with the patient flow and CBU teams daily to ensure that there is adequate capacity for all patient groups to be admitted.
- ITU business continuity plans have been agreed to escalate critical care as and when required.
- Clinic templates have been revised to ensure social distancing measures are in place and patients are not brought to a face to face appointment unless clinically indicated. Virtual appointments are in place (telephone and video) for use where this is clinically appropriate.
- Suspected cancer, cancer and clinically urgent patients are allocated out patients and diagnostic appointments as a priority.
- Waiting lists are reviewed through the performance review group weekly – outpatients and diagnostics.
- Workforce is continually reviewed to ensure that all wards and teams are staffed safely.



Board Assurance Framework

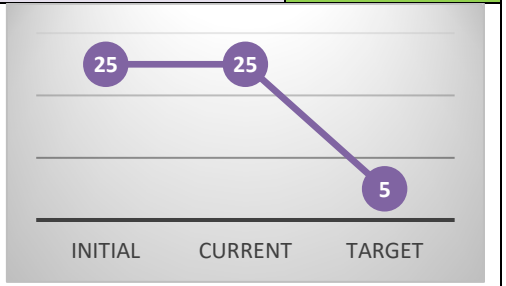
	• NHS 111 First pilot went live on 8th September 2020 to reduce attendances to the emergency department and to support the planning of activity in a more streamlined way to reduce overcrowding and risk of nosocomial infection. • Business Case for ED Plaza Scheme approved in 2021/22 Capital Plan • Reconfiguration of Paediatric ED completed and operational • Phase 2 ED Plaza commenced in October 2021. And due for completion in May 2022 • Deployment of Bioquell Pods in ICU live and operational Planned Care • Deployment of modular build at the Halton site to provide additional pre-operative assessment capacity in support of elective recovery. • All elective patients have been clinically reviewed and categorised in line with national guidance. • Suspected cancer, cancer and clinically urgent patients are treated as a priority. • Theatre capacity has been reviewed and additional capacity is now available with the de-escalation of the theatre PODs • The Halton site is being developed as a covid secure site and will be run as an Elective Centre. • Elective Surgery Standard Operating Procedure (SOP) in place • Capacity identified and being utilised at spire Healthcare • Clinical Services Oversight Group (CSOG) established • Clinical Recovery Oversight Committee (CROC) established • Clean/green pathways have been developed for those priority 2 patients (cancer & urgent) that cannot or are unable clinically to have their procedure undertaken at the Captain Sir Tom Moore site then they will be treated via Ward 5 on the Warrington site. This pathway is set to commence w/c 8th February and replaces the B18 pathway. • A separate pathway has been developed for Emergency surgery and future plans and bed base has been agreed as part of the ward reconfiguration process. • New working arrangements are in place to maximise capacity whilst operating in line with IPC guidance. • Workforce plans are continually reviewed to ensure that all wards and teams are staffed safely. • Waiting lists are reviewed through the performance review group weekly • Weekly theatre scheduling to ensure listing of patients in line with national guidance. • Post Anaesthetic Care Unit (PACU) operational from January 2021 • Continued use of the independent sector (Spire Cheshire) under new contract in 2021/22 with support from the CCG. • Participation in the national 'My Planned Care' scheme to support and inform patient waiting time status and support safe management of waiting lists. • Working in collaboration with system partners to increase adult social care capacity for pathway 1 & 2 categories of patients. This will in turn create additional capacity for managing the pandemic, restoration & recovery in Q3 2022/23 • New Clinical Treatment Suite opened in the Nightingale Building in May 2022 (capital investment of £145K) to support the reduction in chronic pain waiting lists an increase theatre capacity to support restoration and recovery.	
Assurance Gaps:	Radiology 1. Harm may be caused due to the incompleteness of clinical information on a referral. This may also be compounded by the referrer incorrectly entering the wrong priority code on the referral. • It is thought that the letter to the referrer will highlight the exam has been delayed and that the provision of a direct link to the Radiology Consultant team by phone/email will allow these cases to be expedited where appropriate. 2. Harm may be caused by the delay of a routine examination where there is an unlikley serious pathological finding present. • This risk is present in all routine exmas as the waiting time for routine diagnostic imaging is up to 6 weeks as per national targets. This risk is hightened due to Covid-19 and the reduced capacity at present. It is thought the letter to the patient advising to contact their Doctor with any concern will reduce this risk. Unplanned care 1. Estates work is required to complete the segregation of paediatric patients in the emergency department.	

Board Assurance Framework

	• This is being progressed with the support of the estates and capital planning team. 2. Expansion of the emergency department is required to ensure any increase in demand can be accomodated in line with RCEM guidance 3. Referrals do not include adequate information to triage and prioritise patietns appropriately • Regular meetings and communication with the CCG and GP's to inform them with recovery progress within the organisation and to highlight/address any identified problems 4. Reduction in face to face primary care appointments having a negative impact on increased attendances. 5. Capacity challenge with social workers to keep on top of demand and necessary patient assessments. 6. Estates work required to increase general ICU Capacity & ICU cubicle capacity e.g. Installation of Bioquell cubicles Planned Care 1. Estates work is required to complete the development of the Elective Centre at Halton and the reconfiguration of the day case facility. • This is being progressed with the support of the estates and capital planning team. 2. Waiting list do not include adequate information to triage and prioritise patients appropriately • Regular meetings and communication with the waiting list and scheduling teams and inform them of recovery plans and to highlight/address any identified problems 3. New framework for ISP will not include all specialties currently being undertaken. This will increase waiting list pressure for those specialties on this site.

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Working with wider system on wider sustainability	Recruit to Dom Care ICAHT & Discharge Team posts	Complete Recruitment	Dan Moore	31/03/2023	
Build Urinary Investigation Unit & Paediatric Outpatients (one footprint)	Complete building works	Complete Building work	Val Doyle	31/08/2022	

Board Assurance Framework

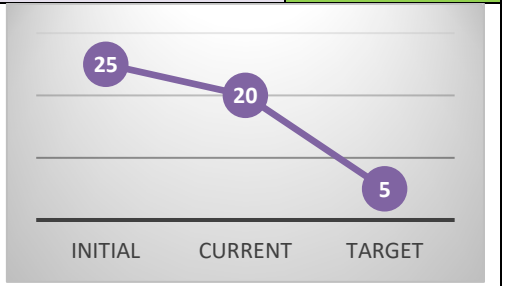
Risk ID:	1273	**Executive Lead:**	Moore, Daniel	**Rating**	
Strategic Objective:	Strategic Objective 1: We will… Always put our patients first delivering safe and effective care and an excellent patient experience.				
Risk Description:	Failure to provide timely patient discharge caused by system-wide Covid-19 pressures, resulting in potential reduced capacity to admit patients safely.			**Initial:**	25 (5x5)
				Current:	25 (5x5)
				Target:	5 (5x1)
Assurance Details:	Integrated Discharge Team comprising of hospital and Local Authority colleagues from Warrington and Halton to develop systems and process of discharge acknowledging difficulties of Covid-19. Daily system pressures meeting that reviews hospital and wider system bed capacity to support safe and timely discharge of patients from hospital to support flows Trust participates in Mid-Mersey Operational Group which supports Out of Hospital Cell discussions in relation to system discharge planning. The number of discharge delays in relation to Super Stranded patients is reported daily in the Executive Summary and reviewed so that Executive Directors can support and escalate pathway delays. 'Where's best next' event initiated in January 2021 with system partners to support safe discharge of patients with long lengths of stay to create capacity through December and January expected winter pressures and support wave 3. Scheme issued by the Government to support indemnity concerns of care homes in relation to caring for COVID-19 patients. It will support the system in the creation of COVID-19 designated setting capacity. New 'Discharge to Assess' process has gone live to reduce the length of stay for a cohort of patients who would otherwise be assessed in hospital can be assessed in a transitional care bed. Progressing the procurement of a new software programme which will be able to accurately track and share system delays with partners. By improving information, it will enable quicker and more effective decisions on discharges. Meetings with senior leaders from the CCG and Local Authority to review and discharge taking place weekly. Monthly Focus on Flow weeks scheduled every month until July 2022 Daily bed meetings organised by the Director of Operations & Performance to provide timely and effective benefits to patient flow Approval of IMC business case which will support a reduction in frailty length of stay and admission avoidance through geriatric input in to the Emergency Department. 500-700 additional domiciliary care hours to be released from w/c 6th December 2021 to support reducing long length of stay and super stranded patients Command & Control initiative in place since 8th December 2022 and ongoing to support pathway 0 and pathway 1 discharges. This is creating necessary capacity to support wave 5. This is in line with national guidance. w/c 10th January 2022, the Trust is supporting system designation of the Lilycross facility as being able to receive COVID positive patients. This is supporting wave 5 bed capacity. Working closely with Warrington Borough Council on a short, medium and long term solution to community bed capacity, matching demand to capacity. An increase in capacity in the community and a decrease in community prevalence and transmission has resulted in almost all the Care Homes in Warrington & Halton to be open. This has seen a decrease in the number of super stranded patients form a peak of 170 to 115 (03.03.22) Revenue investment to be proposed to increase the Hospital Discharge Team . This would increase the number of discharges and reduced length of stay. Working with system partners to double the amount of intermediate care at home capacity by Quarter 3 2022/23 System-wide agreement to invest in Dom Care ICHAT & Discharge Team recruitment now underway and set to complete in Q4 2023 Funding agreed by Warrington Borough Council to keep Lilycross open for 2022/23				

Board Assurance Framework

	Trust Executive approval to keep Ward B3 open for 2022/23	
Assurance Gaps:	Delays in discharge caused by adherence to Covid-19 infection control pathways and the patient's Covid-19 status. Intermediate Care and other community capacity impacted and restricted by Covid-19 e.g. Care Home and other facility closures due to outbreaks. Access to community capacity impacted by Covid-19 as a result of staff sickness Internal staff shortages to help support discharge planning. Restricted as a result of Covid-19 sickness and self-isolation High number of patients in Warrington awaiting social work assessment, causing a delay in discharges from the acute site in to care homes and intermediate care capacity Significantly reduced capacity in the domiciliary care market due to the high number of vacancies. This is causing package of care delays.	

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Working with wider system on wider sustainability	Recruit to Dom Care ICAHT & Discharge Team posts	Complete Recruitment	Dan Moore	31/03/2023	

Board Assurance Framework

Risk ID:	1275	**Executive Lead:**	Salmon-Jamieson, Kimberley	**Rating**
Strategic Objective:	Strategic Objective 1: We will… Always put our patients first delivering safe and effective care and an excellent patient experience.			
Risk Description:	If we do not prevent nosocomial Covid-19 infection, then we may cause harm to our patients, staff and visitors, which can result in extending length of inpatient stay, staff absence, additional treatment costs and potential litigation.			**Initial:** 25 (5x5) **Current:** 20 (4x5) **Target:** 5 (5x1)
Assurance Details:	Triage and testing on emergency admission using molecular and PCR testing. Planned procedure testing SOP Guidance for staff returning to on-site working (previously considered extremely vulnerable) COVID-19 incidents are monitored daily. Risk assessments are in place in all Wards/Departments and rest rooms and have been revised as per hierarchies of control. Mask stations and santiser remain in place at all entrances and designated points throughout the Trust. Agile working policy is in place. Information technology infrastructure is in place to support remote working. Risk assessment in place to support safe visiting. Providing and maintaining a clean environment that facilitates the prevention and control of infections. Communications through TWSB to staff reinforcing updates to Covid-19 SOPs. Environmental Safety Action plan in place reported by exception to Silver Infection Control. Outbreak meetings held with lessons learned shared across the Trust. PPE audits completed weekly on wards and increased frequency during outbreaks. PPE & swabbing champions identified. Clear curtains are in place in all wards as a form of mitigation whilst maintaining patient privacy and dignity with existing curtains. Process for assurance of 3 and 5 day swabs in place. Bioquell Pods now in place in ICU, ED and B18. Trust completed learning from Nosocomial outbreaks sessions. COVID-19 quality metrics in place. Cohorting of COVID-19 positive patients in place. Surveillance of patient in bays for 7 days following Covid-19 exposure. Risk assessment in place for use of beds in Covid-19 exposed bays to protect immunosuppressed and unvaccinated patients. Asymptomatic staff testing using Lateral Flow Device testing is encouraged. Revised guidance in place for respiratory and non-respiratory pathway. Testing amended to included Influenza A&B & RSV. Agreed patient flow pathways based on results of screening. IPC Team liaison with clinical teams on AGP precautions IPC Team liaise with Patient Flow Team on patient placement FFP3 fit testing programme in place. Staff training in safe donning and doffing of PPE is included in mandatory training Updated IPC measures in place including the relaxation of mask wearing in certain areas of the Trust, a return to pre pandemic visiting arrangements and 1 relative/carer to accompany patients in the Emergency Department. Updates to Trust Guidance/SOPs in line with publication of national guidance and upload to the Hub			
Assurance Gaps:	Increased risk from return to pre-pandemic standards with removal of social distancing requirements, removal of universal masking and opening up visiting Non-compliance with PPE Non-adherence to Trust Staff isolation policy Mask station not present at all entrances Cleanliness score (on small number of ward items) sit just below 95%			

Board Assurance Framework

	Site-wide assessment of ventilation (mechanical and manual) – action plan required to ensure all areas with mechanical ventilation are compliant with standards Unknown uptake of asymptomatic staff testing – LFD testing as this is not centrally reported

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Review Nurse cleaning roles & responsibilities	Reviewed as part of a Task & Finish Group to implement revised cleanliness standards (published April2021) within an 18-month timescale	Agree roles and responsibilities	McGreal, Julie	30/09/2022	
Review findings of site-wide ventilation survey to assess compliance with HTM.	Reviewed within the Ventilation Group which reports to Health & Safety Sub-Committee	Develop action plan to address non-compliance with HTM ventilation standards	Wright, Ian	30/09/2022	

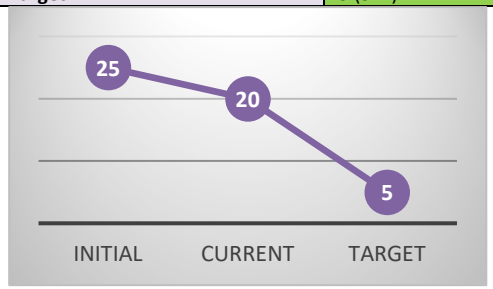
Board Assurance Framework

1289	**Executive Lead:**	Moore, Daniel

Strategic Objective 1: We will… Always put our patients first delivering safe and effective care and an excellent patient experience.

Failure to deliver planned elective procedures caused by the Trust not having sufficient capacity (Theatres, Outpatients, Diagnostics) resulting in potential delays to treatment and possible subsequent risk of clinical harm

Rating	
Initial:	25 (5x5)
Current:	20 (4x5)
Target:	5 (5x1)

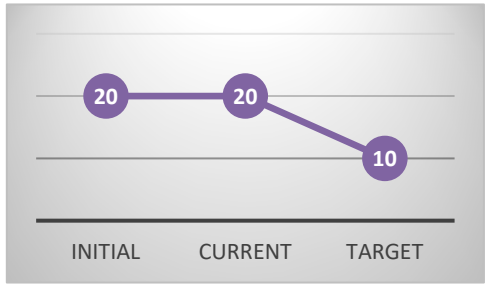


Waiting lists monitored and measured weekly
Post Anaesthetic Care Unit (PACU) remains open and operational
Continue to undertake harm review process and triangulate with waiting list process and Priority 2 patients
Continue to specifically focus on and monitor patients waiting greater than 52 weeks & 104 weeks
Continue to ensure urgent cancers are prioritised in line with national guidance
Bioquell Pods deployed in ICU in March 2021 to support flow and IPC compliance. This will help reduce instances of having to escalate capacity to the Main Theatre at the Warrington site.
Bioquell Pods in ED live and operational
B18 footprint development to support improved Respiratory & Critical response to peaks in the pandemic is underway and set to complete in September 2021.
Harm and waiting lists reported to Quality Assurance Committee, Finance & Sustainability Committee and Patient Safety & Clinical Effectiveness Sub-Committee.
Safe staffing levels reviewed daily. If necessary this may mean a review of clinical services to support the release of staff on a temporary basis.
The re-start of the Warrington site green pathway commenced w/c 8th February in the newly established ward A5 elective footprint. At present this supports cancer and other green pathways on the Warrington site
Clinical Recovery Oversight Committee (CROC) established
Clinical Services Oversight Group (CSOG) established
Deployment of modular build at the Halton site to provide additional pre-operative assessment capacity in support of elective recovery.
B18 opened in October 2021
Respiratory nursing business case approved to support step down of respiratory patients from ICU to B18 earlier in their care pathway thus creating ICU capacity to support planned care
Additional ultrasound contract awarded to start in January 2022
Successful bid of c£3m to support elective recovery in H2
All priority/urgent cancer P1 and P2 elective plans have been maintained through wave 5
To support capacity for Wave 5, elective activity moved to CSTM Halton facility to protect elective programme
Reviewing workforce pay incentives to create additional capacity in non-contracted work time e.g. evening and weekends. This links to the MIAA WLI Review & recent review of the rate card payments
Increase in Trust WLI rate extended until 31.05.2022 to support restoration and recovery. Business Case to support the increase in to 2023/24 currently in development and planned to be presented to the Trust Board in May 2022
Additional echo activity as per the H2 elective fund plan starting w/e 12th February 2022 delivery an additional c104 echos per week.
New Clinical Treatment Suite opened in the Nightingale Building in May 2022 (capital investment of £145K) to support the reduction in chronic pain waiting lists an increase theatre capacity to support restoration and recovery.
Business Case to increase WLI rate approved by the Trust Board in June 2022
Appointment of Outpatient transformation role in July 2022 to support increased efficiency and effectiveness of Outpatients

Theatres 3 and 4 currently used for Endoscopy rather than as Theatres until the Endoscopy rooms are completed in October 2021
Limited bed base within A5 elective footprint
Increase in COVID-19 ICU patients as a result of wave 4 (July 2021) impacted on scheduling for patients requiring ICU post op

Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Develop Business Case to increase WLI rate for 2023/24	Develop Business Case	Dan Moore	31/05/2022	27/06/2022

Board Assurance Framework

Risk ID:	134	**Executive Lead:**	McGee, Andrea	**Rating**	
Strategic Objective:	Strategic Objective 3: We will...Work in partnership with others to achieve social and economic wellbeing in our communities.				
Risk Description:	Financial Sustainability a) Failure to sustain financial viability, caused by internal and external factors, resulted in potential impact to patient safety, staff morale and enforcement/regulatory action being taken. b) Failure to deliver the financial position and a surplus places doubt over the future sustainability of the Trust. There is a risk that future loans will be required which would raise the question if the Trust is a going concern.			**Initial:** **Current:** **Target:**	20 (5x4) 20 (5x4) 10 (5x2)
Assurance Details:	•Core financial policies controls in place across the Trust •Finance and Sustainability Committee (FSC), Financial Resources Group (FRG) and Capital Resources Group (CRG) oversee financial planning •Weekly review at extended Executive team meeting • Achieved Break Even in 2021/22 • Delivered 2021/22 Capital Plan • Unqualified audit opinion (2021/22) • Workshop undertaken with - Exec, CBU, Corporate to review 2022/23 cost pressures • Workshops undertaken 2022/2023 budget setting • Completed MIAA Governance Checklist received by Audit Committee • Capital Plan 2022/23 approved by Trust Board on 30th March 2022 • Monthly Report to Executive Team Meeting and FRG includes review of outstanding MIAA recommendations and actions. The report also highlights the number of retrospective waivers compared to the same period in the previous year • Procurement/tender waiver training in place • Capital is reported monthly detailing all schemes above £500k monitoring underspends against plan and expected end date. This is in line with MIAA recommendations. • Phase 3 of the Health Infrastructure Programme (HIP) announced. WHH submitted an Expression of Interest (EOI) in September 2021. WHH assessed & submitted by Cheshire & Merseyside Health & Care Partnership to regional and national NHSE/I team as the top priority for the New Hospital Build Programme in C&M • TIF funding application to support recovery at Halton c£8m over 3 years and also £26.4m bid for a Community Diagnostics Centre (CDC) at Halton • Latest guidance from MIAA Counter Fraud Team circulated • Clinical Review Oversight Committee (CROC) established to provide oversight and assurance on recovery performance. • Revised approach to GIRFT/CIP. Leadership from Executive Medical Director and joint reporting to F&SC introduced. • Financial strategy developed to support improvement in financial sustainability. 2022-2027 Financial Strategy approved by the Trust Board in May 2022 • ICS executive peer to peer review June 2022, next planned at the end of month 6				
Assurance Gaps:	• CIP of 15.7m (£7m identified) • Non-recurrent and unidentified CIP presents a risk to in-year and future year financial position. • Requirement for £3m additional income and delivery of activity plan to achieve c £8m ERF. • No external funding support for Halton Healthy New Town or Warrington Hospital new build. • Increased threat of fraud as a consequence of global instability (e.g. conflict in Ukraine) • Risk of unforeseen costs due to further COVID-19 surge • Availability of social care to support the current super stranded position (currently c25% of bed base) • Current financial plan shows deficit of £6.1m, which is the control total set by the ICS				

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Submit Bids to ICB for Capital	Submit Bids	Submit Bids	Forkgen, Alice	30.06.2022	

Board Assurance Framework

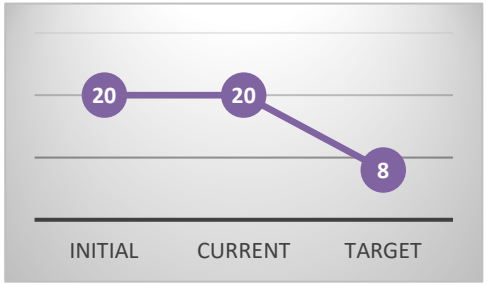
Identify CIP to support delivery of the overall financial plan	Identify CIP	Establish Leadership and oversight with the Executive Medical Director and meeting with Care Groups. Joint reporting to F&SC	McGee, Andrea & Fitzsimmons, Paul	30.03.2023	

Board Assurance Framework

Risk ID:	1134	**Executive Lead:**	Cloney, Michelle	**Rating**	
Strategic Objective:	Strategic Objective 2: We will .. Be the best place to work with a diverse, engaged workforce that is fit for the future.				
Risk Description:	Failure to provide adequate staffing caused by absence relating to COVID-19 resulting in resource challenges and an increase within the temporary staffing domain			**Initial:**	20 (4x5)
				Current:	20 (4x5)
				Target:	8 (4x2)

Assurance Details:

- Trust continues to be challenged by high sickness absence rates nationally the North West has higher sickness absence rates. North West Acute Trusts make up 45% of quartile 4 - Highest 25% for sickness absence nationally. WHH currently sit in quartile 3 nationally and rank 10th out of 20 for North West Trusts.
- Overall absence rate was 7.44% for April 2022, 6.31% for May 2022, 6.25% for June 2022 and June 2021 absence rate was 5.90% against a target of 4.25%
- COVID Related absence rate is 1.42% for May-22, in May-21 it was 1.20%, in June-22 it was 1.47%
- New Supporting Attendance Policy has been live since February 2022
- Supporting Attendance bitesize briefings on the new policy continue to be offered, these include a focus on Welcome Back Conversations
- Full training sessions are planned, due to the success of the current bitesize offering and operational pressures, a decision has been made to continue to offer these at present.
- Specific support continues within areas of high N&M sickness and low compliance RTW figures.
- The People Directorate have launched a series of Roadshows, where the team host face to face and virtual drop-in sessions to provide a platform for line managers to ask questions and hear about the latest updates to support attendance.
- The UK Health Security Agency issued guidance on 30th March 2022 following up the governments white paper on Living with Covid-19. This guidance is for staff and managers and provides updated guidance for health and social care staff if they develop any of the main COVID-19 symptoms, receive a positive LFD test result or are identified as a contact of a COVID-19 case. It also updates the guidance on repeat/routine testing for COVID-19 for staff in health and social care settings
- Overall vacancy rate was 10.31% for April 2022, 10.80% for May 2022, 10.89% for June 2022 and June 2021 absence rate was 10.4% against a target of 9%
- Reliance on bank and agency staff increased to 18.23% in June 2022 compared to a peak of 23.3% in Jan 2021, or 14.72% in May-22.
- The Trusts wellbeing offers continue to be well utilised, supporting people to remain in work. The Trust received national recognition from NHS Employers, for our Check In Conversation and local recognition for our Health and Wellbeing Hub.
- Throughout 2021, the Mental Wellbeing Team have been able to deliver:
    - 2056 calls with staff accessing services themselves or managers seeking advice and support for their staff
    - 3842 emails with staff accessing services themselves or managers seeking advice and support for their staff
    - 3254 1:1 sessions or group setting interventions
- In additional over 40 areas have been supported delivering over 150 workshops and training sessions on topics such as CBT, anxiety and resilience.
- Following the evaluation of the Brathay programme, where 90% recorded an improvement in their mental wellbeing, a further programme of work has now been secured offering a 'lite' version over 2022.
- Rugby League Cares have been supporting WHH since July 2021, providing a range of physical and mental fitness offers to our workforce.
- Grief and Menopause cafes have also been setup to offer guided support sessions both virtually and face to face
- The guidance from UKSHA published on the 1st April 2022 regarding decreasing the spread of respiratory infections, including COVID-19 in the workplace states that there is no longer a requirement for employers to explicitly consider COVID-19 in statutory health and safety risk assessments with a reduction in individuals who are considered to be at higher risk of COVID-19, which was published by UKSHA on the 4th April 2022.



Board Assurance Framework

	• In line with these updates the COVID Risk Assessment process has been reviewed to align to the Living with COVID principles and the updated COVID vulnerabilities:
	  ○ Blood cancer (Leukaemia or Lymphoma)
	  ○ Weakened immune system due to treatment (such as steroid medication, biological therapy, chemotherapy or radiotherapy)
	  ○ Organ or bone marrow transplant
	  ○ A condition that means that individuals have a high risk of getting infections
	  ○ Down's syndrome
	  ○ Sickle Cell disease
	  ○ Pregnancy
	  ○ Chronic kidney disease
	  ○ Severe liver disease
	  ○ Certain autoimmune or inflammatory conditions (such as rheumatoid arthritis or inflammatory bowel disease)
	  ○ HIV or AIDs
	  ○ A condition affecting the brain or nerves (such as Multiple Sclerosis, Motor Neurone Disease, Huntingdon's, Myasthenia Gravis
	• Only staff who are both vulnerable to COVID and working with Aerosol Generated Procedures, are required to consider reasonable adjustments, all other staff can return to their full duties, within their substantive role.	

Assurance Gaps:	• Continued lack of national/regional clarity of the management of long Covid in the context of the national agreement. • Administrative & Clerical are experiencing 0.8% absence rate related to COVID-19 in Jun-22 • Estates & Ancillary staff are experiencing over 1% absence rate related to COVID-19 in Jun-22 • Additional Clinical Services are experiencing 2.4% absence rate related to COVID-19 in Jun-22 • Nursing & Midwifery staff experiencing 1.8% absence rate related to COVID-19 in Jun-22 This impacts requirements for temporary staffing.	

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Continue the promotion and development of Wellbeing interventions/initiatives.	To further enhance the wellbeing offer	• Embed a 'lite' version of the Brathay offer in 2022 • Ongoing evaluation of the Mental Health Wellbeing team offers • Expansion of the education programme to include a focus on CBT and trauma sessions including bespoke sessions for specific teams	Patel, Rebecca	30/08/2022	
Improve the Education offer for Leaders to support them supporting their Staff to remain healthy in work	Offer a range of Supporting Attendance educational offers to ensure they are accessible and conducive to the range of leadership experience/skills.	• Continue the 1:1 bespoke training sessions • Enhance the bitesize training offers to improve their accessibility Embed a Supporting Attendance development session as part of a wider Leadership Development offer	Hilton, Laura	30/08/2022	

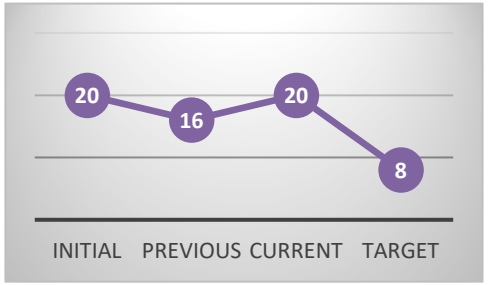
Board Assurance Framework

Risk ID:	1114	**Executive Lead:**	Fitzsimmons, Paul	**Rating**	
Strategic Objective:	Strategic Objective 1: We will… Always put our patients first delivering safe and effective care and an excellent patient experience.				
Risk Description:	FAILURE TO provide essential and effective Digital Services CAUSED BY increasing demands upon resources (e.g. cyber defences), new technology skillsets (e.g. Cloud), unfit solutions (e.g. Maternity), end-of-life solutions (e.g. Telephony), poor performance (e.g. Lorenzo EPR)RESULTING in a potentially reduced quality of care, data quality, a potential failure to meet statutory obligations (e.g. Civil Contingency measures) and subsequent reputational damage..			**Initial:**	20 (5x4)
				Current:	20 (5x4)
				Target:	8 (2x4)

Assurance Details:

Assurance:

- Risks for Cyber on risk register in line of national requirements of the DSPT & NHS Digital
- **Digital Governance Structure** including weekly structured Senior Leadership Team meetings, Risk Register Reviews, monthly Budget Meetings (where CIP and cost pressures are reviewed), Data Standards Group reporting to the Information Governance and Corporate Records Sub-Committee with escalations to the Quality Assurance Committee and onwards to the Digital Board, which itself submits highlights to the QAC and resource go to FSC. The **Quality Assurance Committee report provides** assurance against all key security measures (i.e. Risks/GDPR/Data Security & Protection Toolkit/Cyber Essentials Plus/Audit Actions/IG training figures).
- **Digital annual IT audit** plan inclusive of ever-present overarching Data Security & Protection Toolkit baseline and final report, with progress monitored at the Trust Audit Committee.
- **Trust benchmarking** activities including Use of Resources reviews (Model Hospital).
- ITHealth Assurance Dashboard is live, monthly external penetration testing is now in place using NHS Digital's VMS service and BitSight security score is live.
- Approval of the subsequent Annual Prioritised Capital Investment Plan as managed via the Trust Capital Management Committee. (March 2021)
- Digital Services have implemented all national guidance regarding Log4J vulnerabilities highlighted by NHS Digital (December 21)
- WHHT return for assurance re cyber security to NHS England (March 22)
- Cisco Phase 2 business case being approved (for financial year 22/23). Providing the procurement mini tender is done on time and the orders are place in advance and there are no other world-wide changes happen impacting on supplies, kit will be delivered and installed within 22/23.



Controls:

- **Digital Operations Governance** including supplier management, product management, cyber management, Business Continuity And Disaster Recovery Governance and customer relationship management with CBUs (e.g. The Events Planning Group) and an Information Security Management System (ISMS) based upon the principles of ISO27001 security standard.
- Active membership of the **Sustainability Transformation Partnership Cyber Group.**
- **Digital Change Management** regime including the Solutions Design Group, the Technical Request For Change Board, the Change Advisory Board, The Digital Optimisation Group, Trust communication channels (e.g. the Events Planning Group) and structured Capital Planning submissions.
- **Trust Data Quality** Policy and Procedures (e.g. Data Corrections in response to end user advice) plus supporting **EPR Training** regime for new starters including doctor's rotation and annual mandatory training.
- **Cyber Training** for the Trust Exec Board
- The use of automatic patching software to rollout security updates to devices.
- Existing external network traffic is monitored by NHS Digital for both HSCN & Internet links.
- 5 servers 2008 R2 unable to install security patches: Symphony document server, Data warehouse app server, Trust Print Server, Dawn Anticoagulant system & Winscribe dictation system (all issues resolved).

Board Assurance Framework

	• Office 2010 being used while end of life due to the N365 deployment plan (100% migrated) • Secondary secure backup at Halton Data Centre • Remote devices no longer bypassing the web proxy • Active Directory password set to expire again (covid working from home-related). • Fully recruit to the Digital Service restructure Phase 1 restructure • Outcome of the second Phishing exercise by NHS Digital, communications have been sent out to staff members who entered details for awareness.	
Assurance Gaps:	**Gaps In Assurance:** • Mostly achieving of mandated compliance with DSPT, incorporating CE+ (moderate assurance given by MIAA for the standards audited and substantial in respect of the veracity of the self-assessment) **Gaps In Controls:** • No real-time early warning of zero-day attacks due to the lack of network pattern matching software. • Current performance of Lorenzo and whether migration to the cloud will provide any benefit. • Development of staff behaviours to protect data evidenced via reduced IG incident report levels, impacted training due to Covid-19 pandemic. • Ability to mitigate cyber configuration of nationally provided systems (e.g. ESR) and non-Microsoft devices (that meet a clinical need). • Not all Windows Server 2003 server will be migrated to Windows Server 2016 before the N365 agreement starts. (1 out of 77 servers are at risk of not being migrated in time. The system at risk is Medicorr.) • No local device (PC & laptop) based firewalls in use while on site, dependant on the site boundary firewalls • Using generic logins staff usernames and passwords are stored in browser when selecting "remember me" • No dedicated logging tool to pull all key logs together and provide useable alerts. MIAA to review processes and tools (July 21) •Using no longer supported Exchange 2010 email system for mail archive • Using SharePoint 2010 for the Hub • Lack of process to check antivirus alerts in console. MIAA to review processes and tools (July 21) • Administrator accounts still have access to the Internet & email, although only used when required (SIRO approved process, best solution between operational vs security).. • No controls in place for Bluetooth connectivity. • No agreed patching schedule for network equipment with the Trust. • Temporarily Uninstalled Mcafee on PACS servers for 1 week (10/03/22) • The extension of the mainstream support for SQL Server 2012 will end on 12 July 2022 • Vulnerability identified by Dedalus obtaining elevated SQL access to data in ORMIS	

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Support for Windows Server 2003 has now ceased and Windows Server 2008 becomes unsupported from January 2020. As a consequence, Microsoft will no longer provide security updates or technical support for these operating systems. Consequently, any server or system reliant on Windows Server 2003 and Windows Server 2008 (from Jan 2020) presents a cyber-security risk to the Trust. We either need to migrate or decommission the unsupported Windows Server 2003 and Windows	Migrate all 2003 and 2008 servers to 2016.	• Engage with the CBU's/Departments regarding migration and potential costs and plan migration. • Migrate the servers to Windows Server 2016 • Extend Support for Windows Server 2008 until Feb 2022 NB: Windows Server 2003 is out of support; however, Windows Server 2008 is still in support until March 22. [All simple migrations have been completed by IT Services. A report was presented at the October's Digital	Deacon, Stephen	30/06/2022	

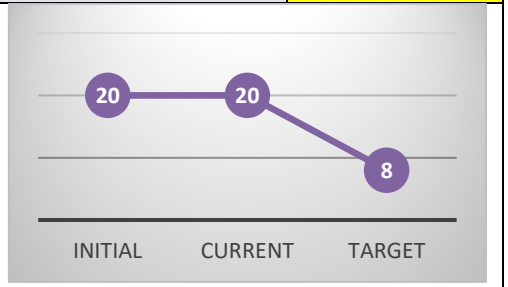
Board Assurance Framework

Server 2008 to Windows 2016 (Latest server operating system). [Delivers: Best Practice]		Board, providing progress made in the decommissioning of Windows 2003/2008 servers, the timetable for decommissioning the remaining servers and the mitigations identified for those servers which are unlikely to be decommissioned before 31st December 2020. The only server at risk is the Medicorr Server. As part of the DSPT requirements we have asked for an update action plan.]			
Migrate the last 9 endpoints devices to Windows 10	Migrate the last 9 endpoints devices to Windows 10	4 devices migrated with 5 devices left The below endpoint devices can be replaced: 1 x Laptop in Medical Engineering – Unsure why this is still in use. (Deployment contacting ME regarding whether still in use) Endpoint devices more complicated to migrate: 1 x Dexa Scanner computer – This cannot be replaced at the moment, however, a new dexa scanner has been procured, just waiting on delivery and installation (waiting on date). 1 x Ophthalmology Fundus imaging computer – This cannot be upgraded/replaced as the Fundus camera is not Windows 10 compatible. Conversations on going with the department around replacement camera or removing use of the system altogether. 1 x Pathology Cognos client – This is some sort of information reporting system used in Pathology. They have supposedly purchased a replacement, just not implemented it yet (waiting on date) 1 x Cardiology (can be replaced but need to contact the 3rd party)	Waterfield, Tracie	30/07/2022	
Turn on device firewalls, to help limit a spread of an infected device infected other devices on the internal network	Turn on local device firewalls	Prioritise workload to look at turning on personal firewalls Create a test group Phase turn on / turn on	Deacon, Stephen	31/01/2023	

Board Assurance Framework

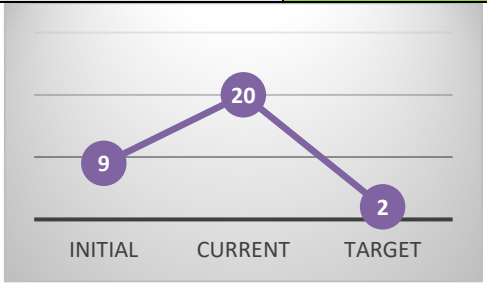
		[Meeting set up for 03/09/21]			
Business case for SQL Server 2012	Business case for SQL Server 2012	To be part of the new N365 agreement. NHS Digital Need to provide the financial plans before local Trust can renew the agreement.	Waterfield, Tracie	31/03/2023	
Cisco Phase 2 upgrade to replace aging network equipment	Approve the business case Complete mini tender Place orders in advance Delivery of equipment Install and configure equipment	New equipment has been installed and used.	Waterfield, Tracie	31/03/2023	
Enable Anti-Virus on PACS Cluster Nodes	Enable Anti-Virus on PACS Cluster Nodes	Work with Phillips on getting a working anti-virus on the PACS Cluster Nodes	Waterfield, Tracie	29/07/2022	
Mitigations to be put in for ORMIS security issue	Mitigations to be put in for ORMIS security issue	To set up security groups to stop unauthorised access to the SQL database.	Deacon, Stephen	08/07/2022	
Support for Windows Server 2012 will cease . As a consequence, Microsoft will no longer provide security updates or technical support for these operating systems from that date going forward. We either need to migrate or decommission the 70 unsupported Windows Server 2012 to the latest server operating system.	Migrate/decommsion Server 2012 servers	• Engage with the CBU's/Departments regarding migration and potential costs and plan migration. • Migrate the servers to the latest Windows Server operating system or decommission them.	Waterfield, Tracie	31/10/2023	

Board Assurance Framework

Risk ID:	1125	**Executive Lead:**	Moore, Daniel	**Rating**
Strategic Objective:	Strategic Objective 1: We will… Always put our patients first delivering safe and effective care and an excellent patient experience.			
Risk Description:	Failure to achieve constitutional access standards caused by the global COVID-19 Pandemic resulting in high attendances and occupancy, non-compliance for RTT, Diagnostics, Cancer and ED Performance			**Initial:** 20 (5x4) **Current:** 20 (5x4) **Target:** 8 (2x4)
Assurance Details:	• Following national EPRR guidance for Cancer & RTT • All patient referrals are being prioritised due to clinical need • Rejected referrals are following recognised procedures particularly ensuring all have a clinical review to determine outcome • Moved a high proportion of OPD activity to virtual. • One elective theatre maintained for cancer and clinically urgent cases • Maintaining monthly reporting for each external standard • Discussed at the NED led Clinical Recovery Oversight Committee (CROC) • Discussed at the Clinical Services Oversight Group (CSOG) • Constitutional Standard Performance reporting to the Finance & Sustainability Committee (F&SC) • Executive attendance at the weekly Elective Restoration meeting for Cheshire & Merseyside. Linked with the ICS Governance Structure • H2 planning linked to restoration & recovery agreed with NHSE/I • Reviewing workforce pay incentives to create additional capacity in non-contracted work time e.g. evening and weekends. This links to the MIAA WLI Review & recent review of the rate card payments • Additional echo activity as per the H" elective fund plan starting w/e 12th February 2022 delivery an additional c104 echos per week. • Increase in Trust WLI rate agreed until 31.05.2022 to support restoration and recovery. Business Case to support the increase in to 2023/24 currently in development • Halton to become a Community Diagnostic Centre (CDC) as part of the second tranche of national funding. This would be situated on the Halton Campus. • The Trust has been successful in being selected for a Targeted Investment Fund (TIF) bid. This will be ratified in May 2022 • Capital Works for new procedure room completed in April 2022 and no live. This will release an additional 10 Theatre session per week to support recovery.			
Assurance Gaps:	Some weekly reporting reduced as per guidance			

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Develop Business Case	Develop Business Case to increase WLI rate for 2023/24	Develop Business Case	Dan Moore	30.04.2022	

Board Assurance Framework

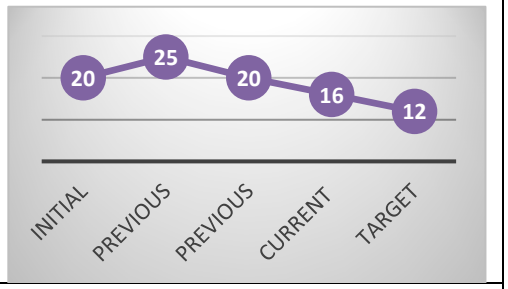
Risk ID:	1079	**Executive Lead:**	Salmon-Jamieson, Kimberley	**Rating**	
Strategic Objective:	Strategic Objective 1: We will… Always put our patients first delivering safe and effective care and an excellent patient experience.				
Risk Description:	If we do not provide an electronic patient record (EPR) system that can accurately monitor, record, track and archive antenatal (including booking information, intrapartum and postnatal care episodes because we have an IT system (Lorenzo) which is not maternity specific and does not have a robust internet connectivity, with inadequate support to cleanse data and no intra-operability between services, then we will be unable to capture all required data accurately, have a robust electronic documentation process in cases of litigation or adverse clinical outcome and poor data quality. In addition, inadequate communication with allied services, such as health visitors will be uninformed of women within the system requiring antenatal assessment. This can also result in women being allocated to the wrong pathway and the wrong payment tariff.			**Initial:**	9 (3x3)
				Current:	20 (4x5)
				Target:	2 (2x1)
Assurance Details:	Chief Nurse, medical director and head of safety and risk aware of system issue Digital IT paper to QAC and PSCE in collaboration with IT director to highlight system failures and inoperability Paper based backup systems introduced Additional administration in significantly affected areas Site visit to MBFT for lessons learnt in improving system Miro meeting with IT manager to look for interim solutions Scoping new systems with procurement Capital funding meeting attended to seek funds to support alternative maternity specific system New mobile phones for community to support hot spotting in areas with no connectivity IT visited community clinics with Lorenzo connectivity issues Support from lead midwife for IT to ensure data quality. Data is cross-checked to ensure that accurate data is submitted for screening and Payment By Results Quick reference guides have been created for users to improve data quality related to erroneous input Off line version of Lorenzo to assist Community midwives to input real time data and reduce errors (LCM) Support currently in place to cleanse historical data In order to ensure health visitors are notified, the previous paper based system has been replaced with an electronic notification system, with a fail safe in place to ensure no patients are not notified to the appropriate service. AN electronic HV notification has been set up and tested in Warringotn and new are ow working with IT teams in Halton CCG to replicate the elctronic notification system we have in Warrington. Presentation provided by prospective suppliers on 18th December 2020 Clevermed identified as the preferred supplier in February 2021 EPR Strategic Outline Case supported by the Trust Board in December 2020 Temporary fix for CTG archiving agreed and fitted in December 2020 with review in January & February 2021 Following completion of supplier decision making process, implementation due to complete in May Digital Maternity board in place to ensure full oversight is provided. Weekly digital transformation meetings in place to progress operational actions. Staff training schedule initiated to ensure all staff can be supported during the implementation phase. Increased training sessions may pose a potential staffing pressure and risk in terms of COVID/Omicron variant status and potential reduction in staffing. Off line working on Lorenzo launched in January 2022 to mitigate risk prior to Badgernet implementation in May . This will support implementation of Maternity Incentive Scheme Safety Action 2 : MSDS submission June 2022 - Women's and Children's CBU in the process of extracting data reports to assess compliance with national maternity data set requirements. Reports are monitored at Women's and Children's monthly Governance meetings.				
Assurance Gaps:	Lack of connectivity to ensure that systems can operate Lack of data to provide internet hotspot				

Board Assurance Framework

	The current digital solution is contributing to poor data quality and its detrimental care quality and activity income effects, poor staff moral and concerns by regulators Work related stress due to additional hours required to achieve correct level of data inputting leading to sickness absence Lack of assurance that all women are captured for both operational clinical and financial ends. This leads to uncaptured activity and risk to safety if women are not entered onto the system appropriate due to the above Loss of income due to poor data quality. The cross checking is dependent on time being available for the team to complete this time consuming task Ineffective use of midwifery time- midwives continuing to report excessive additional effort to correct omissions and inaccuracies, impacting upon carer/woman relationship and data quality, and leading to concerns that the current situation may impact the Trust's aspirations to achieve outstanding status.

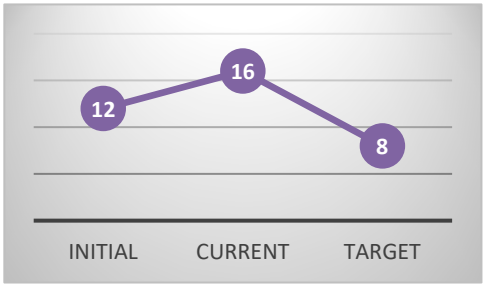
Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date

Board Assurance Framework

Risk ID:	115	**Executive Lead:**	Salmon-Jamieson, Kimberley	**Rating**	
Strategic Objective:	Strategic Objective 1: We will… Always put our patients first delivering safe and effective care and an excellent patient experience.				
Risk Description:	If we cannot provide minimal staffing levels in some clinical areas due to vacancies, staff sickness, patient acuity and dependency then this may impact the delivery of basic patient care.			**Initial:**	20 (5x4)
				Current:	16 (4x4)
				Target:	12 (4x3)
Assurance Details:	• Twice daily review of red flag data to identify staffing, patient acuity and dependency across all clinical areas. • Redeployment of staff (consideration of skill mix) and review allocation of NHS Professional pool staff as part of the agreed escalation process. Shifts added to the system, communications sent to all NHS Professional staff to fill shifts. • If required Executive authorisation for off framework agency usage – Greenstaff or Thornbury. • Staffing numbers, skill mix and moves are stored in 'gold command' file for assurance of clinical decision making. • Site Manager and Matron on site until 8pm (Warrington and Halton site). On weekends this is a full day shift. • Rolling recruitment for RN and HCA posts. 2- 4 weekly interviews. • Part of National Recruitment Programme and Care Support Worker Development Programme for HCAs. • Workforce Group in place for monitoring and assurance. • Retention – Transfer policy in place for staff. • Workforce plan/ strategy under review.				
Assurance Gaps:	• Increased operational capacity and demand results in the need to open additional areas to provide patient care, increasing the staffing need (E.g. B3, CAU and Cath lab). • Increased staffing pressures anticipated due to winter surge. • Time to post when recruiting new staff.				

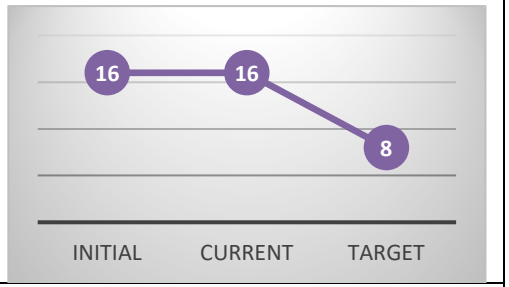
Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Focus upon the Workforce Strategy to proactively retain, fill and review vacancies alongside care need. To include succession planning and staff opportunities.	Assurance of Workforce Strategy progress through the Workforce Review Group and associated workplans.	Workforce Review Group to provide updates on specified workstreams to the Quality Assurance Committee and Strategic People Committee as part of the staffing report, ahead of submission to the Board of Directors. This will include: • Domestic and international nursing recruitment • Position and plans for staff retention. • Planning for the future – succession planning and staff development. • 6/12 establishment reviews. • Triangulation of staffing position alongside patient safety measures.	Kennah, Ali	30/09/2022	

Board Assurance Framework

Risk ID:	1372	**Executive Lead:**	Paul Fitzsimmons	**Rating**
Strategic Objective:	Strategic Objective 3: We will...Work in partnership with others to achieve social and economic wellbeing in our communities.			
Risk Description:	If the Trust is unable complete a successful EPR strategic procurement project in line with the Trust's time, budget and quality requirements, due to: • An inability to develop an affordable business case due to, baseline costs, strong existing benefits & lack of new cash releasing benefits • An inability to garner ICS and NHSE support to progress the EPR business case • An inability to deliver Managed Convergence in line with emergent national policy and the ICS Convergence strategy (currently poorly defined and in development) Then the Trust will be unable deliver a future Electronic Patient Record Solution Resulting (sequentially) • A continuation of the Trust's challenges with the incumbent EPR, Lorenzo (as identified in the Strategic Outline Case) • Potential for a costly extension to the existing Lorenzo contract or the highly retrograde step of returning to paper systems as Lorenzo will be at end of life at (or before) the end of the tactical contract extension			**Initial:** 12 (3 x 4) **Current:** 16 (4 x 4) **Target:** 8 (2 x 4)
Assurance Details:	Assurance: • A revised OBC is being progressed for August 2022 Trust Board approval in line with emerging guidance on managed convergence. • A relaunched procurement process complying with Managed Convergence planned to start November 2022 • Adherence to this timetable will allow go live of a new EPR before Lorenzo contract ends - November 2024. • Progress managed through EPR Project Board (with escalation/assurance through Digital, FSC and Trust Board) • Regular progress meetings with ICS, NHSE and NHSD supportive of managed convergence relaunch. Controls: • Business case approved and contract in place for a 3 year tactical Lorenzo contract • Trust financial modelling includes 3-year Lorenzo costs • ICB Executive Leads supportive of procurement relaunch to achieve Managed Convergence • Senior Programme Manager assigned • Financial modelling of realistic collaboration options to provide genuine 5, 10 and 15 year options to control whole life costs • Identification of further realistic cash releasing benefits as part of full business case development			
Assurance Gaps:	Gaps In Assurance: • Potential inability to develop an affordable business case due to strong existing benefits & lack of new cash releasing benefits • ICS strategic approach to delivering managed convergence remains unclear • Mechanism of delivering and ability to deliver Managed Convergence through an open procurement process remains unclear • Procurement process planning is thus being developed on a 'most likely guidance' basis – due to the uncertainty of the above • Limited assurance regarding ICS and NHSE sign off OBC and support for progression to FBC – working assumption of a 10 week timeframe for approval Gaps In Controls: • Lorenzo is at end of life and is unlikely to see significant future development or enhancements			

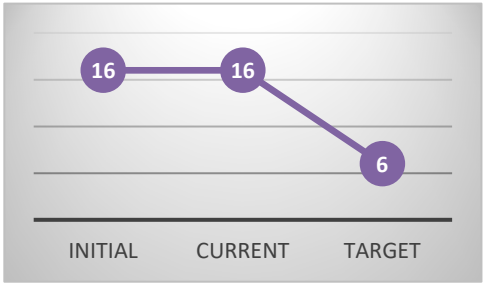
Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Presentation of OBC v3 to Executive Team	Presentation of OBC v3 to Executive Team	Review the contents of OBC v3 Presentation of OBC v3 to Executive Team in May 22	Caisley, Sue	30/09/2022	

Board Assurance Framework

Risk ID:	1579	**Executive Lead:**	Daniel Moore	**Rating**	
Strategic Objective:	Strategic Objective 1: We will… Always put our patients first delivering safe and effective care and an excellent patient experience.				
Risk Description:	Failure of the Trusts ability to transfer patients with time critical urgent care needs to specialist units able to deliver time critical specialist interventions (Primary PCI, Hyperacute Stroke Intervention, Emergency Vascular Surgery, Major Trauma services etc) CAUSED BY an inability of the North West Ambulance Service, to provide the expected response times for critical transfers due to overwhelming demand on ambulance services, RESULTING IN a delay in transfer and thus potential severe patient harm due to the inability to access time critical specialist interventions without undue delay			**Initial:**	16 (4 x 4)
				Current:	16 (4 x 4)
				Target:	8 (2 x 4)
Assurance Details:	• LHCH PPCI pathways have been adjusted to give guidance for patients not being transferred for more than 120 minutes. • UEC are following the escalation process to the ROC/NWAS Control room to discuss patients transfer needs on an individual basis. • All SMOCs and Silver Command are aware of the escalation process. • With regards to trauma issues, UEC have raised this at the regional network meeting. For assurance a high level paper is presented to Trust Wide Trauma Group and Patient Safety and Clinical Effectiveness Sub Committee. • Trust continues to perform well against the ambulance handover times thus supporting the ambulance service • Implementation of a new handover escalation process in times of high demand went live in April 2022 with support from AQuA				
Assurance Gaps:	NWAS assess there response times based upon current active and waiting calls when there regional activity is high. However, there is still significant delays.				

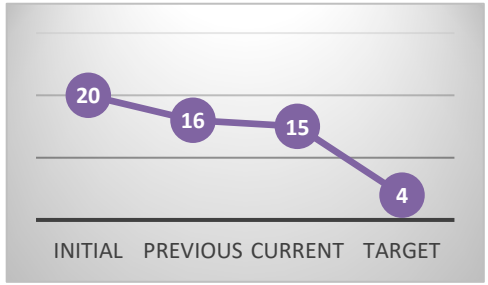
Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Implement new escalated ambulance handover process	Work with NWAS to support the development of a regional escalated handover process.	Implement new escalated ambulance handover process	Sharon Kilkenny	30.04.2022	05.04.2022

Board Assurance Framework

Risk ID:	1233	**Executive Lead:**	Paul Fitzsimmons	**Rating**	
Strategic Objective:	Strategic Objective 1: We will… Always put our patients first delivering safe and effective care and an excellent patient experience.				
Risk Description:	If we bed the Combined Assessment Unit (CAU) then we will not have a suitable environment to review surgical patients in a timely manner resulting in a lack of surgical assessment bed capacity, poor patient experience, delays in treating surgical patients and increased admissions to the surgical bed base.			**Initial:**	16 (4 x 4)
				Current:	16 (4 x 4)
				Target:	6 (2 x 3)
Assurance Details:	Assurance: • CAU assessment capacity and availability considered on a thrice daily basis in bed meetings • CAU assessment capacity status considered at twice weekly Tactical Board • Regular CAU steering group meetings will continue to review effectiveness of controls Controls • Ensuring CAU assessment capacity is preserved or reinstated is a standing priority at bed meetings and Tactical Board • Other escalation areas bedded before escalation to bed CAU • A surgical ambulatory nurse co-ordinator supports surgical emergency admission patient flow • New ways of surgical working implemented 17/1/22 to mitigate risk by pulling patients requiring operative intervention directly to theatres from the ED and CAU to avoid delays to surgery caused by a lack of beds • Completion of the ED plaza will negate this risk as the dedicated assessment areas in the ED plaza cannot be bedded and as such surgical assessment capacity will be preserved				
Assurance Gaps:	Gaps in Controls • An admission avoidance clinic is set up but cannot be utilised effectively as no alternative assessment area is available to bring patients back to when CAU is bedded. • During periods of excess bed demand CAU is very likely to be a bedded area limiting the availability for the surgeons to review any admission avoidance patients. • Surgeons may struggle to find assessment areas in ED to treat patients • Any delay in the ED Plaza program will delay the resolution of this risk				

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
ED Plaza - Clinic Room	Provide dedicated clinic room/s for surgical referrals/emergence to be seen as in an ambulatory clinic with dedicated medical rota.	Develop surgical rota and agree location for clinic rooms	Smith, Glenna	29/07/2022	
Escalate Delays	Escalate issues with patients on CAU through surgical bed coordinator	Bed meetings, patient flow to escalate any delays to daily patient flow coordinator	Smith, Glenna	29/07/2022	
Governance process for surgical attendees	Any issues to be discussed and reviewed with plans to prevent replication of any issues.	Discussions at monthly Governance Meetings Escalation of any incidents with the team	Smith, Glenna	29/07/2022	

Board Assurance Framework

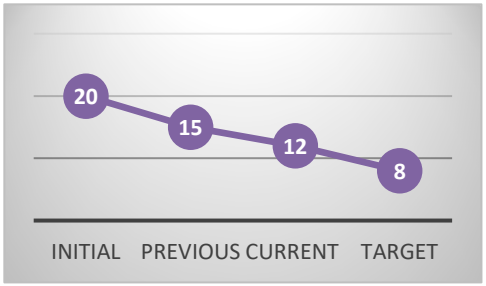
Risk ID:	125	**Executive Lead:**	Dan Moore	**Rating**
Strategic Objective:	Strategic Objective 1: We will… Always put our patients first delivering safe and effective care and an excellent patient experience.			
Risk Description:	Failure to provide safe, secure, fit for purpose hospitals and environment caused by the age and condition of the WHH estate and limited available resource resulting in a risk to meeting compliance targets, staff and patient safety, increased backlog costs, increased critical infrastructure risk and increased revenue and capital spend.			**Initial:** 20 (5x4) **Current:** 15 (3x5) **Target:** 3 (3x1)
Assurance Details:	**Controls:** Annual capital funding is allocated to business critical, mandated and statutory estates projects Planned Maintenance Program Reactive maintenance process Six Facet survey – condition appraisal of estate (annually) which informs a prioritised schedule for managing backlog maintenance Estates 10 year capital program which is updated annually as a result of the 6 facet survey and any capital works that have been carried out Capital Planning Group and associated capital funding allocation process Annual asbestos survey - asbestos management survey makes an assessment of the condition of any materials present and determine the likelihood of any fibres being released. Annual PLACE assessments **Assurance:** Estates and Facilities Health, Safety and Risk Group – managing health and safety issues and monitoring risk registers Non funded capital schemes are risk rated and monitoired through the above group Fire Safety Group – monitors fire safety issues across the trust and provides assurance to Cheshire fire and rescue service on Fire Safety Management PLACE assessment with subsequent action plan Capital Planning Group – determine how the trust capital is spent Use of resources group – monitors how cost effective and value for money estates and facilities are in relation to a number of national and regional benchmarks Cleanliness monitoring identifies estates issues that are addressed through the estates building officer Ventilation Group – gives assurance on the appropriate levels of trustwide ventilation in particular approves upgrades and new installations Mechanical Craftsperson and Electrician business case approved providing stability of workforce and retention of skills			
Assurance Gaps:	Limited capital funding to address backlog Compliance – evidencing compliance in line with national guidelines and mandated returns (Premises Assurance model) PAM) Estates staffing - recruitment and retention of trade staff due to banding of technical trades being lower than local and national peers Accessibility – some equipment is not accessible for maintenance due to age and design. Without a permanent decant ward this proves difficult to overcome Cost pressures – unfunded elements of unforseen and emergency maintenance in I&E budget Threat to the delivery of capital schemes due to the pandemic e.g. manufacturing delays, additional costs of construction relating to IPC guidelines and the unavailability of an appropriately skilled workforce.			

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Upgrade Warrington kitchen facilities	Following a review of the kitchen facilities at Warringotn Hospital. An improvement plan in place to progress	Complete upgrade of kitchen facilities	Ian Wright	31/12/2022	
Develop estates maintenance compliance monitoring tools	Integrate performance and compliance into0 routing estates maintenance operations	Head of compliance and performance in post in April 2022 and will develop initiatives, processes and protocols to drive estates maintenance performance	Ian Wright	31/03/2023	

Board Assurance Framework

		and in turn improve compliance against recommended guidelines and internal KPIs			
Complete premises Assurance Model for 22/23	Complete and submit PAMS to NHSEEI	Identify gaps and workplan for 22/23 compliance improvement plan	Ian Wright	31/10/2022	
Apply for additional capital from ICS	Submit bid for additional 22/23 backlog capital from C&M ICS	Provide capital finance team with information to submit bid to regional finance team	Ian Wright	31/05/2022	

Board Assurance Framework

Risk ID:	145	**Executive Lead:**	Constable, Simon	**Rating**	
Strategic Objective:	Strategic Objective 3: We will...Work in partnership with others to achieve social and economic wellbeing in our communities.				
Risk Description:	If the Trust does not deliver our strategic vision, including two new hospitals and influence sufficiently within the Cheshire & Merseyside Integrated Care System (ICS) and beyond, the then Trust may not be able to provide high quality sustainable services resulting in a potential inability to provide the best outcome for our patient population, possible negative impacts on patient care, reputation and financial position.			**Initial:**	20 (5x4)
				Current:	15 (5x3)
				Target:	8 (4x2)
Assurance Details:	The board has developed the Trust's strategy and governance for delivery of the strategy to ensure that all risks are escalated promptly and proactively managed. The Trust has developed effective clinical networking and integrated partnership arrangements. Some examples include: - The Trauma and Orthopaedic service has developed excellent links with the Royal Liverpool and the Walton Centre for complex spinal patients. - Council and CCG in both Warrington & Halton supportive of development of new hospitals. Agreement with key stakeholders to progress single programme and proceed with OBC development. - Regular Strategy updates are provided to the Council of Governors & Trust Board - Clinical strategies at Specialty level are in the processess of being refreshed - Breast Centre of Excellence opened. Bid for targetting investment fund (TIF) to further develop the elective offer at Halton has been prioritised by Cheshire & Merseyside - DoH launched Health Infrastructure Programme (HIP) announcing a £2.8b investment. WHH not included in the first 2 phases of investment. Phase 3 of the HIP announced. WHH submitted an Expression of Interest (EOI) in September 2021 - WHH assessed & submitted by Cheshire & Merseyside ICS to regional and national NHSE/I team as the top priority for the New Hospital Build Programme in C&M - Strategic Outline Cases (SOC) for both new hospital developments approved by the Trust Board and both CCGs. Formally supported by wider partners through both Warrington & Halton Health & Wellbeing Boards, Warrington Health Scrutiny and Halton Health Policy & Performance Board. - Pathology – Draft outline business case for pathology reconfiguration across Cheshire & Merseyside. Currently options for further development do not include any option where WHH is a hub. All options proposed include Essential Services Labs (ESL) at WHH. Detailed feedback provided by the Trust included in strategic outline business case to ensure quality standards and turnaround time are sustained for proposed ESLs. - Bid for Community Diagnostics Centre (CDC) at Halton site submitted Pathology OBC supported by the Trust Board - Funding secured via Halton Borough Council and Liverpool City Region Town Centre Fund to provide some services within Shopping City in Runcorn. This contributes to a potential phased approach to delivering reconfiguration of the Halton site. Matched investment approved by the Trust Board to enable delivery of Ophthalmology, Audiology & Dietetics services to commence from Autumn 2022. - Director of Strategy invited to be a member and the health representative on both Runcorn and Warrington Town Deal Boards, tasked with planning for the investment of £25m (each) to regenerate Runcorn Old Town and Warrington - Town Deal plan for Warrington approved. Included the proposed provision of a Health & Wellbeing hub in the town centre and a Health & Social Care Academy. £22.1m funding approved for the Town investment plan, including £3.1m for the Health & Wellbeing Hub and £1m for the Health & Social Care Academy. - Full Business Case for the Health & Wellbeing Hub approved by the Government - Town Deal plan for Runcorn approved by the Government securing c£23m, including c£3m for Health Education Hub in Runcorn. Full Business Case for Health & Education Hub developed for approval. Submission to Government due in August 2022 - Strategy refresh completed and approved at Trust Board to confirm 2022/23 priorities.				

Board Assurance Framework

	- In February 2021 the Government White Paper, "Integration and Innovation: working together to improve health and social care for all - The Department of Health and Social Care's legislative proposals for a Health and Care Bill" was published. - The Trust Board agreed in March 2021 that a transaction between BCH and WHH is no longer required, given that the White Paper enables an acceleration of place-based integration including all commissioners and providers. - The Trust has been awarded Social Value Award status recognising the contribution to the outcomes of local populations. It is one of only two organisations in Cheshire & Merseyside to receive the award. - £90k funding received from One Public Estate to support progression of the Halton site redevelopment and a full review of the public sector estate in Warrington. Drafts of both reviews complete. - WHH commenced a focussed programme of work on addressing health inequalities, the green agenda and our role as an anchor instiution. Initial work recognised as the exemplary within Cheshire & Merseyside. - Consistent Trust representation within Cheshire & Merseyside ICS to support transition to ICS. WHH CEO appointed as lead for Clinical Pathways within C&M and the Trust is playing an active role within the Cheshire & Merseyside Acute & Specialist Trust (CMAST) provider collaborative. - Trust representation on newly established place based Boards within both Warrington & Halton. Trust continues to inform placed based strategies to ensure the Trust's priorities are reflected. - Discussions with neighbouring Trusts to accelerate collaboration taking place - Formal partnerships developed with key educational partners to enable tailored education & training and research opportunities.	
Assurance Gaps:	Risk to securing capital funding to progress new hospitals Self assessments of both Warrington & Halton hospitals place based governance development indicate that Halton is 'emerging' (stage 2 of 4) and Warrington is established (stage 3 of 4). There is a requirement to further develop as places to ensure both boroughs can benefit from potential future autonomy.	

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Continue to progress plans for new hospitals to be best placed to secure funding when available	Further develop SOCs and participate in competitive process for HIP funding	Further develop SOCs and participate in competitive process for HIP funding	Lucy Gardner	30/09/2022	SOCs – March 2020
Actively participate in and contribute to the development of integrated care partnerships at PLACE & provider collaboratives at regional level.	Participate in meetings and influence new governance development.	Participate in meetings and influence new governance development.	Simon Constable	31/03/2023	

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/22/07/96**			
SUBJECT:	**Strategic People Committee Cycle of Business 2022-2023**			
DATE OF MEETING:	27th July 2022			
AUTHOR(S):	John Culshaw, Trust Secretary			
EXECUTIVE DIRECTOR SPONSOR:	Simon Constable, Chief Executive			
LINK TO STRATEGIC OBJECTIVE: (*Please select as appropriate*)	SO1 We will.. Always put our patients first delivering safe and effective care and an excellent patient experience.	x		
	SO2 We will.. Be the best place to work with a diverse and engaged workforce that is fit for now and the future	x		
	SO3 We will ..Work in partnership with others to achieve social and economic wellbeing in our communities.	x		
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): (*Please DELETE as appropriate*)	All			
EXECUTIVE SUMMARY (*KEY ISSUES):*	In accordance with the Foundation Trust's Constitution 'Board of Directors – Standing Orders' the Board and Committees of the Board are required to review their Terms of Reference and Cycles of Business on an annual basis. The Cycle of Business for the Strategic People Committee (SPC) is attached for consideration and approval.			
PURPOSE: (*please select as appropriate*)	Information	**Approve √**	To note	Decision
RECOMMENDATION:	The Trust Board is asked to review and approve the 2022-2023 Cycle of Business for the Strategic People Committee			
PREVIOUSLY CONSIDERED BY:	**Committee**	Strategic People Committee		
	Agenda Ref	SPC/22/07/73		
	Date of meeting	20th July 2022		
	Summary of Outcome	Approved		
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: (*if relevant*)	None			

STRATEGIC PEOPLE COMMITTEE Work Plan 2022-2023

OPENING BUSINESS	Lead	23.03.2022	18.05.2022	20.07.2022	21.09.2022	23.11.2022	Jan 2023	March 2023
Apologies for Absence	Chair	√	√	√	√	√	√	√
Declarations of Interest	Chair	√	√	√	√	√	√	√
Minutes of the last meeting	Chair	√	√	√	√	√	√	√
Matters Arising / action log	Chair	√	√	√	√	√	√	√
STANDING ITEMS								
Hot Topic	Chief People Officer	√	√	√	√	√	√	√
Deep Dive	Chief People Officer	√	√	√	√	√	√	√
Chief People Officer Report	Chief People Officer	√	√	√	√	√	√	√
BAF & Risk Register – Staff	Trust Secretary/Deputy Director HR & OD	√	√	√	√	√	√	√
WHH People Strategy Report & Strategic Projects (People) including Equality, Diversity and Inclusion Strategy Update	Deputy Chief People Officer	√		√		√		√
CQC –Moving to Outstanding – Red Flags	Chief People Officer	√	√	√	√	√	√	√
Policies and Procedures Report (as required)	Deputy Chief People Officer	√	√	√	√	√	√	√
Employee Relations Report	Deputy Chief People Officer	√	√	√	√	√	√	√
Employee Relations Report Detailed investigation/disciplinary report alternate meetings	Deputy Chief People Officer	√		√		√		√
National Staff Opinion Survey	Deputy Chief People Officer	√						√
Freedom to Speak Up Bi-Annual Report	Chief Nurse & Deputy CEO	√			√			√
Workforce Key Performance Indicator Recommendations for 2022/23 (annual)	Chief People Officer						√	
VIP + Celebrity Visits Policy Annual Report	Director of Communications + Engagement						√	
Engagement and Recognition Annual Report	Chief People Officer	√						√
Trust Board Monthly Staffing Report – Key Issues Report	Chief Nurse & Deputy CEO	√	√	√	√	√	√	√
Hospital Volunteer Annual Report	Chief Nurse & Deputy CEO						√	
Bi-Annual Health & Wellbeing Guardian report	Chief People Officer	√			√			√
NATIONAL/STATUTORY REPORTS								
GMC Patient Survey Response Report when required	Executive Medical Director							
HENW Monitoring Visit (Annual Assessment Visit)	Executive Medical Director				√			
GMC National Trainee Survey	Executive Medical Director				√			
GMC Revalidation Annual Report (Medical Appraisal)/NHSE Statement of Compliance + NHSE Annual Organisation Audit (AOA)	Executive Medical Director				√			
Guardian Quarterly Report, Safe Working Hours Jnr Doctors in Training	Executive Medical Director		**Q4√**		**Q1 √**	**Q2√**	**Q3√**	
EQUALITY DIVERSITY + INCLUSION – Regulated Reports (as required)								
Equality Duty Assurance Report (EDAR) PSED Standard (sign off)	**Deputy Chief People Officer**							
Workforce Equality Assurance Report (WEAR) PSED Standard (sign off)	**Deputy Chief People Officer**							
Equality Delivery System 2 (EDS2)	**Deputy Chief People Officer**				√			
Gender Pay Report	**Deputy Chief People Officer**	√						√
Workforce Race Equality Standard (WRES)	**Deputy Chief People Officer**			√				
Workforce Disability Equality Standard (WDES)	**Deputy Chief People Officer**			√				
Facilities Time Off Annual Report (for sign off)	**Deputy Chief People Officer**			√				
GOVERNANCE								
Terms of Reference	**Chair /Trust Secretary**		√					
Annual Cycle of Business	**Chair/Trust Secretary**	√						√
Committee Chairs Annual report to Trust Board	**Chair/Trust Secretary**	√						√
Committee Effectiveness – Annual survey	**Chair/Trust Secretary**		**circl √**		**Report √**			
Committee Effectiveness Survey – 6 month survey	**Chair/ Trust Secretary**					**Circl √**		
Sub Committee Chairs Log / High Level Briefing Papers/Closing								

STRATEGIC PEOPLE COMMITTEE Work Plan 2022-2023

Operational People Committee	Chief People Officer	√	√	√	√	√	√	√
Equality, Diversity and Inclusion Sub Committee	Chief People Officer	√	√	√	√	√	√	√
Workforce Recovery Steering Group	Chief People Officer	√	√	√	√	√	√	√
Review of meeting	Chair	√	√	√	√	√	√	√

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/22/07/97**			
SUBJECT:	**Emergency preparedness, resilience and response (EPRR) annual report for 2021-22**			
DATE OF MEETING:	27th July 2022			
AUTHOR(S):	Rachel Clint, Acting EPRR Manager			
EXECUTIVE DIRECTOR SPONSOR:	Daniel Moore, Chief Operating Officer			
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	SO1 We will.. Always put our patients first delivering safe and effective care and an excellent patient experience. SO2 We will.. Be the best place to work with a diverse and engaged workforce that is fit for now and the future SO3 We will ..Work in partnership with others to achieve social and economic wellbeing in our communities.			X
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): **(*Please DELETE as appropriate)***	All			
EXECUTIVE SUMMARY *(KEY ISSUES):*	This report will:- • Provide an overview of the emergency preparedness arrangements within Warrington and Halton Hospitals NHS Foundation Trust. • Outline the work that has been undertaken in the area during the past 12 months. • Describe the trust response to incidents which have occurred during 2021-22. • Describe the response to COVID-19 and highlight the associated work to be prioritised in 2022-23. • Summarise the planned work streams and priorities for the year ahead.			
PURPOSE: *(please select as appropriate)*	Information	Approval	**To note**	Decision
RECOMMENDATION:	The Trust Board is asked to note the EPRR Annual Report.			
PREVIOUSLY CONSIDERED BY:	**Committee**	Finance + Sustainability Committee		
	Agenda Ref.	**FSC/22/07/124**		
	Date of meeting			
	Summary of Outcome	Noted		
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: *(if relevant)*	None			

REPORT TO BOARD OF DIRECTORS

SUBJECT	**Emergency preparedness, resilience and response (EPRR) annual report for 2021-22**	**AGENDA REF:**	**BM/22/07/97**

1. BACKGROUND/CONTEXT

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

Like most NHS organisations WHH has had our resilience tested on several occasions over the last year, most notably in the form of the continued pressures of the COVID-19 pandemic and the associated impacts on recovery and patient flow. The NHS declared the transition from Level 4 to a Level 3 incident on 25th March 2021. Level 3 escalation was maintained until the incident level was increased once again to Level 4 on 13th December in response to the Omicron variant. On 19th May 2022 the national decision was made to reduce the incident to Level 3 with a transition from COVID-19 response to recovery.

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

2. KEY ELEMENTS

Purpose

The purpose of the annual report is to: -

- Provide an overview of the emergency preparedness arrangements within Warrington and Halton Teaching Hospitals
- Outline the work that has been undertaken in emergency planning during the past 12 months
- Describe the trust response to incidents which have occurred during 2021-22.
- Summarise the planned work streams and priorities for the year ahead

3. ACTIONS REQUIRED/RESPONSIBLE OFFICER

Emergency Preparedness Structure

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

Lead Officers

- Dan Moore- Chief Operating Officer is the designated Lead Executive Director with responsibility for Emergency Planning within the Trust.
- Terry Atherton is the Non-Executive Director nominated to support the Chief Operating Officer in this role.
- The Lead Director is currently supported by Rachel Clint, Acting EPRR Manager.

Committee Structure

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

The Event Planning Group (EPG), chaired by the Chief Operating Officer, is charged with the responsibility of overseeing the development of emergency preparedness arrangements within the Trust. The group meets on a monthly basis and its membership includes senior managers from Planned Care, Unplanned Care and Clinical Support Services, there is clinical attendance and appropriate representation from corporate services. The operational pressures in 2021-22 have meant the EPG group has met less frequently, however Tactical Group has remained as a forum for the communication of national guidance along with being a platform to oversee updates to trust policies.

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

EPRR External Structure:

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

4. IMPACT ON QPS?

All NHS organisations are required to deliver their legal duties and responsibilities for Emergency Preparedness, Resilience and Response (EPRR) set out in The Civil Contingencies Act 2004.

5. MEASUREMENTS/EVALUATIONS

Training

The Trust has an ongoing programme of exercises and training events to test and validate emergency plans. In 2021-22 there have been more opportunities to engage teams in training exercises and this programme will continue with some routine training along with standalone tabletop exercises.

Assurance Process

The Trust is required to undertake an annual self-assessment against the NHS England Core Standards for EPRR. The full assurance exercise was last undertaken in September 2021 (after a lighter assurance process was carried out in 2020). The annual self-assessment provided by NHSE returned to its pre-pandemic format with some slight amends. The Trust self-assessment was submitted as 'substantial compliance'. There was a deep dive assessing the oxygen capabilities of acute settings.

The self-assessment indicated WHH met full compliance in 89-99% of the relevant NHS EPRR Core Standards (49 out of 53 at full compliance). Four areas were assessed as being 'partially compliant': Data Protection and Security Toolkit, Decontamination Capability available 24/7 and within the deep dive Medical Gasses Workforce and Medical Gasses Governance were marked as having partial compliance. Work continues to address the partially compliant measures.

Measures to progress against these standards have been picked up through Event Planning Group and training. Formal outcomes of the 2021 compliance are shared prior to the publication of the 2022-23 process.

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

Incidents & Exercises

During 2021-22 the following significant incidents and exercises occurred:

NHS National Incident Level 3 (March -December 2021)

NHS National Incident Level 4 (12th December 2021- present)

The Trust Silver Command Tactical meetings remain in place and within this forum operational, clinical, nursing and corporate staff continue to support the Trusts response to the national incident. Key policies pertaining to COVID-19 including the vaccination, Infection Prevention and Control and HR, Occupational Health and Wellbeing have been governed through this forum. Surveillance and escalation planning have also been managed via the Tactical Group.

COVID-19 related pressures have continued to impact on the operational activity at WHH, in Cheshire and Merseyside and nationwide. There has been less of an impact on critical care during 2021-22, however the number of patients with COVID-19 surpassed the quantities experienced in the first wave and during the most recent winter there were significant staffing challenges associated with the impacts of the Omicron variant. Robust monitoring of the local, regional and national situation has occurred and

the trust has once again responded to rapidly changing guidance and activity whilst maintain quality standards.

COVID-19, alongside the recovery plan and increased pressures on patient flow has dominated the trust emergency planning workstream in the last year. Learning from 2020-21 was embedded to support the response to the subsequent surges of COVID-19. External factors impacting upon discharge have exacerbated the challenges associated with periods of increased community infection rates.

WHH Tactical Group will continue to manage the response to COVID-19 once again capturing the learning from previous experiences.

Creamfields (26th- 30th August 2021)

After a two-year hiatus, the Creamfields Music Festival returned to Daresbury in August 2021.

The August Bank Holiday weekend has historically been a busy period for the Trust. Fluctuations in demand associated with bank holiday periods exist, but the August Bank holiday weekend also coincides with the staging of the Creamfields Music Festival (CF) in Daresbury, of which Warrington Hospital is the primary receiving hospital for the event.

Creamfields 2021 was held between Thursday 26th August and Monday 30th August. A series of planning meetings with external organisations and partners took place, along with internal Bank Holiday weekend planning meetings.

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

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

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

Representatives from clinical, nursing and operational teams met with the event organisers and medical team twice in advance of the festival weekend (10th June 2021 and 4th August 2021). There were weekly Tactical updates form 10th August 2021 and in the week before the event there were daily staffing and capacity updates shared through Tactical meetings. A bank holiday handover meeting took place on Friday 27th August. The Creamfields Event Team invited the Trust to attend two daily Silver Command meetings at 10am and 8pm across the 4-day festival. NHS England and NHS Improvement initiated daily 12pm Gold Command meetings with senior (Executive or SMOC) representation from acute Trusts in Cheshire and Merseyside, along with Wigan. The aim of these meeting was to coordinate any items to escalate or plans for mutual aid if required.

A Trust debrief was carried out, along with a health debrief and a full event debrief. Successful elements of the response have been captured and will be incorporated into the planning for the 25th anniversary event in 2022.

What went well?

- Communication – before and during the event. The CF21 team were accessible to share and update planning, respond to queries and a detailed catalogue of contacts was shared
- NWAS Operational plan and communication of the plan
- Access to NWAS contact on site
- Internal plans from CBUs including enhanced staffing models across the weekend
- Security was helpful with difficult patients in the ED
- Communication of standby patients between the CF site and WHH ED
- Resus emergency registrar calls from the CF site to WHH ED
- Enhanced weekend planning enabled the site position on the bank holiday Monday to be better than forecast

Learning

- Plan for the week after the festival as part of the bank holiday planning approach
- Keep communications channels open with event team / wider partners
- Enhance SMOC over the CF festival weekend
- It would be helpful if a system escalation plan could be devised by Gold Command with forward planning for mutual aid opportunities across C&M
- Continued command and control structure to pick up and escalate key national / regional communications
- Cascading of significant information was useful (through 8pm and 10am Silver Command calls – e.g. types of drugs found on site)

Impact on WHH

- 52 festival related attends, 6 admitted, 0 ICU
- Significant amount of learning to take forward to 2022 and wider event planning (Christmas planning etc.) 2022 is the 25-year anniversary festival with advertising and tickets sales commenced immediately after the 2021 event
- Strengths included the collaboration with partners, the sharing of key information and contacts, the senior support from WHH, clear communication of plans, weekend template, Silver Command meetings with the site and wider partners
- Learning – definition / clarity on mutual aid through C&M, ensuring Patient Flow / SMOC are fully aware of escalation plans ahead of weekends / as part of handovers
- Actions – maintain the level of detail and organisation for future largescale events / bank holidays. Bank holiday planning should also include planning for the subsequent week.

Planned Lorenzo Cloud Migration (11th -12th September 2021)

Lorenzo and ORMIS Planned Downtime Saturday 11th - Sunday 12th September 2021 to support the migration of Lorenzo to the Cloud. These changes were mandated through NHSD and needed to be completed by November 2021, with Lorenzo updated and improved as an outcome.

The downtime was planned to be concluded for medical rounds on Sunday morning. Saturday night to Sunday morning was selected due to a trend of lower admissions overnight, Outpatients not impacted upon on Sunday and Theatre scheduling not affected if the downtime took longer than the expected time allocated.

There were contingencies in place and if this downtime overran and impacted on the medical rounds, the work could be rolled back, and the previous version of Lorenzo recovered. There were several go/ no-go meetings in advance of the planned downtime. Two previous planned downtime occurrences in July and August were stepped down due to site pressures.

An impact assessment was carried out in advance of the downtime with a range of impacts considered, including; impact on EPMA – increased workload for Pharmacists and associated reconciliation of paper records, scanning of paper records from ED and wards inc Observations and Manual Paper on Take list for patients DTA'd during downtime. A number of actions were carried out in preparation for the planned downtime, These included; a review of Business Continuity Plans, checks of Manual Documentation Kit [Battle Boxes] and a check of Fallback PCs

Weekly planning meetings commenced in June 2021 with Deadalus and the WHH ePR and Digital Programmes departments. The service desk was included in planning meetings. A robust operational plan was implemented and escalated two weeks in advance of the downtime to compliment the planning delivered by the ePR and Digital Programmes department.

What went well?

- Advanced planning and mitigation
- Reporting through Digital Optimisation Group, Event Planning Group, Tactical Board and Change Authority Board – wide communication across Information and Operational forums
- Runners – ePR floorwalkers were visible and performed designated tasks to ensure checklists were complete
- Use of checklists for all wards
- Action cards
- Compliment of staff on site in response to the planned downtime
- Executive support
- The senior decision making on the morning when the downtime lasted longer than expected

Learning

- More education around retrospective administration for nursing staff
- Old apps – remove when updated
- Increased ward communication when handovers occur
- Involvement of nursing teams in the planning and debrief process
- Review the action cards in the eyes of a user.

Business Continuity Desktop Exercise (7th October 2021)

Digital Compliance developed a bespoke tabletop, scenario-based exercise for delivery to key stakeholders from across the Trust. The purpose of this exercise was to assist and enable stakeholders within the Trust:

- To identify gaps in the incidence response policy and procedure, and in doing so refine and improve these documents
- Enhance understanding of any key considerations associated with unplanned downtime of the key clinical systems
- Test and validate co-ordination and information-sharing amongst the stakeholders

Summary of exercise:

- 40 attendees were invited to attend and conduct the exercise, but due to other work commitments and operational pressures, 18 were able to attend and there was limited operational attendance
- The group recorded their discussion points and reviewed with the wider attendees after each session completed. This approach enabled an immediate sharing of ideas and understanding, that incorporated various viewpoints. Ideas from group were then discussed in open forum, allowing for the comparison of differing opinions and a broader discussion of common themes

The recommendations resulting of the exercise were:

- Widen the desktop exercise to include Silver Command structure
- The Trust should consider how best to provide centralised BCP function for easier location of key documentation
- Review of battle boxes. Ensure they are up-to-date and ensure that they are topped back up once used

The next steps include:

- There is an aspiration to continue with the tabletop exercises as it is a key enabler in preparing for a real-world event. Digital Services and the EPPR Manager to set up another Desktop Exercise and consider the timing of the exercise.

Trustwide Evacuation Exercise (2nd December 2021)

A scenario was provided by UKHSA to test the response and resilience of WHH to a large-scale fire requiring full site evacuation. The Trust Evacuation policy was updated ahead of the exercise and incorporated the latest national guidance on Evacuation and Shelter, published in October 2021.

The tabletop exercise was facilitated by the Emergency Planning Manager from NHSE NW, with representation from Cheshire Fire Service and NWAS. The aims were to rehearse the 'people' and test the plans. A full (tabletop) evacuation of the main building was required as part of the exercise with further aims to capture the learning, analyse the gaps and enhance the Trust emergency plans.

The exercise was attended by 32 senior managers across Ops, Nursing & Governance, Clinical Support services and EFM. Attendees from Cheshire Fire Service expressed confidence in the WHH Evacuation Plan

There were a number of lessons learned from the exercise:

- Warrington site would be problematic to manage in the event of a full evacuation – limited peripheral areas for shelter, lack of provisions for comfort away from the main building (blankets, seating), no back-up Switchboard
- Major Incident materials all located in the Trust Conference Room – the need to identify at least one additional peripheral location for resources, tabards and emergency phones
- With increased activity at Halton specific plans need to be developed to manage emergency planning on that site – is a Manager of the Day appropriate? Control Room, action cards and specific site plans require consideration
- Traffic management and site access plan (Early lessons learned from the incident at LWH include consideration of traffic management in to and out of the site and access OOH- staff need to carry ID badges if access is required)
- Clarity of roles required – e.g. Who is the SPOC in the event of fire / IT infrastructure failure / etc. Clearer defined roles required in emergency plans

Actions

- Develop and test emergency plans at Halton site – Cheshire Fire Service will support a live face-to-face simulation exercise
- Consideration of a face-to-face exercise upon completion of ED Plaza (before it is operational) with more of a focus of training colleagues on the floor
- The location and number of Battle Boxes / Major Incident resources to be reviewed and procure additional resources, including resources for Halton.

End of the EU transition period / Brexit management (ongoing to March 2022)

The UK exited the EU on 31 January 2020 and was in a transition period until 31 December 2020. An EU Exit deal was established on 24th December 2020. The impacts of the terms of this deal and the implications on the supply of medicines and consumables have been monitored nationally and locally since the end of the transition period. The Brexit Subgroup have continued to meet to monitor the implications of the established deal.
In anticipation of the end of the transition period on 31st December 2020, the Trust reinstated the Brexit Subgroup on 8th September 2020. On 16th September 2020, Keith Willet's letter outlined the NHS intention to manage the EU Exit alongside the ongoing COVID-19 response, through the established national, regional and local coordination centres.

A system stand up letter was received on 4th November with the instruction for the NHS to take steps to prepare for the end of the transition period. Cross system assurance was completed and daily

SitRep submissions were stepped up between November 2020 and July 2021. The national requirements for Emergency Preparedness Resilience and Response command and control structures were in place and all communications to the Trust were received via a single point of contact. The Chief Finance Officer and Deputy Chief Executive was dedicated as the SRO for this work stream. The EPRR Manager continued to attend Local Health Resilience Forum meetings and national webinars to keep abreast of updates and actions required by the trust.

The Brexit Subgroup consisted of leads from Pharmacy, Procurement, HR, Communications, Pathology, Finance, Information and EPRR. Meetings have continued into 2022 with each lead updating the group with information pertaining to their work stream and any associated risks during these meetings. Updates were shared with the Tactical Group as appropriate. There has been no further indication from the national or regional EPRR management teams that the monitoring of changes relating to the end of the transition period needs to continue. Brexit is no longer an item discussed at local resilience meetings. Brexit updates will now be monitored through the monthly Event Planning Group as a standing agenda item. Event Planning Group reports to Finance and Sustainability Committee. Any items of an urgent nature will be considered through Tactical Group and will always be escalated to the Chief Finance Officer and Deputy Chief Executive.

The Brexit Group was concluded in March 2022.

Senior Manager on-call (SMOC) Training (November 2021, May 2022)
Bi-annual SMOC training has been revised and has been delivered ensuring both experienced and newer members of the senior operational management team are confident with trust plans and out of hour arrangements. An accompanying SMOC handbook acts as a guide to support the role and gives an overview of a number of significant documents that may require access at pace. The trust On-Call Guidelines have also been updated.

Site Manager Training (May 2022 and monthly thereafter)
The EPRR Manager is supporting the training of the nurse site management team to establish understanding of key emergency planning policies, action cards and escalation out of hours. This training will occur monthly through Ward Managers meetings.

Decontamination Training (April-May 2022)
A new decontamination tent was procured, and training has been delivered to ED Matrons, Coordinators and six nurses to support the trusts CBRN capabilities. Further CBRN training has been delivered within the department and this will remain as an ongoing programme of training.

Planned IT and Telephony Downtime (ongoing)
There have been a number of instances of IT and Telephony downtimes. A robust operational management plan has been developed to ensure all wards and departments are aware of the details of each period of downtime, the mitigation, actions, service impact and recovery from the downtime. A series of preparatory meetings have enabled thorough planning ahead of scheduled downtime and in the last year there have been no service impacts as a consequence of the installation of appropriate updates to systems. Learning from 2021-22 has been captured to ensure a thorough response to future periods of planned and unplanned downtimes.

Wider events / disruptions

A number of events with potential implications on the Trust have been monitored. These include:

- Conflict and refugee movements from both Afghanistan and the Ukraine
- Cybersecurity threats (enhanced surveillance due to Russian invasion of Ukraine)
- Fuel disruptions (August – September 2021)
- RSV – Paediatric management of potential surge
- Avian Flu (WHH involvement in providing prescribed medicines to individuals working with infected birds)
- Liverpool Womens Hospital incident (November 2021) and increased level of terrorism threat.

Work undertaken in 2021/22

The following policies were reviewed and updated to reflect local and national developments during 2021-2022:

- The Major Incident Plan
- Trust Escalation Plan
- Full Capacity Plan
- Evacuation Plan
- Lockdown Plan
- Bomb Threats and Suspicious Behaviour Guidelines
- Severe Weather Plans (including Cold Weather Plans and Heatwave Plans)
- Fuel Plan
- On-call Guidelines
- SMOC Handbook
- Omicron escalation plan
- Ward Escalation Plans
- Internal Winter Plan
- System Winter Plan
- Bank Holiday Plans

Engagement has continued with the following external groups:

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

Patient Flow Initiatives

There have been a number of 'Perfect Week' style initiatives to support planning for holiday periods. These have included:

- Operation Reset
- Focus on Flow
- Home for Christmas
- New Year, New Start
- Home for Easter
- Home for Bank Holiday (Early May and Jubilee)

Learning has been captured from these initiatives and will be used to support event and holiday planning in the future.

Single Point of Contact

The EPRR Manager has continued to act as the trusts Single Point of Contact (SPOC). This includes the monitoring, storing and cascading of national and local guidelines. In a Level 4 incident the SPOC maintains vigilance for any key communication both within working hours and between the hours on 08.00am and 20.00pm Monday to Friday and between 09.00am and 18.00pm on weekends and bank holidays.

6. TRAJECTORIES/OBJECTIVES AGREED

Work programme for 2022/23

In 2021-22 the focus has primarily been on supporting the Trust response to the continued COVID-19 pandemic and associated operational pressures. This has included phases of command-and-control tactical management, surge management and recovery.

The Single Point of Contact / Control Room function (as outlined in NHS Operational Planning Guidance for 2021/22) remains in place for the year ahead and will continue to be managed by the EPRR Manager.

For 2022-23 the focus will include reviewing all EPRR Plans in line with the Core Assurance Framework and testing a number of these plans. EPRR in an ongoing cycle of planning, training, testing and improving. Although debrief activities have been carried out, it is prudent to continue to capture the learning through response and recovery to enable effective winter preparation for 2022/23. This will include collaboration with key stakeholders involved in the responses, raising staff awareness, testing plans and identifying any areas for improvement.

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

- Continue to deliver training to key staff in Emergency Preparedness and Incident Management through SMOC training, Site Manager training and ad-hoc events
- Update and test the Trust Major Incident plan ensuring wider stakeholder input
- Continue to develop Trustwide CBRN plans to complement the plans in UEC
- Develop specific plans for managing winter pressures
- Continue as a full and active member of the Local Health Resilience Planning Group
- Update plans and procedures in line with any new National guidance
- EPRR education within care groups and the workforce to enhance resilience
- Review the Corporate Business Continuity Plan and request all areas revisit their plans
- Monitor the lessons learned from other local, regional and national incidents
- Support the trust response to the Public Inquiry into COVID-19 as appropriate.

7. MONITORING/REPORTING ROUTES

The NHS England led LHRP meets bi- monthly externally and is attended by the Trust Emergency Planning Lead; the outcomes are fed into the Trusts Event planning meeting / Tactical group meeting.

The 2022 NHS EPRR Core Standards Audit is yet to be confirmed by NHSE.

Review and implementation of the latest NHSE and UKHSA guidance occurs through Tactical meetings. The Tactical Board function remains in place to oversee the management of incidents and escalation planning. Appropriate items are escalated to the Strategic Executive Oversight Group (SEOG).

8. TIMELINES

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

9. ASSURANCE COMMITTEE

The EPRR Manager escalates issues to the Tactical Board. The Event Planning Group continues to escalate changes through Finance and Suitability Committee, the Tactical Group and SEOG.

10. RECOMMENDATIONS

The Board is asked to note the significant work and achievements undertaken during 2021-22 and the planned work programme for 2022-23 in support of the Trust's objectives.

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/22/07/98**	
SUBJECT:	**Charitable Funds Committee – Trustee Checklist**	
DATE OF MEETING:	27th July 2022	
AUTHOR(S):	Helen Higginson, Head of Fundraising	
EXECUTIVE DIRECTOR SPONSOR:	Pat McLaren, Director of Communications and Engagement	
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	SO1 We will.. Always put our patients first delivering safe and effective care and an excellent patient experience.	X
	SO2 We will.. Be the best place to work with a diverse and engaged workforce that is fit for now and the future	X
	SO3 We will ..Work in partnership with others to achieve social and economic wellbeing in our communities.	X
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): **(*Please DELETE as appropriate)***		
EXECUTIVE SUMMARY *(KEY ISSUES):*	The Trust Board is the Corporate Trustee of Warrington and Halton Teaching Hospitals' Charity. In June 2016 the Charities Commission (the regulator) issued new guidance for Charity Trustees. This checklist is designed to help the Corporate Trustee (delegated authority to the Charitable Funds Committee) evaluate the Charity's performance at suitable intervals against the legal requirements and good practice recommendations set out in the Charities Commission guidance: 1.Planning effectively 2.Supervising fundraisers 3.Protecting charity's reputation, money and other assets 4.Identifying and ensuring compliance with the laws or regulations that apply specifically to charity's fundraising 5.Identifying and following any recognised standards that apply to charity's fundraising 6.Being open and accountable The Corporate Trustee is requested to note the update: 1. Item 4.1 2022-2025 strategy approved March 2022 and KPIs are monitored at each CFC 2. Item 4.3 The resources we use and the costs we incur in our fundraising - The refreshed FR Strategy has identified limits to overhead expenditure based on income growth with the intention of reducing cost/income ratios to ensure that donated funds are used in majority for patient benefit	

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

RECOMMENDATION:	That the Trust Board note the responsibilities of the Corporate Trustee (delegated to CFC) and the changes to the checklist as indicated above.	
PREVIOUSLY CONSIDERED BY:	**Committee**	Charitable Funds Committee
	Agenda Ref.	CFC 21/12/92c
	Date of meeting	9 December 2021
	Summary of Outcome	Submit to Trust Board
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None	

Charitable Funds Committee CFC 22/06/10b

Charities Commission – Checklist for WHH Charity Trustees

June 2022

Guidance	Current status	Mitigations/actions/notes
Section 4: Planning effectively	RAG	
4.1 We have set out our fundraising plan		• 2022-25 Strategy approved March 2022 and KPIs are monitored at each CFC • We continue to review our Strategy periodically in line with changing trends in charitable giving.
4.2 It reflects our charity's values		• WHH Charity's values are: Ethical, Transparent, Accountable, Compassionate, Creative and the Charity also adopts the values of the Corporate Trustee of Working Together, Excellent, Inclusive, Kind and Embracing Change.
4.3 The resources we use and the costs we incur in our fundraising		• Our overheads are subject to scrutiny at each CFC meeting as part of the Finance Report • The refreshed FR Strategy has identified limits to overhead expenditure based on income growth with the intention of reducing cost/income ratios to ensure that donated funds are used in majority for patient benefit • Income and expenditure (actual and forecast) are scrutinised and challenged at each CFC • A revised reserves policy was adopted in June 2019.
4.4 The key financial and reputational risks we may face		This has been identified in the Risk Strategy developed in Feb 2016. All WHH Charity risks are now managed through the Trust's DATIX system and reported to each CFC
4.5 We monitor progress		A fundraising activity and financial report is reviewed by the CFC at each meeting
4.6 We manage key risks		The key risks are reviewed at each meeting
Section 5: Supervising our Fundraisers		
5.1 We have considered and decided which fundraising issues we will not delegate		Our Fundraising team is directly accountable to and line-managed by a member of the executive team
5.2 Our fundraising staff have job descriptions		Current and in place
5.3 Our fundraising staff are doing the job successfully		PDR complete October 21, Income objectives subject to approval of WHH Charity refresh forecast Monthly 1:1s with Director and informal catch ups in between meetings
5.4 Our volunteers know who they report to and who to approach with problems or concerns		WHH Volunteers assumed responsibility for all volunteers in September 2016, those on placement with WHH Charity report to and are supervised by the Fundraising Manager
5.5 Our volunteers understand the boundaries within which they must work when representing the charity		They receive Trust induction from WHH Volunteers and local induction from the Head of Fundraising and are supervised at all times

5.6 Our subsidiary trading company is monitored for effectiveness and only enters into commercial partners in the charity's best interest	N/A	
5.7 Our arrangements with commercial providers fully comply with relevant legal requirements		We undertake all procurement through the Corporate Trustee and ensure through contract that all legal requirements are met and maintained
5.8 Are in our charity's best interest because appropriate due diligence is undertaken		We procure using the Corporate Trustee's procurement team
5.9 Our fundraising values and expectations are communicated		These are agreed upon contract
5.10 The costs are justifiable and can be explained		All expenditure is reviewed by the Budget Holder and reported through the Finance Report
5.11 Proper control is kept of the money raised		• All monies are routed into the WHH Charity bank account, no other methodology is permitted. • Staff training and awareness on the correct processing of charitable donations is continuous and written into the WHH Staff Handbook
5.12 Fundraising communications used are reviewed		All communications are approved by the Fundraising Manager and/or Director
5.13 Compliance with the agreement is monitored		Compliance is monitored following contract
5.14 Any conflicts of interest are recognised and dealt with		The Corporate Trustee has a Managing Conflicts of Interest Policy which has been adopted by WHH Charity
Section 6: Protecting our charity's reputation, money and other assets		
6.1 The reputational risks our charity may face are identified, assessed and managed		Reputational risks have been identified in our Risk Strategy
6.2 Likely donor, supporter and public perception is considered when income expectations and other goals are considered		Our bid application process includes this to ensure compliance of all parties via capital campaigns
6.3 The legal rules and recognised standards which apply to our fundraising are followed		We follow the Code of Fundraising Practice, the Chartered Institute of Fundraising and the Association of NHS Charities Together guidance. We are registered with and regulated by the Charities Commission
6.4 Our values are communicated to the people who work on our fundraising		All WHH staff adopt and practice the values of the Corporate Trustee, they and the public are further briefed on the aims and objectives of WHH Charity and are guided on how to proceed with fundraising initiatives on a personal/team/company level.
6.5 The costs of our fundraising are managed and explained		We control our costs through a bid application process We review our costs at each CFC meeting
6.6 Our fundraising finance is planned and monitored		We have an annual plan in place, the KPIs of which are reviewed at each CFC meeting.
6.7 Effective financial controls are in place and followed		The Corporate Trustee's Finance Team monitor all expenditure
6.8 Risks of financial crime and fraud are reduced		WHH Charity provides a letter of authorisation to every fundraiser who is requested to sign acceptance of the 'contract' between us.
6.9 Our charity is alerted to any suspicious donations		• Our Finance Team review all bank statements and incoming direct funds

		• Provenance of all cheque and cash donations is tracked through the donor journey and recorded via Harlequin, with a receipt and thank you letter posted out to the donor.
6.10 our charity can stop or authorise any unauthorised fundraising activity using its name		• We use a letter of authorisation to authorise fundraisers to raise funds on our behalf. • We would alert the police to any suspicious activity undertaken in our name.
6.11 Serious incidents are reported to the Commission, police and other agencies		• NHS Protect may also be contacted where NHS Employees or their families are involved.
6.12 Our data, name, image, logo and IP are protected		• We do not issue our logo independently for 3rd party use • We use letters of authorisation for 3rd party fundraisers • We provide our own branded materials for support • Our intellectual property is protected to the best of our ability and knowledge
Sections 7 and 8 Following the Law and recognised standards		
7.1 the Code of Fundraising Practice and other resources are used to find out about the legal rules and recognised standards which apply to our fundraising		We follow the Code of Fundraising Practice, Institute of Fundraising and the Association of NHS Charities guidance. We are registered with the Fundraising Regulator
.2 These rules and standards are followed		We follow the Code of Fundraising Practice, Institute of Fundraising and the NHS Charities guidance
Section 9: Be Open and Accountable		
9.1 Any legal rules and requirements that apply to how our charity reports and accounts for its fundraising are complied with		We are audited periodically and produce an annual report and accounts each autumn.
9.2 Our open and accessible complaints procedures are followed if concerns are raised		• In the first instance complaints should be raised to the Fundraising Manager or Director • The Charity uses the resources of the Corporate Trustee ie PALS and Complaints procedure. • The Charity will make this process clear via its website
9.3 Our fundraising aims and achievements are clearly communicated to the public and donors/supporters		Our website is maintained and updated regularly, Our social media platforms are updated regularly.

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/22/07/99**	
SUBJECT:	**Director of Infection Prevention and Control Annual Report**	
DATE OF MEETING:	27th July 2022	
AUTHOR(S):	Lesley McKay, Associate Chief Nurse, Infection Prevention + Control	
EXECUTIVE DIRECTOR SPONSOR:	Kimberley Salmon-Jamieson, Chief Nurse + Deputy Chief Executive	
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	SO1 We will.. Always put our patients first delivering safe and effective care and an excellent patient experience. SO2 We will.. Be the best place to work with a diverse and engaged workforce that is fit for now and the future SO3 We will ..Work in partnership with others to achieve social and economic wellbeing in our communities.	✓ ✓ ✓
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): **(*Please DELETE as appropriate)***	**#1215** Failure to deliver the capacity required caused by the ongoing COVID-19 pandemic and potential environmental constraints resulting in delayed appointments, treatments and potential harm **#1273** Failure to provide timely patient discharge caused by system-wide Covid-19 pressures, resulting in potential reduced capacity to admit patients safely. **#115** Failure to provide minimal staffing levels in some wards and departments. Caused by vacancy position, current sickness levels and absence due to COVID 19. Resulting in depleted staffing levels, potentially impacting the ability to provide basic patient care and treatment. **#1275** Failure to prevent Nosocomial Infection caused by high transmitability of variant strains, waning effect of vaccines, asymptomatic carriage (staff or patients), false negative test results, high local community prevalence. **#1134** Failure to provide adequate staffing caused by absence relating to COVID-19 resulting in resource challenges and an increase within the temporary staffing domain **#1125** Failure to achieve constitutional access standards caused by the global COVID-19 Pandemic resulting in high attendances and occupancy, non-compliance for RTT, Diagnostics, Cancer and ED Performance **#1108** Failure to maintain staffing levels, caused by high sickness and absence, including those affected by COVID-19, those who are assessed as only able to work on a non-respiratory pathway, resulting in inability to fill midwifery shifts. This also currently affects the CBU management team.	
EXECUTIVE SUMMARY (KEY ISSUES)	This report outlines the arrangements, activities and achievements of the Trust relating to infection prevention and control for the April 2021 to March 2022 financial year.	

	The Covid-19 pandemic continued to place high demands on the Infection Prevention and Control Team and had an impact of achieving the annual work plan as activity was redirected in response to the pandemic. There were: - • 32 Covid-19 outbreaks • 104 Hospital onset/probable healthcare associated cases • 189 Hospital onset/definite healthcare associated cases HCAI case numbers are comparable with similar sized Trusts. Totals for HCAIs were: - • 46 Clostridium difficile cases - 2 over threshold • 1 MRSA bacteraemia case – re-apportioned to another Trust • 29 MSSA bacteraemia cases – no threshold • 63 E. coli bacteraemia cases – significantly under threshold • 26 Klebsiella bacteraemia cases – 3 cases over threshold • 3 Pseudomonas cases – 1 case under threshold HCAI prevention plans are in place to prevent healthcare associated infections. This report builds on previous annual reports submitted to the Board of Directors to give a full year account of infection prevention and control activity.			
PURPOSE: (please select as appropriate)	Information	Approval	To note ✓	Decision
RECOMMENDATIONS:	The Trust Board is asked to receive and note the report.			
PREVIOUSLY CONSIDERED BY:	**Committee**	Quality Assurance Committee		
	Agenda Ref.	QAC/22/179		
	Date of meeting	5th July 2022		
	Summary of Outcome	Director of Infection Prevention and Control Annual Report was approved.		
FREEDOM OF INFORMATION STATUS (FOIA):	Release in Full			
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None			

REPORT TO BOARD OF DIRECTORS

SUBJECT	Director of Infection Prevention and Control Annual Report	AGENDA REF:	BM/22/07/99

Table of Contents

1. BACKGROUND/CONTEXT

Executive Summary

Organisation

Warrington and Halton Teaching Hospitals NHS Foundation Trust, sits within the mid-Mersey region in the northwest of England, providing healthcare services to Warrington, Runcorn, Widnes, and surrounding areas. The Trust has 3 hospitals across two sites, circa 520 beds, an operating budget of £261 million and employs over 4,200 staff.

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

Infection Prevention Annual Work Plan

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

A robust annual work plan (appendix 1) has been devised for the 2022/23 financial year. The work plan includes attendance at other committee meetings to ensure integration of infection prevention and control across the organisation; compliance with all mandatory surveillance requirements; monitoring of environmental cleanliness standards; audits of practice/policies; policy/guideline reviews and a programme of education and awareness raising events.

The work plan links to the updated Infection Prevention and Control Strategy which was launched in June 2022 and progress will be monitored by the Infection Prevention and Control Sub-Committee.

Covid-19 Pandemic

The Covid-19 pandemic continued to present challenges and timely and integrated working took place between the operational and Infection Prevention and Control Team to ensure safe patient placement.

The Trust complied with recommendations for reporting outbreaks and investigation of hospital onset cases as detailed below: -

- 32 Outbreaks reported
- 104 HO-pHA cases
- 189 HO-dHA cases

Covid-19 root cause analyses review meetings are in place to identify learning for the hospital onset cases, with findings shared at Infection Control Sub-Committee meetings.

Code of Practice on Prevention of Healthcare Associated Infections

Good progress has been made to achieve the requirements of the Health and Social Care Act (2008) Code of Practice on Prevention of Healthcare Associated Infections (2015) which is linked to Regulation 12 of the Health and Social Care Act (2008). The Trust is working towards full compliance with the 10 criterions: -

- 8 are fully compliant
- 2 have minor non-compliances

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

The annual Patient Led Assessment of the Care Environment (PLACE) was deferred due to the Covid-19 pandemic.

Healthcare Associated Infections

NHS standard contracts include a quality requirement to minimise rates of C. difficile and Gram-negative bloodstream infections (GNBSI) to thresholds set by NHS England/Improvement (NHSE/I). The reduction thresholds were set against 2019 calendar year Healthcare associated infection (HCAI) data.

Trust apportioned healthcare associated infection (HCAI) figures include hospital onset/healthcare associated (HOHA) and community onset/healthcare associated (COHA) cases and were reported as below: -

Table 1 HCAI Data and Thresholds

Organism	Trust Apportioned HOHA/COHA	Total	Trust threshold	Comment
C. difficile	34 HOHA: 12 COHA	**46**	44	CCG panel considered 3 cases were unavoidable, resulting in 43 Trust attributed cases
E. Coli bacteraemia	33 HOHA: 30 COHA	**63**	81	Under threshold
Klebsiella Spp. bacteraemia	18 HOHA: 8 COHA	**26**	23	Over trajectory. Increase in cases noted nationally
MRSA bacteraemia	1 COHA case	**1**	Zero avoidable	Case reapportioned to another Trust. Reduction to Zero cases
MSSA bacteraemia	24 HOHA: 5 COHA	**29**	No threshold	Work is in progress with the MRSA/MSSA prevention action plan
P. aeruginosa bacteraemia	3 HOHA: 0 COHA	**3**	4	Under threshold.

Collaborative working with the Quality Academy continued with targeted work to prevent GNBSI. This involved working with wards with higher case incidence and focussed on hydration, continence and urinary catheter management, patient hand hygiene and urinary tract infection (UTI) detection and management.

All Trust apportioned C. difficile cases undergo root cause analysis (RCA) investigation. Cases considered unavoidable are submitted to the Clinical Commissioning Group (CCG) review panel. RCAs have been competed however there was a delay in completing some reviews and submission to the CCG due to the Covid-19 pandemic. Actions in place to prevent C. difficile include; hand hygiene (staff and patients), environmental cleanliness and antimicrobial stewardship.

This report outlines the arrangements, activities, and achievements during the 2021/22 financial year. The report builds on previous annual reports submitted to the Board of Directors to give a full year account of infection prevention and control activity.

Kimberley Salmon-Jamieson
Chief Nurse/Deputy Chief Executive
Director of Infection Prevention and Control (DIPC)
July 2022

Acknowledgements

Lesley McKay	Associate Director of Infection Prevention and Control
Dr Zaman Qazzafi	Consultant Medical Microbiologist
Jacqui Ward	Lead Pharmacist in Antimicrobial Stewardship
Julie McGreal	Head of Facilities
Allen Hornby	Lead Nurse Critical Care

2. KEY ELEMENTS

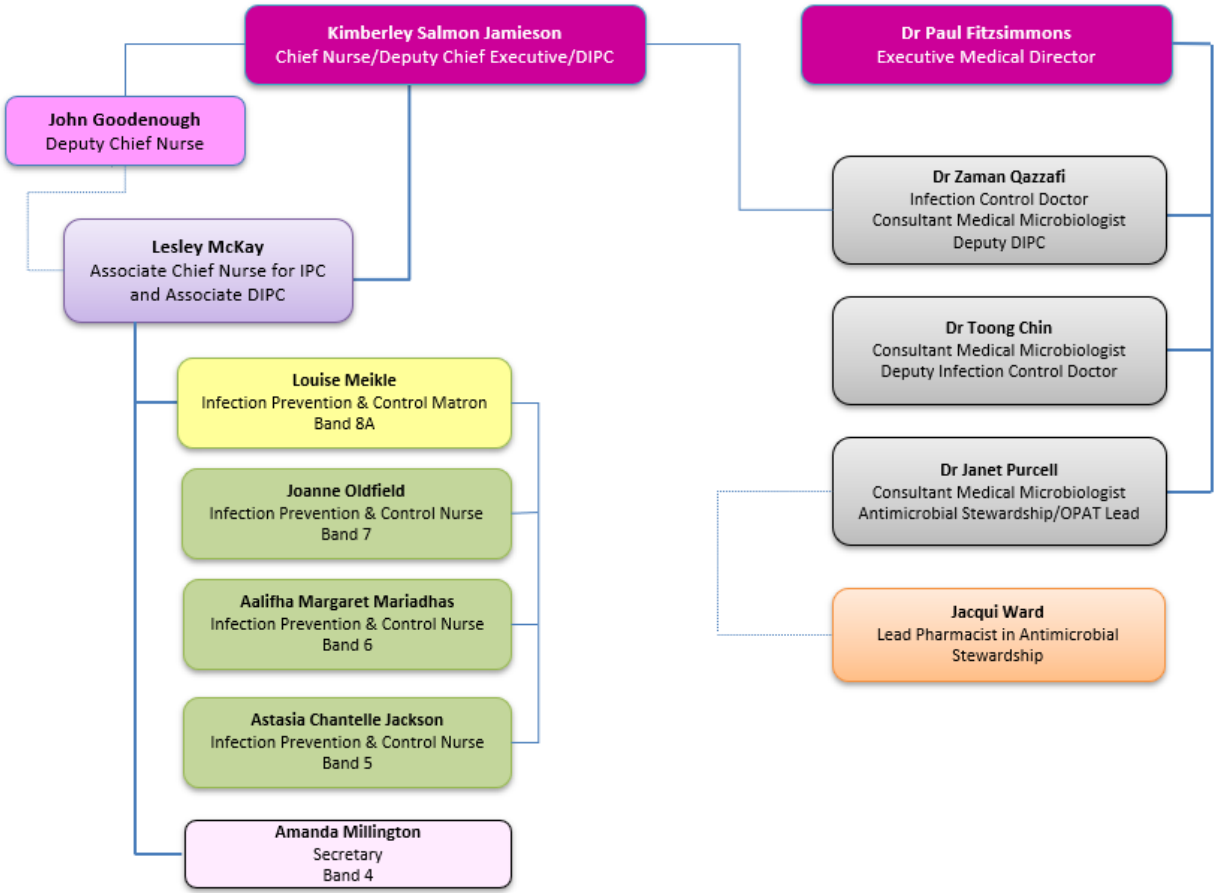
Description of Infection Control Arrangements

Infection Prevention and Control Team

The Infection Prevention and Control Team (IPCT) are scheduled to meet fortnightly. Meeting frequency was affected as efforts were redirected to respond to the continued Covid-19 pandemic. Staff turnover was high with 3 nursing staff member changes.

The Team is structured as per figure 1.

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



Infection Control Sub-Committee

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

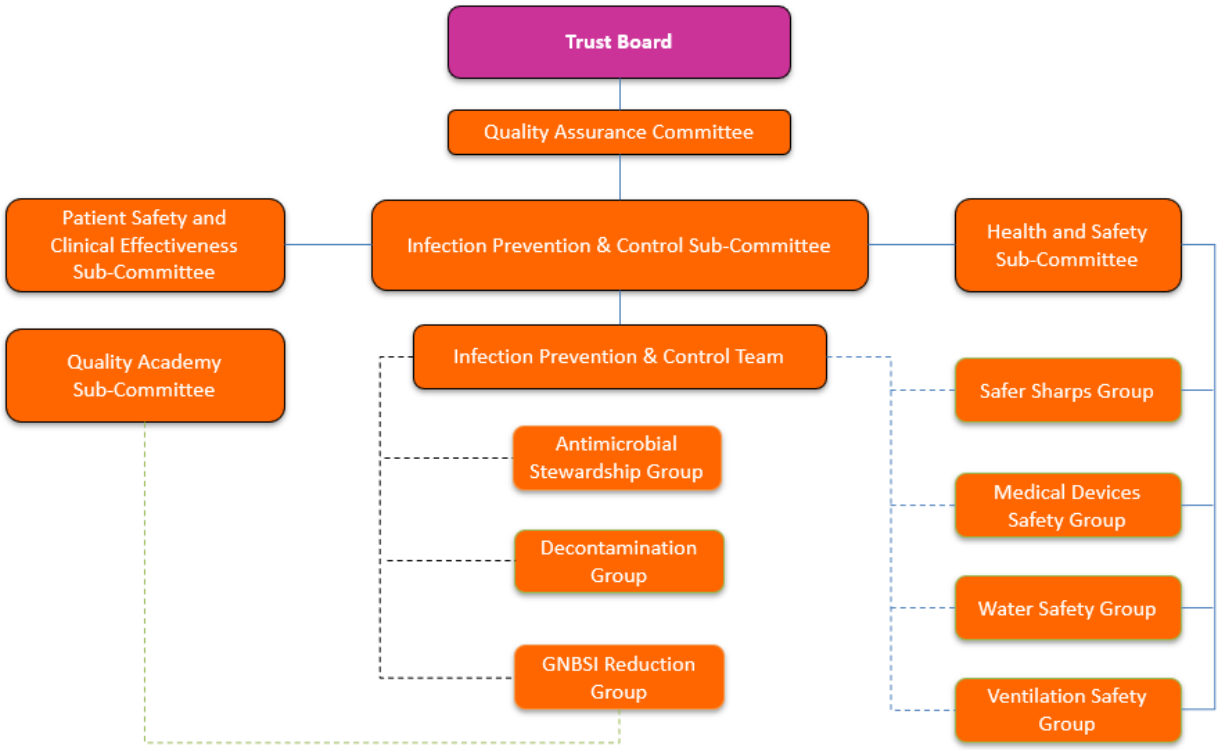
Membership comprises of the Chief Nurse/Deputy CEO/DIPC (Chief Nurse), IPCT, Lead Nurses from each Clinical Business Unit (CBU), Estates and Facilities Managers, Lead Allied Health Professional and an Occupational Health and Wellbeing representative.

The Lead Nurses for each CBU and the Lead for Allied Health Professionals and Estates and Facilities representatives, submit reports at each meeting as a standing agenda item. This allows the Infection Control Sub-Committee to give assurance to the Quality Assurance Committee and Trust Board of

Directors on activity within the Trust, compliance with the Code of Practice is maintained and that there is a programme of continued improvement.

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

Figure 2 Reporting Line to Trust Board



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

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

The Infection Control and Microbiology Cell continued to operate within the Covid-19 Tactical Management Board Structure, providing Trust-wide advice, education and training, support with patient placement and surveillance of Covid-19 cases. This Group was chaired by the Chief Nurse and reported to the Covid-19 Tactical meetings with escalation to the Senior Executive Oversight Group where appropriate.

DIPC Reports to Trust Board

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

- IPC Board Assurance Framework Compliance Report/Action Plan – June 2021
- IPC Board Assurance Framework Compliance Report/Action Plan – August 2021
- IPC Board Assurance Framework Compliance Report/Action Plan – October 2021
- IPC Board Assurance Framework Compliance Report/Action Plan – January 2022
- IPC Board Assurance Framework Compliance Report/Action Plan – March 2022

- IPC Healthcare Associated Infection Report Q1 – August 2021
- IPC Healthcare Associated Infection Report Q2 – November 2021
- IPC Healthcare Associated Infection Report Q3 – March 2022
- IPC Healthcare Associated Infection Report Q4 – May 2022

- DIPC Annual Report – July 2021

Annual work plan

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

This work plan is underpinned by action plans for key performance indicators/mandatory healthcare associated infections and a programme of audit that provides evidence of policy/guideline compliance. Progress against planned activity was impacted by the volume of Covid-19 cases. The annual work plan has been revised for 2022/23 and is included at appendix 1.

Covid-19

Activity to respond to the Covid-19 pandemic continued. The pandemic escalation plan was in place and wards were relocated to maintain patient safety. Molecular and PCR testing was performed on admission followed by day 3, day 5 and weekly testing if initial admission results were negative.

Text message alerting of confirmed results to the Infection Prevention and Control Nurses (IPCNs) continued and the out of hours on call service was maintained. Admissions with Covid-19 peaked in October, December, January, February and March and hospital onset cases rose in line with these increases.

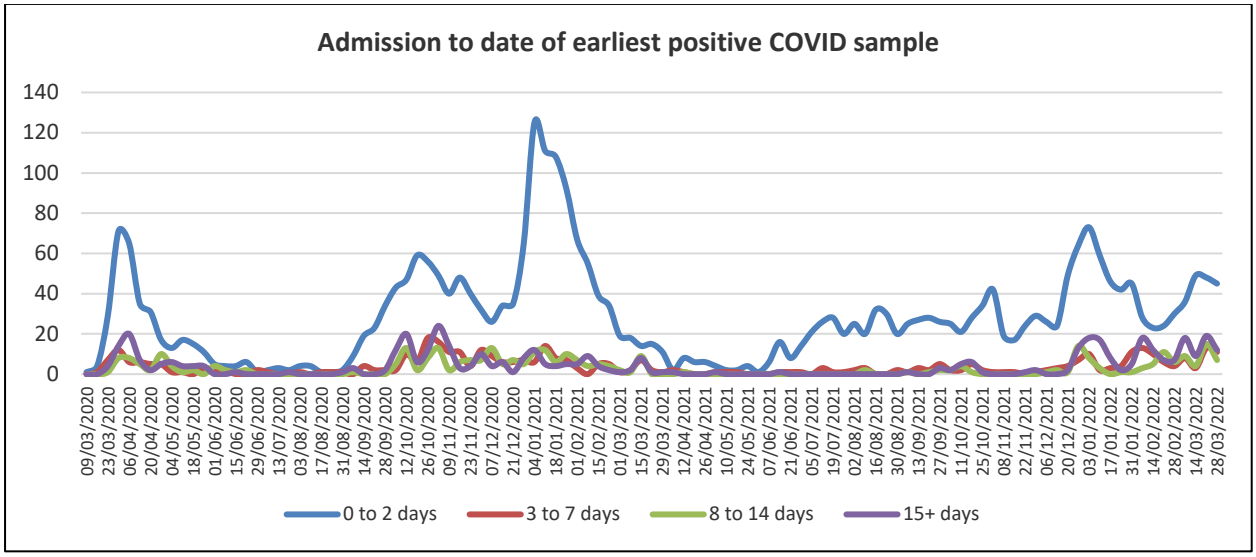
Covid-19 Nosocomial cases

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

- Hospital onset/probable healthcare associated cases (days 8-14) = 104
- Hospital onset/definite healthcare associated cases (>15 days) = 189

Figure 3 shows inpatient cases according to NHSE/I definitions.

Figure 3 Covid-19 Cases by NHSE/I definitions



All cases detected ≥ day 8 of admission underwent root cause analysis investigation (RCA). Learning from the cases has identified several themes including: -

- Length of stay and multiple ward moves
- Missed admission screening (low number)
- Missed day 3 and/or day 5 screening
- Missed swabbing opportunities - symptomatic
- Wander some patients
- Decrease in nursing cleaning score
- Occasional PPE non-compliance

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

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

- Personal protective equipment to be used for surgical procedures during the COVID-19 pandemic
- Guidance leaflet for external inspector visits during Covid
- Clinical extremely vulnerable (CEV) staff return to work in clinical areas
- ED Covid-19 triage tool
- Covid-19 patient screening sop
- Reporting Covid-19 cases after vaccination to the enhanced surveillance system
- Covid-19 risk rating of clinical/non-clinical areas
- Personal Protective Equipment (PPE) and Covid-19 pathways – SOP
- Paediatric admission screening
- Non-Elective and elective admission screening for Covid-19 SOP
- SIREN study SOP
- Duty of candour and nosocomial Covid-19 cases
- SOP for Covid-19 non-elective/elective patient screening and respiratory virus infection control precautions

- SOP for staff Identified as a Covid-19 contact and self-isolation SOP
- SOP stepping down isolation precautions and discharging patients SOP
- Risk assessment for derogation from national infection prevention and control guidance in extremis
- COVID-19: UKHSA IPC guidance for elective surgery – change to pre-procedure testing prior to elective procedures /planned care - SOP

IPCNs and Consultant Microbiologist visits were carried out to a number of clinical areas to support implementation of Covid-19 guidance.

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

Visiting restrictions were lifted nationally. However due to reported higher local incidence of Covid-19, a decision was taken by all Trusts in Cheshire and Merseyside not to lift visiting restrictions. Compassionate visiting arrangements were in place and visitors were supported with training on use of PPE.

The Consultant Microbiologists worked closely with the Human Resources Department to support the safe return of staff previously considered 'Clinically Extremely Vulnerable' to onsite working.

Covid-19 Outbreaks

The IPCNS conducted surveillance of cases to detect Covid-19 clusters. Where outbreaks were declared, Outbreak Control Groups were established. A total of 32 Covid-19 outbreaks were reported to external partners including: - NHSE/I, Public Health England (PHE) [now UK Health Security Agency], CCG, Care Quality Commission (CQC) and the northwest incident control centre (NW. ICC) as per NHSE/I regional guidance.

Challenges to managing Covid-19 included: -

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

Action taken included: -

- Physical barriers clear curtains where inpatient beds are < 2 metres apart
- Increased uptake of Lateral Flow Device Testing
- Repeated communications and updates on Covid-19 IPC precautions
- Staff vaccination programme
- Streaming of patients to Covid/non-Covid wards timely as far as reasonably practicable

Board Assurance Framework

The Infection Prevention and Control (IPC) Board Assurance Framework (BAF), linked to the Code of Practice on prevention of HCAIs, was updated by NHSE/I in December 2021. Compliance assessments were undertaken throughout the year and submitted to the Trust Board of Directors. An action plan is in place for minor gaps in assurance which include centralising records for fit testing, low side room capacity, assurance on testing with the move to day 3 and day 5 testing by Lateral Flow Device (LFD) and natural rather than mechanical ventilation in inpatient areas.

Covid-19 Recovery

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

A risk assessment to support the re-introduction of visiting was developed and ratified by the Tactical Group in September. However due to rising local incidence of Covid-19, the decision taken by all Trusts in Cheshire and Merseyside not to lift restrictions was held. Compassionate visiting arrangements remained in place and visitors were supported with training on use of PPE.

PPE

The procurement team ensured availability of PPE with stock levels under constant review. Due to the plans implemented there were no outages of PPE stock. Compliance with PPE was monitored via an audit programme and supportive training provided where minor compliance issues were identified.

The IPCT members continued to provide education and road shows where staff raised concerns about PPE guidance. The programme of Fit Testing of FFP3 respirators has continued throughout the year.

Health and Social Care Act (2008) compliance assessment

A compliance assessment against the 10 criteria, specified in the *Health and Social Care Act 2008 Code of Practice for preventions and control of infections and related guidance* (Department of Health 2015), linked to regulation 12, is carried out biannually.

The Care Quality Commission (CQC) uses this code to assess registered provider compliance with the cleanliness and infection control requirement set out in the regulations. Compliance with the Code of Practice at the end of March 2022 and areas requiring further action are detailed in table 2.

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

Criterion	*Assessment*	*Action required/in progress*
1. Systems to manage and monitor the prevention and control of infection.	*Compliant*	*Training required on surveillance software. Business case is being developed*
2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.	*Partially compliant*	*Upgrades to some hand washing sinks required (design and location). Audit of handwashing facilities scheduled with Estates Team*
3. Ensure appropriate antibiotic use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance.	*Compliant*	

Criterion	Assessment	Action required/in progress
4. *Provide suitable accurate information on infections to service users and their visitors and any person concerned with providing further support or nursing/medical care in a timely fashion.*	*Compliant*	
5. *Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people.*	*Compliant*	
6. *Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection.*	*Compliant*	
7. *Provide or secure adequate isolation facilities.*	*Partially compliant*	*Continuous liaison with the Patient Flow Team to optimise use of side rooms for appropriate patient isolation*
8. *Secure adequate access to laboratory support as appropriate.*	*Compliant*	
9. *Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections.*	*Compliant*	
10. *Providers have a system in place to manage the occupational health needs of staff in relation to infection.*	*Compliant*	

Healthcare Associated Infection Statistics

The Trust participates in mandatory reporting of HCAIs. There are 3 HCAI prevention action plans, linked to mandatory reporting requirements which were reviewed quarterly. RCA investigations are undertaken for Trust apportioned Clostridium difficile (C. difficile) cases. These reports are reviewed internally and submitted to the CCG where there are no lapses in care. An action plans to promote learning from cases is put in place.

C. difficile

The Trust reported 72 C. difficile toxin positive cases with 46 cases apportioned to the Trust: -

- hospital onset/healthcare associated = 34
- community onset/healthcare associated = 12

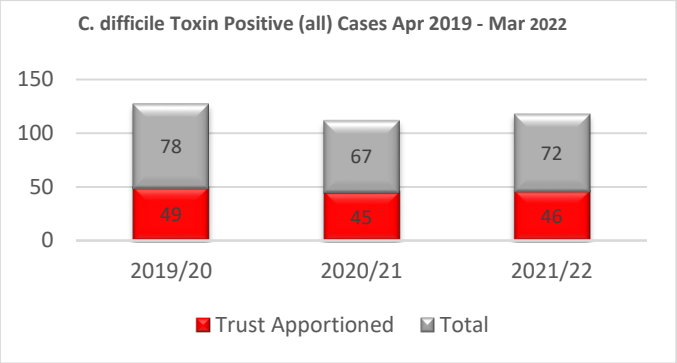
} 46 Trust apportioned cases

- community onset indeterminate association = 6
- community onset community associated = 20

The NHSE/I threshold for C. difficile was set at 44 cases or less (which includes both hospital onset/healthcare associated, and community onset/healthcare associated cases). The Trust was 2 cases over threshold with a total of 46 cases, however 3 cases were successfully appealed as unavoidable, resulting in 43 Trust attributed cases.

A comparison with previous year's data is displayed in figure 4.

Figure 4 C. difficile Toxin Positive Cases (all) April 2019 – March 2022

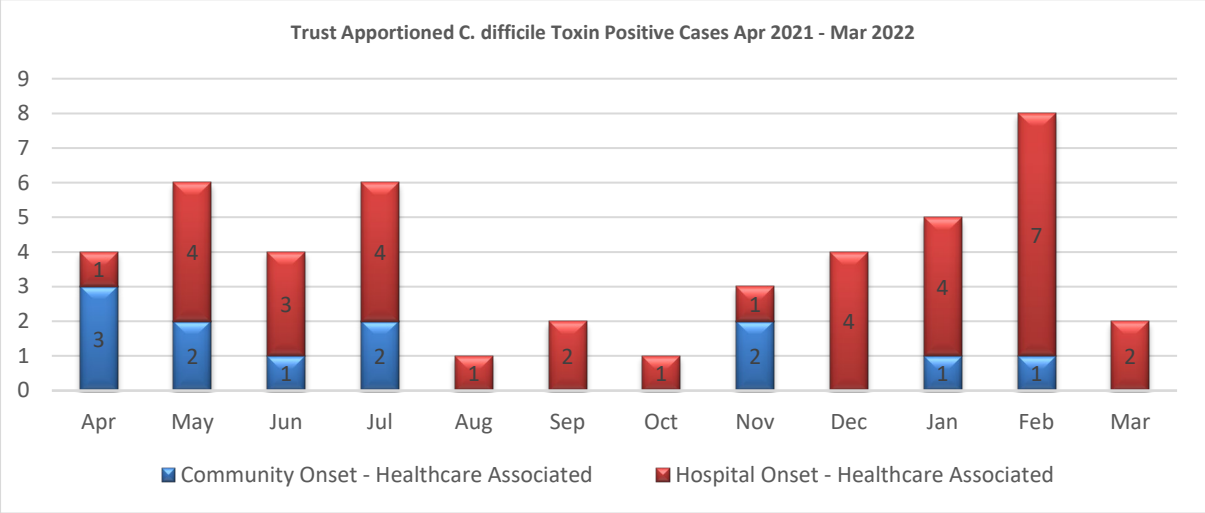


The IPCT focussed activity on C. difficile prevention by: -

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

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

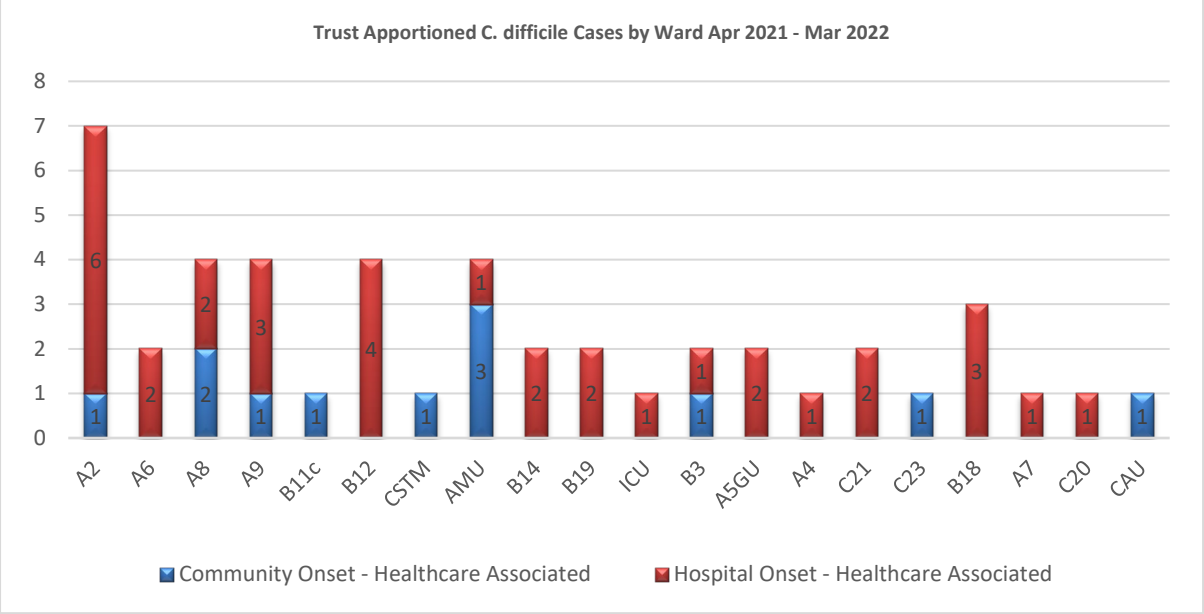
Figure 5 Trust Apportioned HOHA/COHA C. difficile Toxin Positive Cases by Month



HOHA cases by location when the sampled and COHA cases by the discharging ward are displayed in figure 6.

The location the specimens were obtained from is not necessarily where the infection was acquired as patients may have been on the ward/department for less than 48 hours when tested.

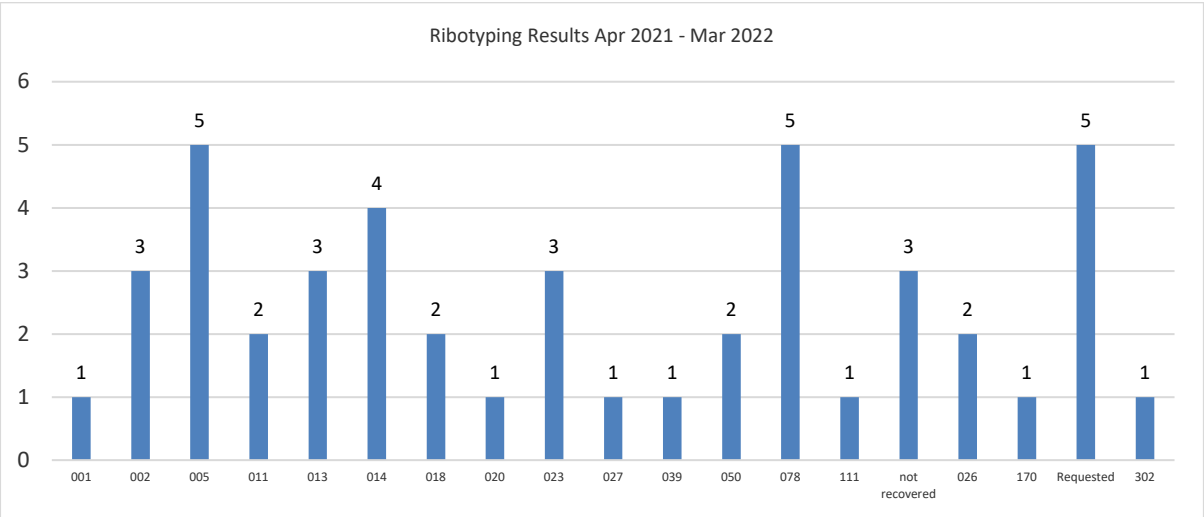
Figure 6 Trust Apportioned HOHA/COHA C. difficile Toxin Positive Cases by Location



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

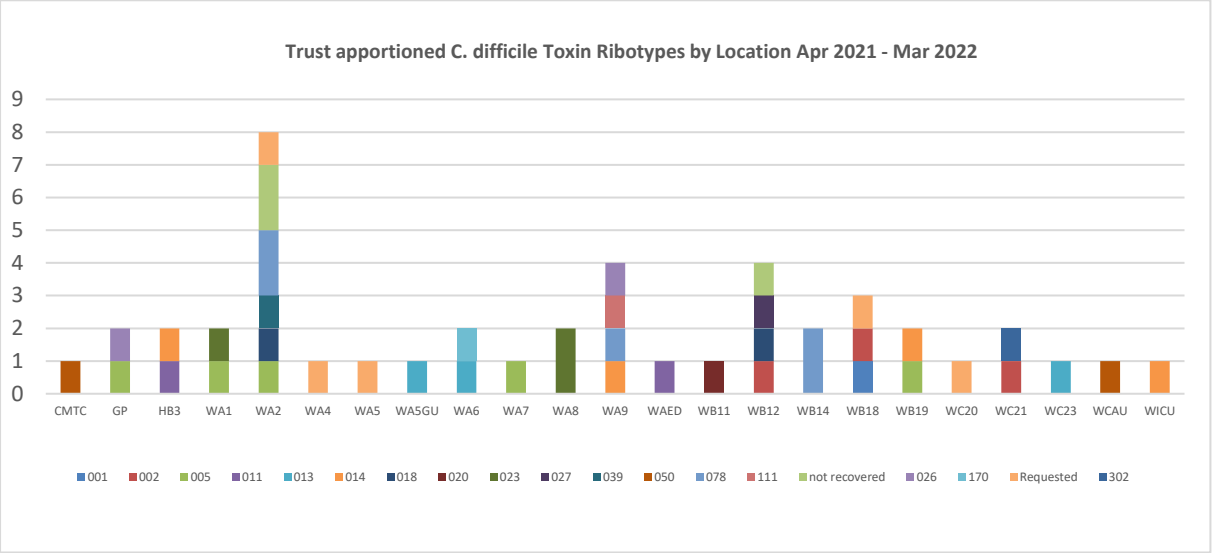
All Trust apportioned C. difficile toxin positive isolates are submitted for ribotyping. From the 46 isolates, 17 different ribotypes were identified. C. difficile was not recovered from 3 of the samples and 5 results were not received. Results are shown in figure 7 and demonstrate 005 and 078 ribotypes are seen more frequently.

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



Ribotyping results by ward are shown in figure 8. One periods of increased incidence (two or more cases within a 28-day period), was identified on ward A2, however links between the cases were not identified and this was concluded as a cluster of cases.

Figure 8 C. difficile Toxin Positive Ribotyping Results by Location



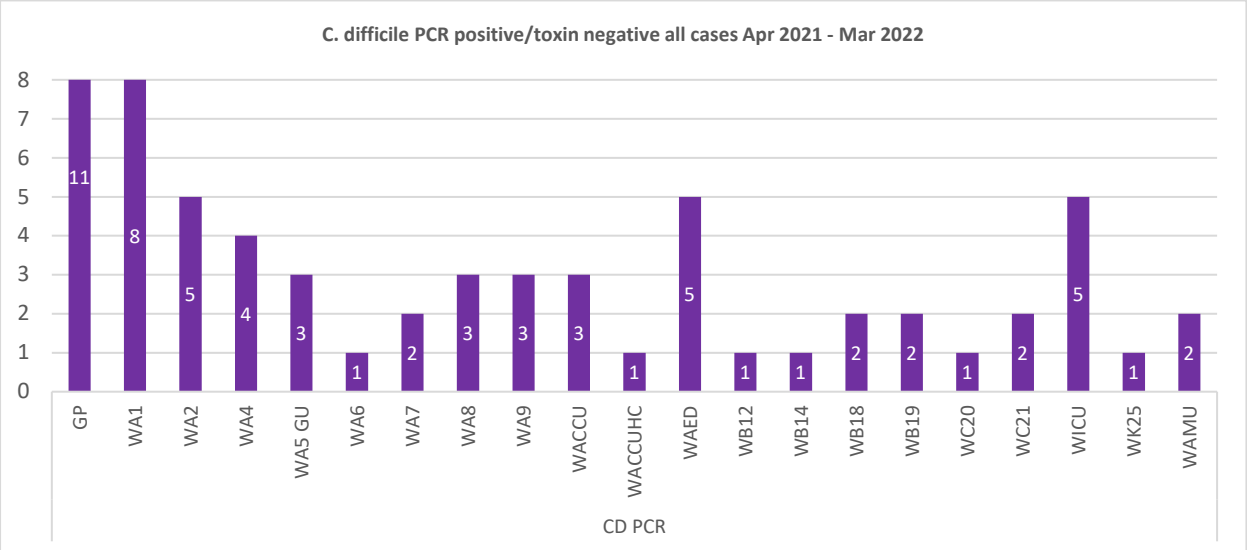
C. difficile (Toxin Negative/PCR Positive)

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

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

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

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



Meticillin resistant *Staphylococcus aureus* (MRSA) bacteraemia

The Trust reported two MRSA bacteraemia cases. One community onset and one community onset/healthcare associated case. Data for comparison with earlier financial years is shown in figure 10.

Figure 10 MRSA bacteraemia cases (all) April 2019 – March 2022

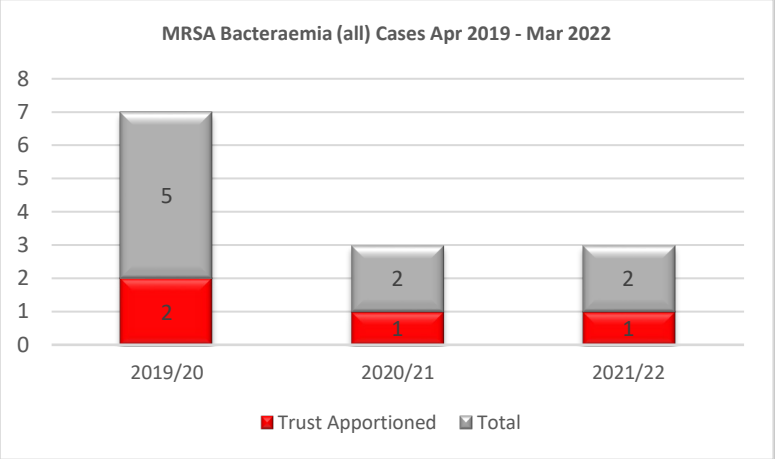
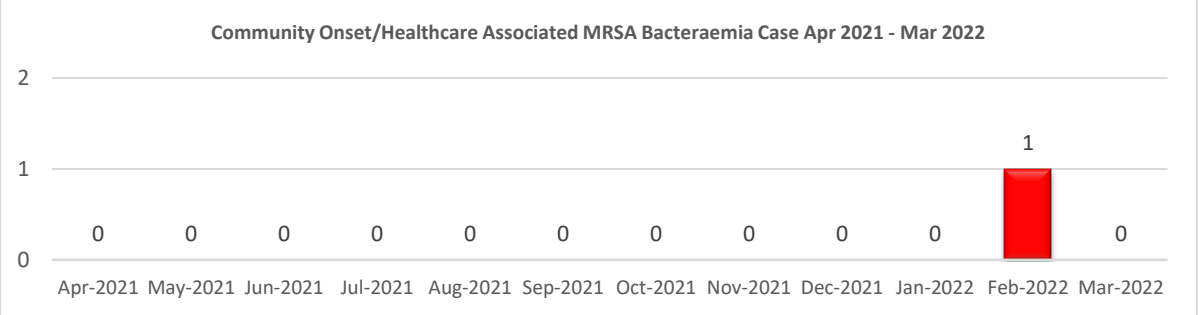


Figure 11 shows the Trust apportioned MRSA bacteraemia case identified within the financial year.

Figure 11 Trust Apportioned MRSA Bacteraemia Cases by Month



Following post infection review the COHA case was re-apportioned to a neighbouring Trust, resulting in zero trust apportioned cases for the year.

MRSA screening

The Trust continues to provide MRSA screening for patients in line with the Department of Health guidance. Work is in progress with the data warehouse team to provide a more robust screening compliance report against the MRSA policy screening requirements.

Meticillin sensitive *Staphylococcus aureus* (MSSA) bacteraemia

The Trust reported 75 cases of MSSA bacteraemia (46 community onset and 29 Trust apportioned). This was an increase of 3 Trust apportioned cases from the previous financial year. Thresholds for the reduction of MSSA bacteraemia have not been set. Data for comparison with previous financial years is shown in figure 12.

Figure 12 MSSA bacteraemia cases (all) April 2019 – March 2021

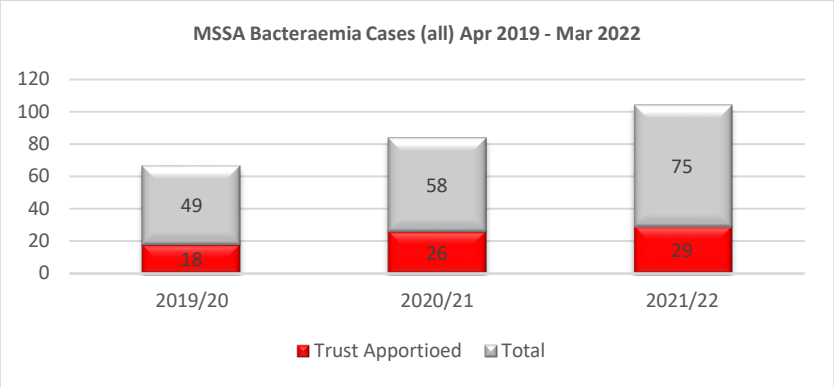


Figure 13 shows the Trust apportioned MSSA bacteraemia cases by month.

Figure 13 Trust Apportioned MSSA bacteraemia cases by month

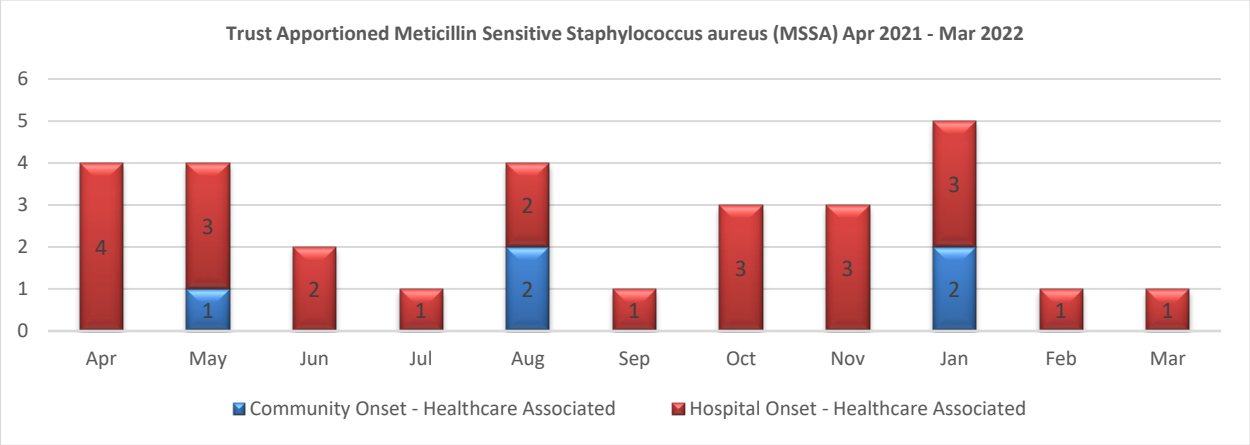
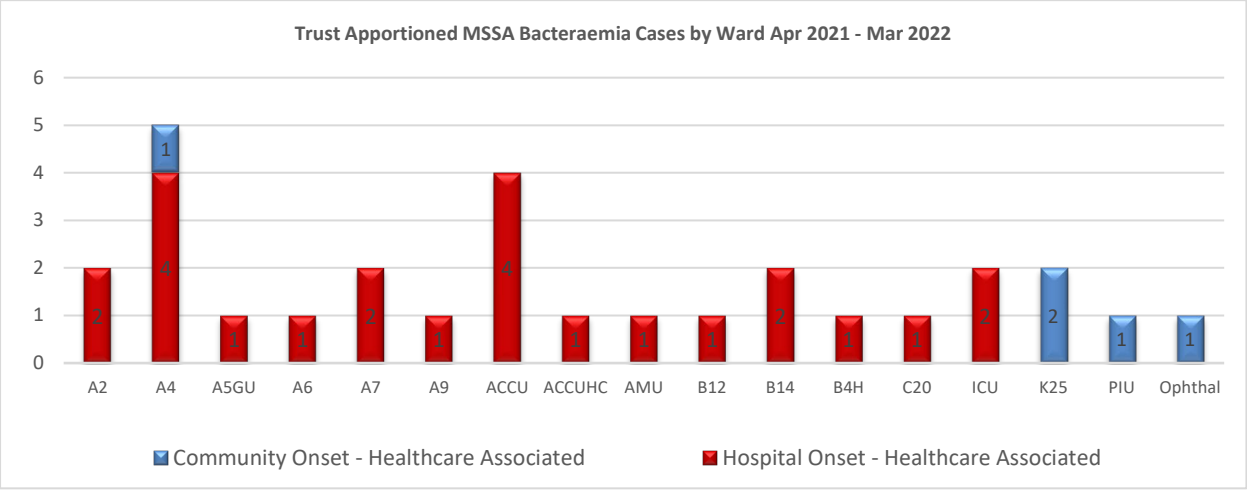


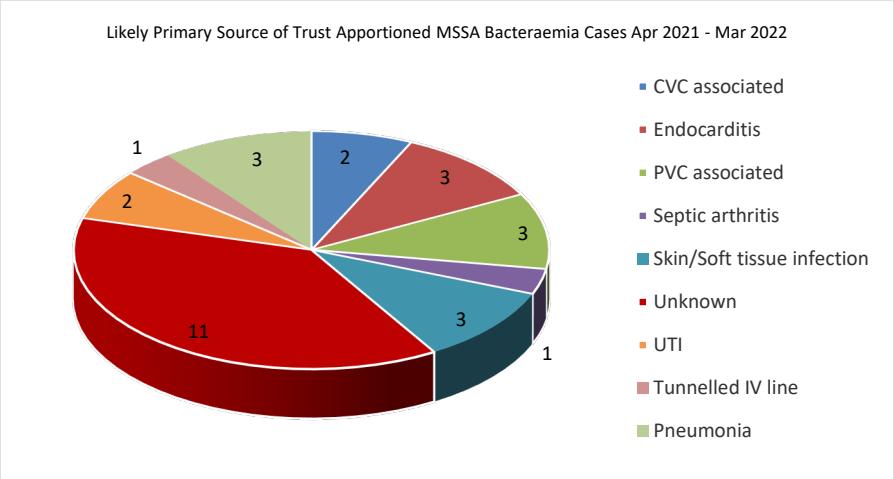
Figure 14 shows the patients location at the time the specimen was obtained for HOHA cases and discharging ward for COHA cases.

Figure 14 Trust Apportioned MSSA Bacteraemia Cases by Location



Case reviews identified several different sources for infection as shown in Figure 15.

Figure 15 Likely Primary Source of Trust Apportioned MSSA Bacteraemia Cases



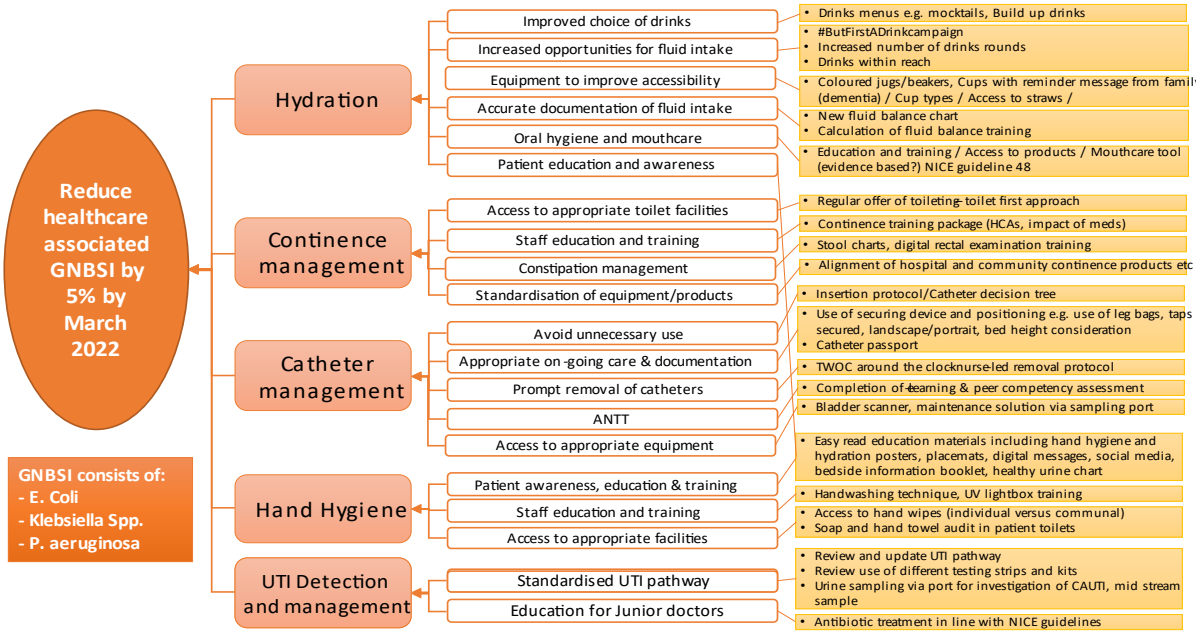
An action plan is in place linked to learning from these incidents that sets out the work required to prevent the risks of MRSA/MSSA bacteraemia cases.

Gram Negative Bloodstream Infection (GNBSI)

The national target to reduce GNBSI (E. coli; Klebsiella spp. and Pseudomonas aeruginosa) published in the Tackling Antimicrobial Resistance 5-year plan (January 2019) remains in place. This publication recommends a systematic approach to preventing infections. In July 2021 NHSE/I published quality requirements for Trusts to minimise GNBSI and set thresholds for providers.

The IPCT worked with the Quality Academy and established a Driver Diagram (figure 16). Meetings were held with phase one ward (A2, A4, A5, A6, A8, B14, B19) and focused on hydration, continence management, reducing usage of urinary catheters and improving care, hand hygiene (including patients) and urinary tract infection detection/management.

Figure 16 GNBSI Prevention Driver Diagram

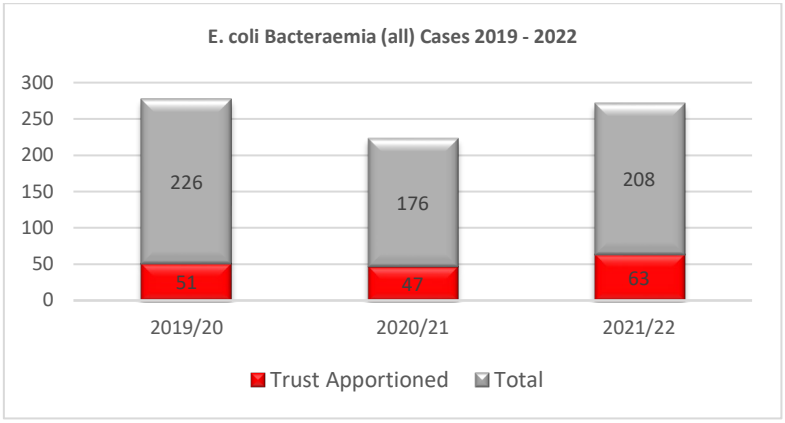


The urinary catheter passport was launched at a series of meetings across the Trust. The Trust led the review of this document, and it has been adapted across Cheshire and Merseyside.

E. coli bacteraemia

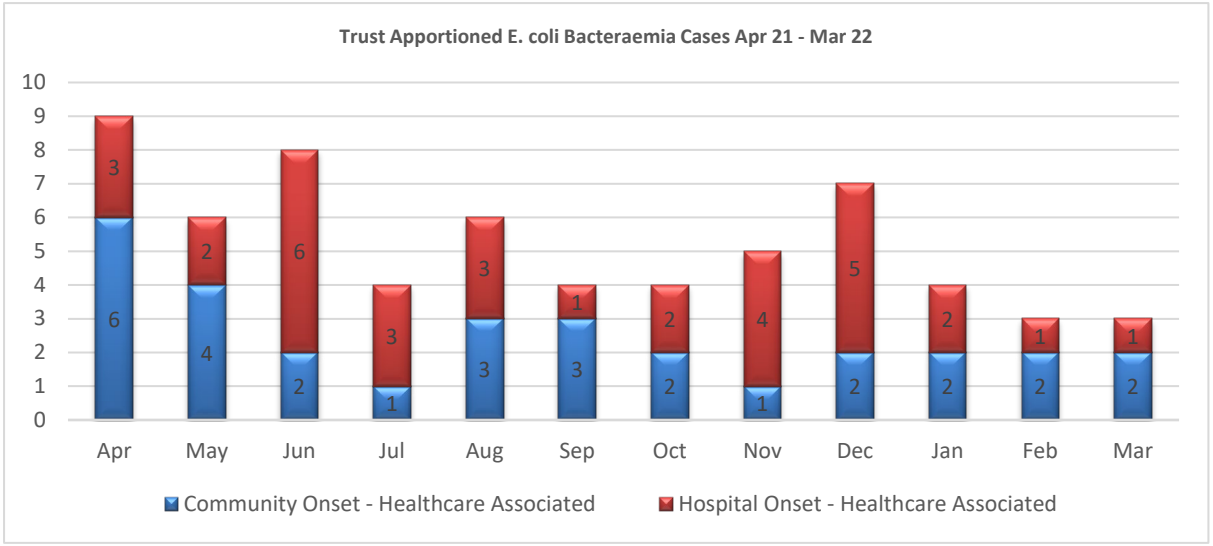
Data for comparison with previous financial years is shown in figure 17 .

Figure 17 E. coli bacteraemia cases (all) April 2019 – March 2022



The Trust reported a total of 208 E. coli bacteraemia cases, 63 of these were Trust apportioned cases (30 community onset/healthcare associated and 33 hospital onset/healthcare associated). This was significantly under the threshold of 81 cases set be NHSE/I. Figure 18 shows trust apportioned cases by month.

Figure 18 Trust Apportioned E. coli Bacteraemia Cases by Month



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

Figure 19 Trust apportioned E. coli Bacteraemia Cases by Location

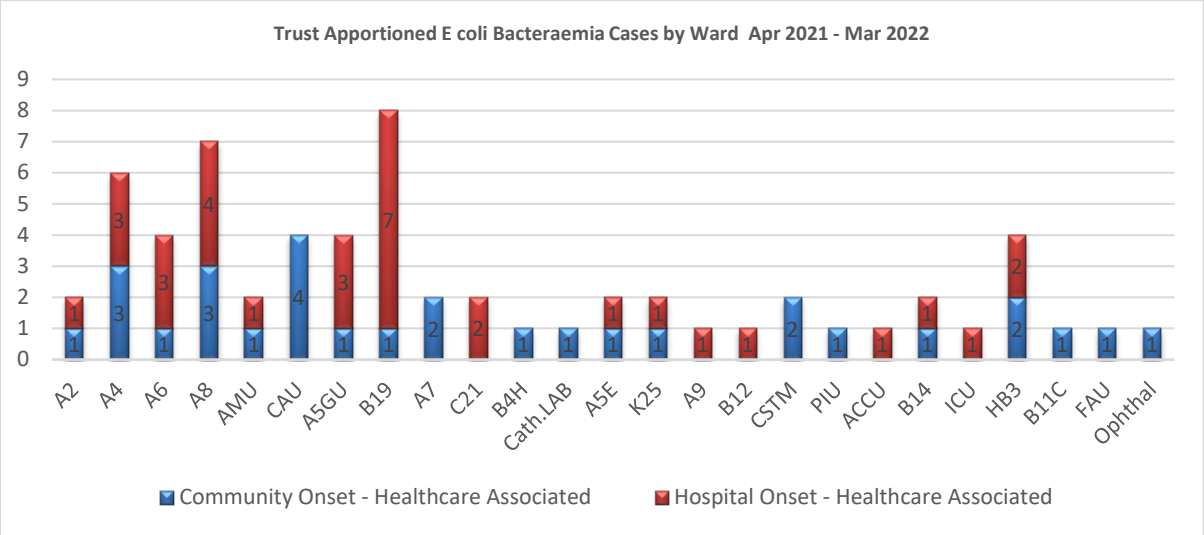
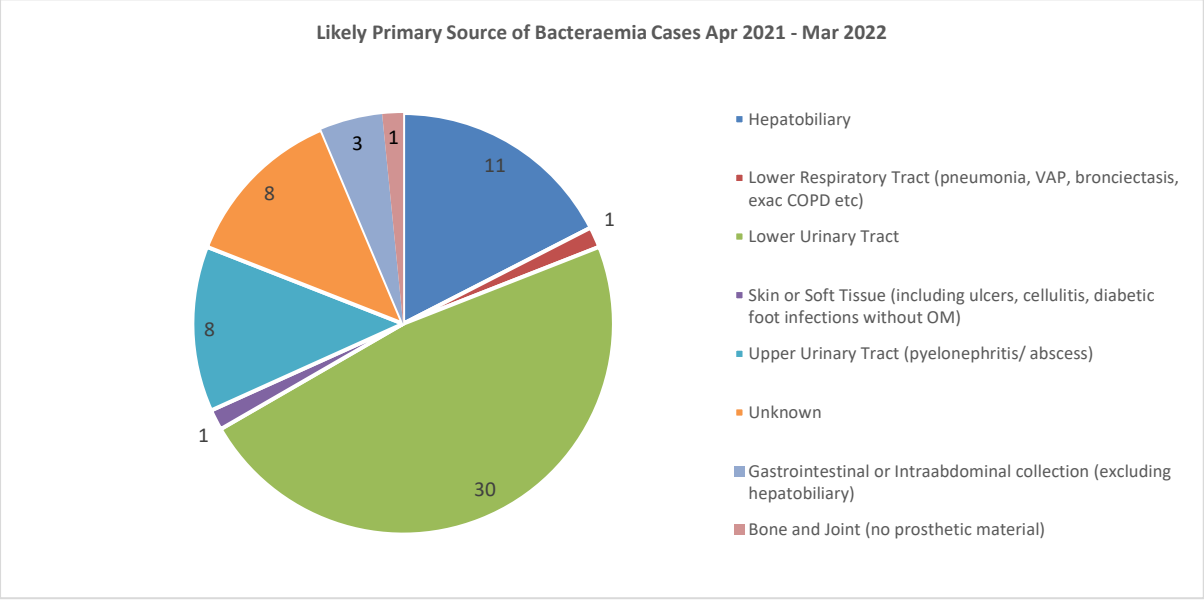


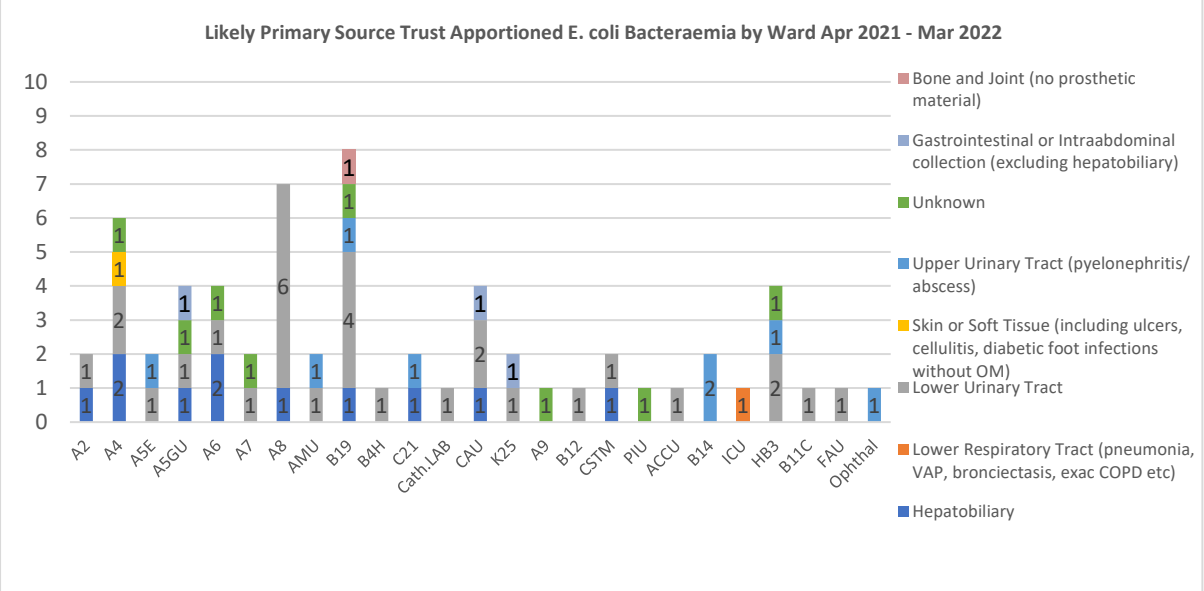
Figure 20 shows the likely primary sources of the 63 Trust apportioned cases.

Figure 20 Likely primary sources Trust apportioned E. coli Cases



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

Figure 21 Trust Apportioned Cases - Likely Primary Source by Location



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

Klebsiella spp. Bacteraemia

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

Figure 22 Klebsiella spp. bacteraemia (all) April 2019 – March 2021

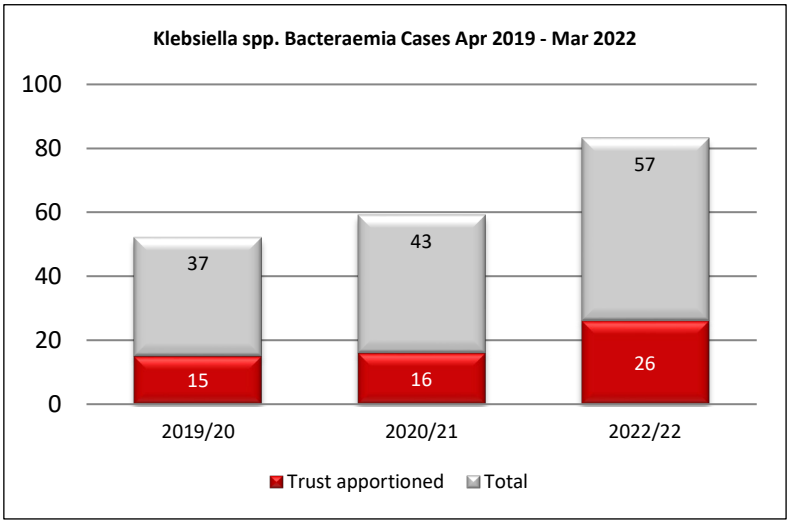


Figure 23 shows trust apportioned cases reported each month.

Figure 23 Trust Apportioned Klebsiella spp. Bacteraemia Cases by Month

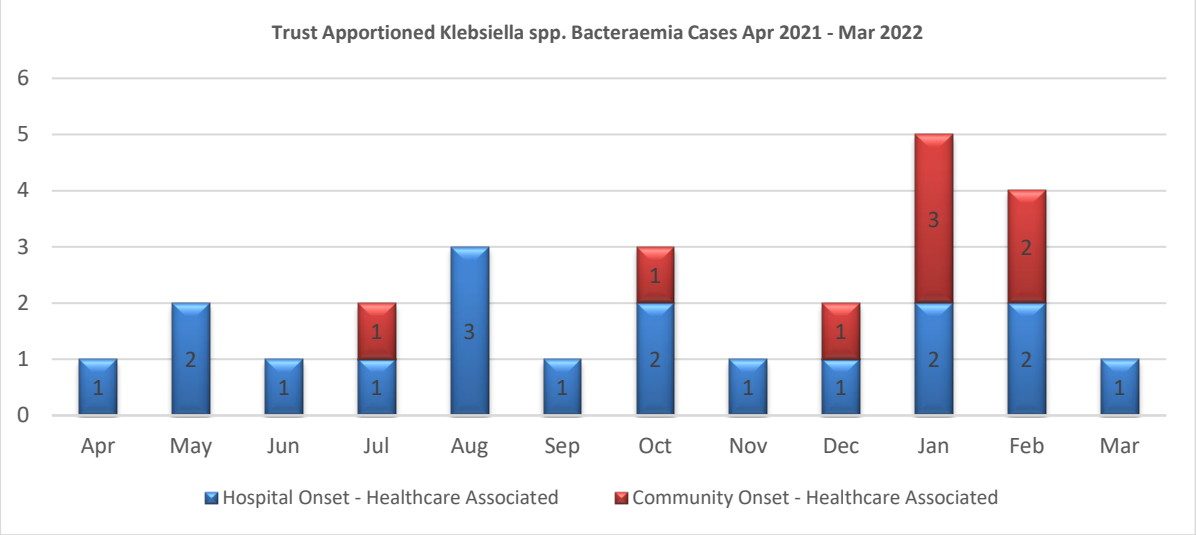


Figure 24 show Trust apportioned Klebsiella bacteraemia cases by location where specimen was taken for HOHA cases and location discharged from for COHA cases.

Figure 24 Trust Apportioned Klebsiella Bacteraemia Cases by Ward Location

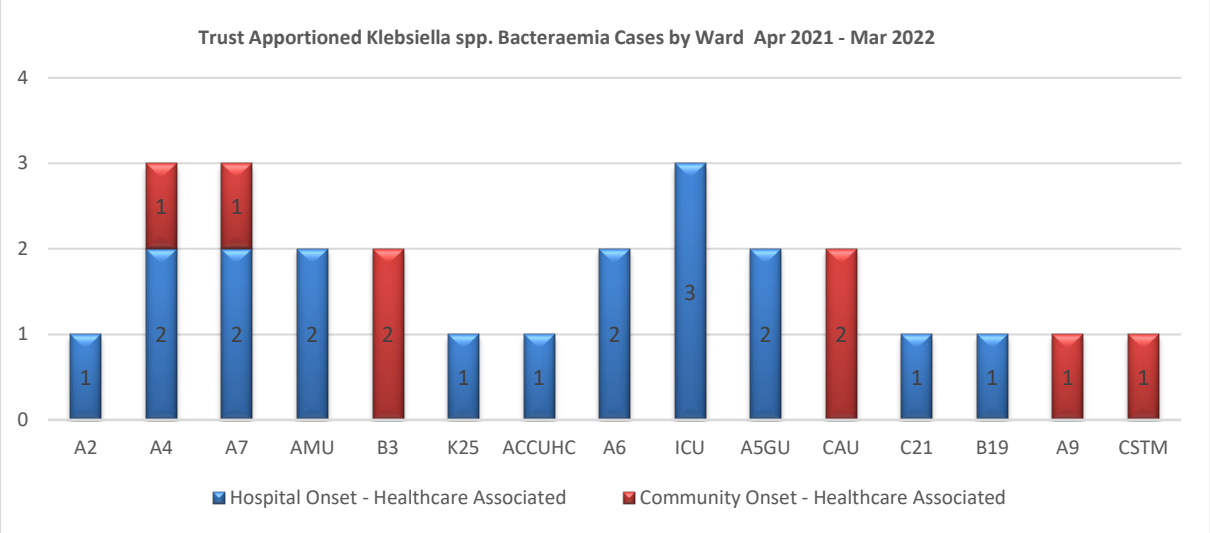


Figure 25 shows the likely primary sources of the 26 Trust apportioned cases.

Figure 25 Likely primary sources of the 26 Trust apportioned cases

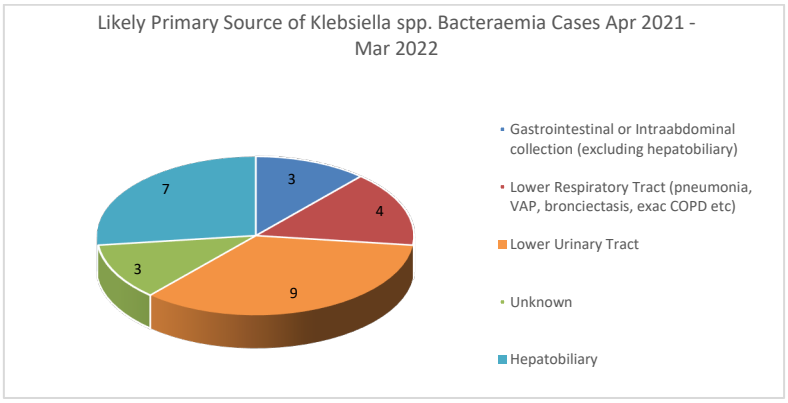
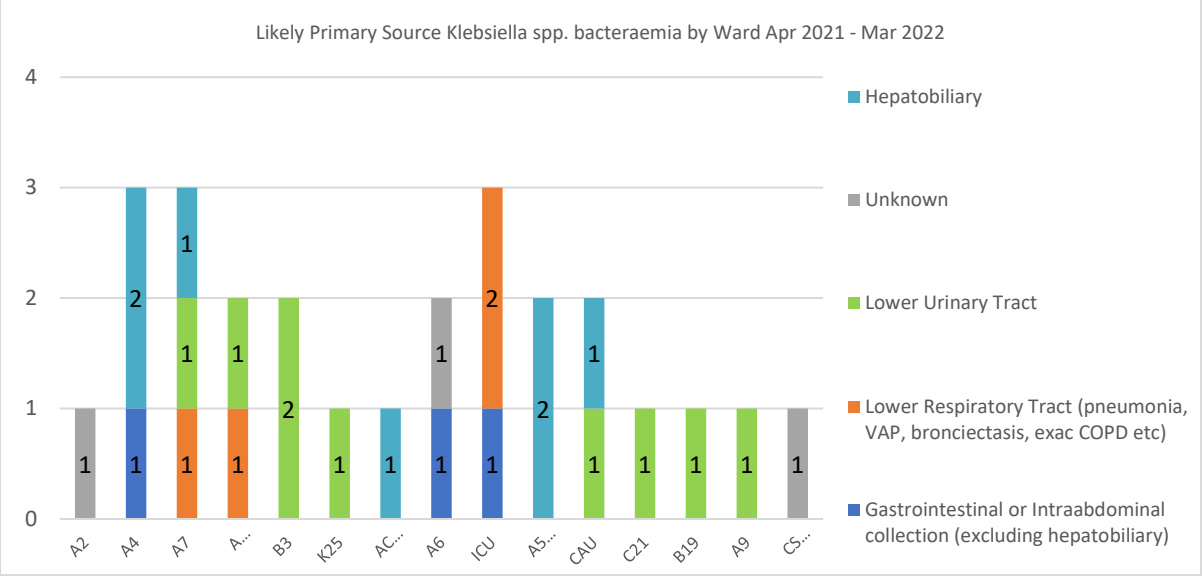


Figure 26 Trust Apportioned Cases - Likely Primary Source by Location



Pseudomonas aeruginosa bacteraemia

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

Figure 27 Pseudomonas aeruginosa bacteraemia cases April 2019 – March 2022

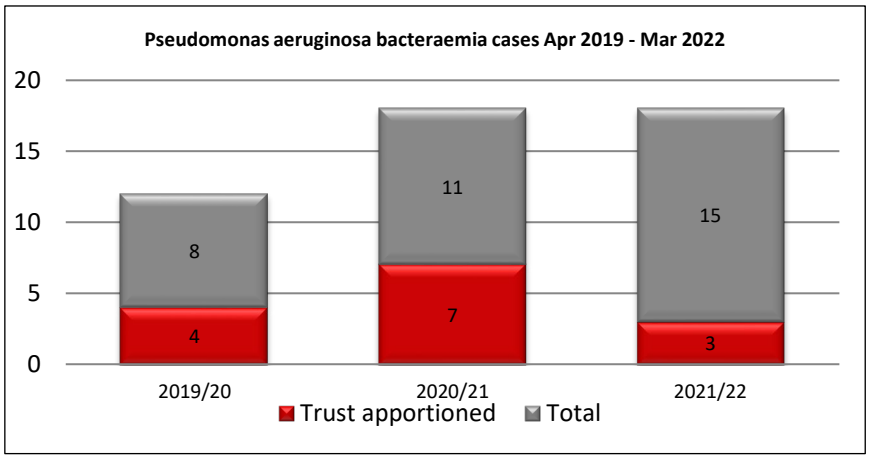


Figure 28 displays the Trust apportioned cases reported by month.

Figure 28 Trust Apportioned Pseudomonas aeruginosa Bacteraemia Cases by Month

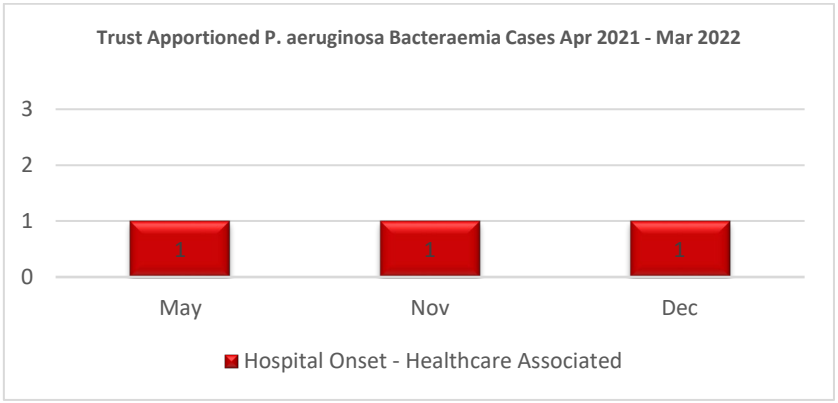
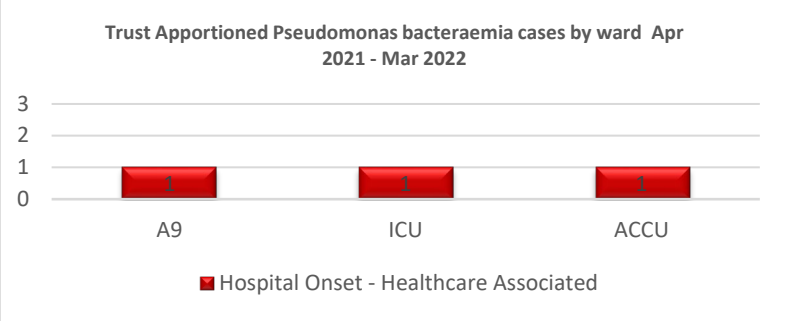


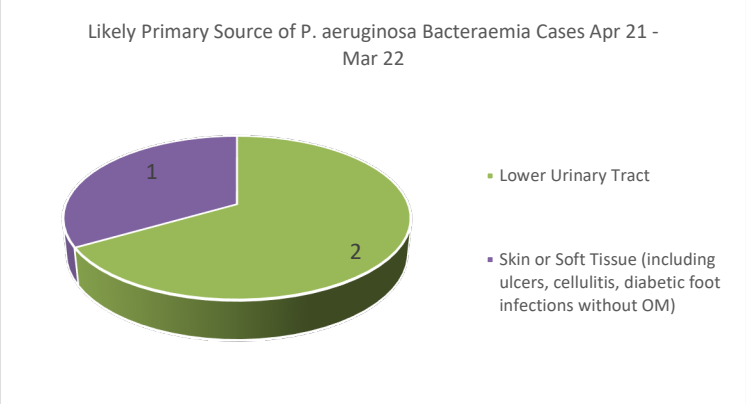
Figure 29 show Trust apportioned Pseudomonas aeruginosa bacteraemia cases by location where specimen was taken for HOHA cases.

Figure 29 Pseudomonas aeruginosa bacteraemia cases by loaction



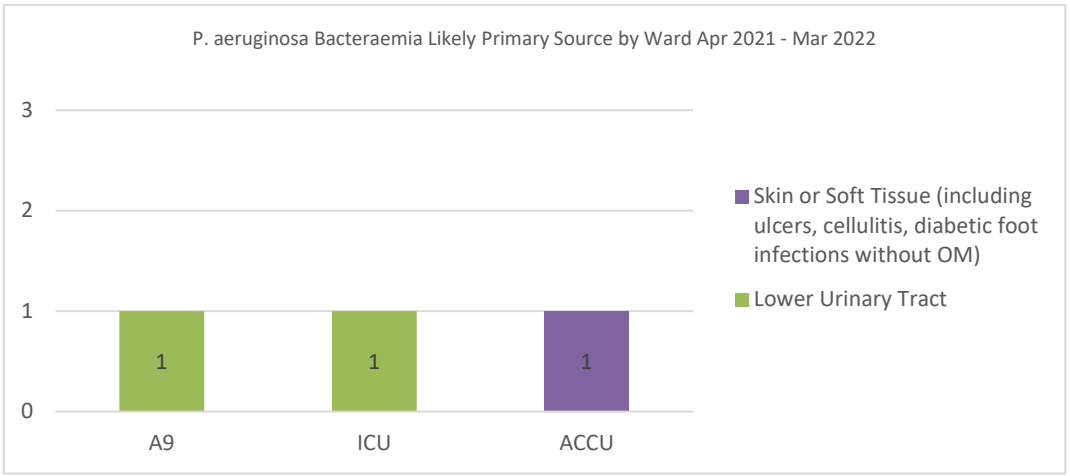
A breakdown of Trust apportioned cases to show likely primary source by location is shown in figure 30.

Figure 30 Likely Primary Sources of Trust Apportioned Cases



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

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



GNBSI prevention activity has recommenced with action that includes: -

- reduction in use of urinary catheters
- improvements to care of urinary catheters - urinary catheter policies are being reviewed
- competency assessments incorporating ANTT
- patient hand hygiene strategy
- patient hydration

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

Incidents/outbreak reports

Viral gastroenteritis (Norovirus)

There were no outbreaks of viral gastroenteritis during the financial year.

Carbapenemase Producing Enterobacteriaceae screening

Antimicrobial resistance presents a major threat to public health globally. Of concern is the risk posed by Carbapenemase-producing Enterobacteriaceae (CPE) and other Carbapenem-resistant organisms. CPE screening is carried out on all patients admitted by inter hospital transfer. During the reporting period just over 1, 252 screens for CPE carriage were undertaken with nil cases detected.

Hand Hygiene and Aseptic Protocols

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

Table 3 Trust wide hand hygiene audit results by month

Month	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-21	Feb-21	Mar-21
Compliance	98%	98%	98%	98%	98%	99%	98%	98%	99%	98%	98%	99%

Decontamination

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

Cleaning Services

MANAGEMENT ARRANGEMENTS

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

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

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

BUDGET ALLOCATION

The budget allocation for domestic services was £4,730,819 with 154 whole time equivalent (WTE) staff.

CLEANING ARRANGEMENTS

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

Very high risk: Consistently high levels of cleaning are maintained.
Areas include Theatres, Critical Care (ICU) and Neonatal Unit.

High risk: Outcomes are maintained by regular and frequent cleaning with 'spot' cleaning in between.
Areas include general wards, public thoroughfares, and sterile supplies.

Significant risk: In these areas high levels of cleanliness are required for both hygiene and aesthetic reasons. Outcomes are maintained with regular and frequent cleaning. Areas include pathology, out-patient departments, and mortuaries.

Low Risk: In these areas high levels of cleanliness are maintained for aesthetic and to a lesser extent hygiene reasons. Outcomes are maintained with regular cleaning and 'spot' cleaning in between.
Areas include offices, record storage and archives.

MONITORING ARRANGEMENTS

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

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

The monitoring programme complies with the Department of Health Specifications, covering domestic cleaning, patient equipment and estates issues.

The monitoring frequency is dictated by the risk grading of areas, which are as follows:-

Very High Risk Areas	Theatres, Neonatal Unit, ICU, Endoscopy - weekly
High Risk Areas	Wards, Accident & Emergency, Public areas, Pharmacy - monthly Ward Kitchens Main Outpatients and X-Ray
Significant Risk Areas	Outpatient Areas 6 monthly
Low Risk Areas	Chapel, Offices annually

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

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

To positively encourage high standards, the Domestic Team working on any area which achieves 100%, are presented with a certificate in recognition of the hard work and commitment.

Terminal cleaning is carried out by the Task Team on request by a Ward when there is an infection or when a patient has been discharged outside normal working domestic hours. Activity is shown in the tables below.

Table 4 Terminal Cleaning

Terminal cleans	A	M	J	J	A	S	O	N	D	J	F	M	Total
2020/2021	1231	1273	775	653	617	848	957	907	921	988	867	427	**10464**
2021/2022	427	525	630	768	781	552	675	808	816	890	591	787	**8250**

Table 5 Curtain changes

Curtain changes	A	M	J	J	A	S	O	N	D	J	F	M	Total
2020/2021	521	191	201	242	265	298	339	360	325	208	197	95	**3242**
2021/2022	95	95	119	101	94	101	143	131	144	224	227	158	**1632**

Table 6 HPV Cleans

HPV use	A	M	J	J	A	S	O	N	D	J	F	M	Total
2020/2021	3	9	13	40	9	20	18	19	30	23	57	26	**267**
2021/2022	37	30	37	51	29	44	75	64	72	88	100	77	**704**

CLEANLINESS SCORES

The 2021/22 cleanliness monitoring scores (Domestic only) for very high risk and high-risk clinical areas were as follows:

- Warrington: 97.8%

- Halton: 97.5%

PLACE (Patient Led Assessments of the Care Environment)

PLACE assessments were deferred in 2021/2022 due to the ongoing Covid-19 Pandemic.

CORPORATE REPORTING

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

TRAINING

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

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

CLINICAL ACCESS/RESPONSIBILITY

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

Facilities also have a close working relationship with the Ward Housekeepers. The Domestic Task Team at Warrington liaises closely with the Infection Prevention and Control Team and Estates when responding to terminal/deep cleans on the Wards.

NATIONAL STANDARDS OF CLEANLINESS

In April 2021 new standards were launched with an 18-month timescale for full implementation. The new standards replace the 2007 National Standards for cleanliness in the NHS (2007) and reflect modern methods of cleaning, infection prevention and control and emphasise transparency to assure patients, the pubic and staff that safe standards of cleanliness have been met.

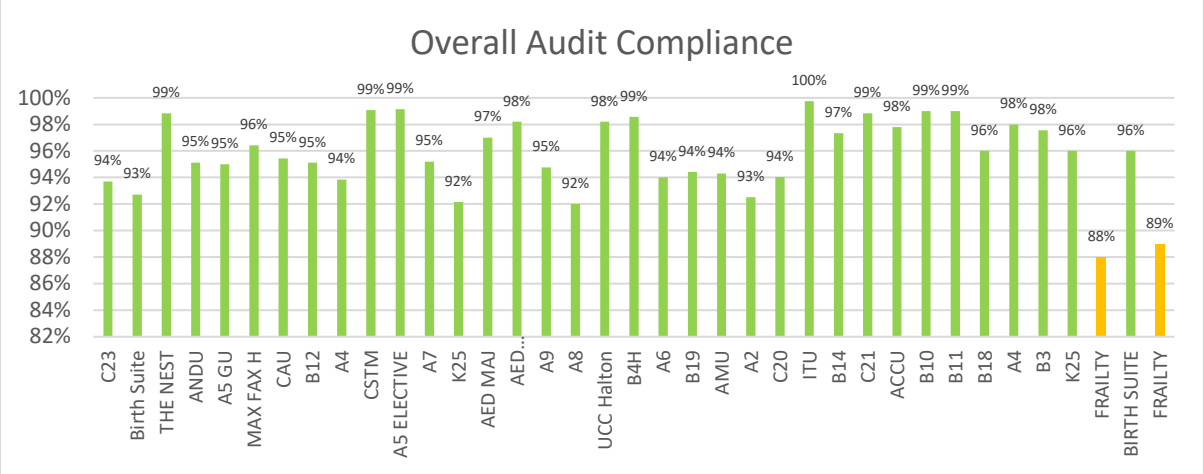
The Trust has a Task and Finish Group for the introduction of the new standards led by Facilities and IPC, focussing on the need for a collaborative approach.

Audit

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

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

Figure 32 Infection Control Audit Results



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

High Impact Interventions

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

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

Antimicrobial Prescribing

From 1st April 2021-31st March 2022, 59 joint Consultant Microbiologist and Antimicrobial Pharmacist ward rounds were carried out at Warrington hospital.

There was a decrease in the number of ward rounds carried out compared to the previous year where there were 69 joint Consultant Medical Microbiologist and Antimicrobial Pharmacist ward rounds. This reduction in activity may in part be explained by reduced staffing within pharmacy, limited pharmacists trained to cover the antibiotic ward rounds and clinical pressures within the Trust. Over the last 12 months there has been a large turnover of staff within the pharmacy department (made up of resignations and internal promotions) and pharmacy have been holding a number of vacancies meaning that essential clinical services have had to be prioritised and antibiotic ward rounds have been cancelled where necessary. The Pharmacy department has been trying to recruit staff into the vacancies, but this is proving challenging.

Over the last 4 months additional Pharmacists have been trained to cover the antibiotic ward round to build resilience within the service and there are plans to extend this training further when staffing allows. Furthermore, a business case has recently been approved for 1 part time (50%) band 7 pharmacist and a full-time band 5 technician to help support the Lead Antimicrobial Pharmacist in their Antimicrobial Stewardship (AMS) role.

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

A Consultant Microbiologist continues to attend the AMU board round on Fridays to review patients prescribed antibiotics and establish an antibiotic plan for the weekend.

This year we have introduced an additional weekly antibiotic MDT on ward A9 due to persistent low compliance with the antimicrobial formulary (identified in the quarterly point prevalence audit). This MDT is attended by a Consultant Microbiologist and was introduced with an aim to improve antibiotic prescribing standards on this ward and during the last point prevalence audit undertaken in March 2022 compliance had increased to 100%.

Joint Consultant Medical Microbiologist and Antimicrobial Pharmacist Ward Rounds

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

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

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

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

The "target antimicrobials" within the Trust are:

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

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

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

- Concerns that patient is deteriorating from an infection point of view and the clinical team have requested a review
- Patient is prescribed antimicrobials that are non-compliant with the antimicrobial formulary
- Culture and sensitivity results are available to allow rationalisation of antimicrobials but not actioned by clinical team
- Patient clinically well and suitable for oral step down or cessation of antimicrobial therapy but the team with clinical responsibility for the patient are not undertaking this or are requesting Consultant Microbiologists advice

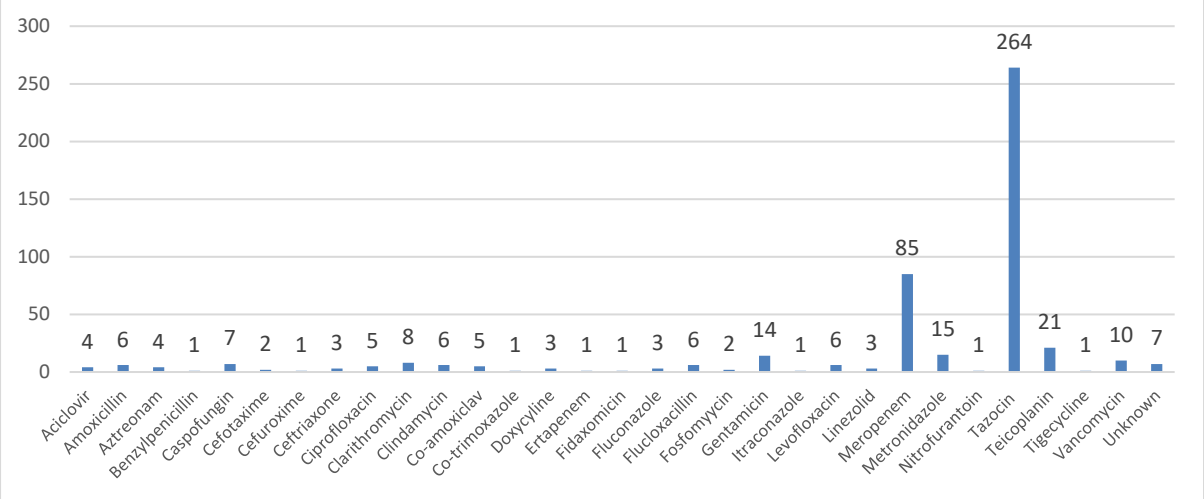
Summary of Antimicrobials Reviewed

A total of 414 patients and 497 antimicrobials were reviewed on the ward rounds between 1st April 2021 and 31st March 2022. The 2 antibiotics most frequently reviewed were Piperacillin/Tazobactam (Tazocin®) and Meropenem. These antibiotics are targeted on the ward round because they are broad-spectrum antibiotics that should be prescribed only as per formulary, or inpatients who are known to have previously grown a multi-drug resistant (MDR) organism. The antibiotic ward round provides an opportunity for the Consultant Microbiologist and Antimicrobial Pharmacist to review patients prescribed these antibiotics to ensure they have received appropriate investigations and microbiological sampling so that an appropriate antibiotic de-escalation plan can be provided upon clinical improvement.

Table 7 Total Number of Antimicrobials Reviewed

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

Figure 33 Summary of the different antibiotics reviewed on the ward rounds



Summary of Ward Round Interventions

Of the 497 antimicrobial prescriptions reviewed, we were able to add a stop date/course length to 211 (42%) prescriptions. A further 127 prescriptions were de-escalated, and 39 prescriptions were escalated. 82 antibiotic prescriptions were stopped. De-escalation is defined as: -

- a change in IV antimicrobial regimen to a narrower spectrum agent

- IV to oral step down.

Escalation is defined as:

- additional antimicrobial cover added

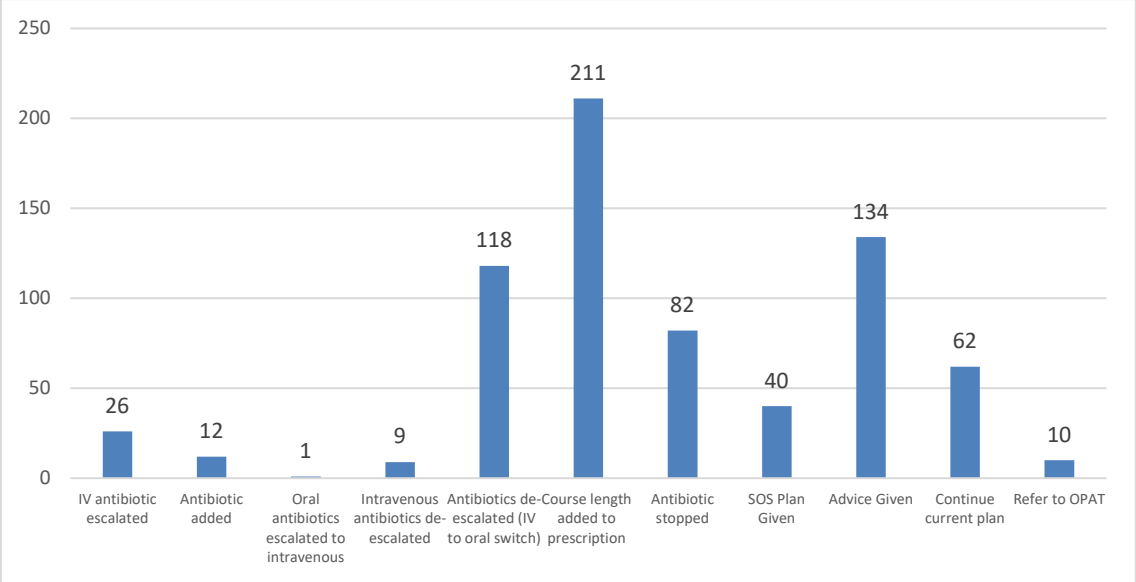
- oral to IV switch.

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

Further advice and an "SOS" plan were provided for 40 patients. The "SOS" plan provides the clinical teams with advice in case of clinical deterioration. In addition to the antibiotic escalation plan it will include details of further investigations or microbiological sampling to be undertaken if clinical deterioration occurs. Figure 34 summarises the outcome of the antimicrobial reviews in more detail.

(Note total exceeds 497 prescriptions, often multiple actions for 1 prescription i.e., de-escalation and addition of stop date).

Figure 34 Outcome of Antimicrobial Reviews



Benefits of the ward round

Patient Safety

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

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

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

Junior Doctors & Antimicrobial Stewardship (AMS)

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

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

Financial benefits

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

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

Compliance with NICE Guidance

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

Other benefits

The ward rounds help the Trust to manage antimicrobial shortages.

Participation in the antimicrobial ward rounds is a good development opportunity for junior Pharmacists and improves their knowledge and confidence in AMR and AMS. Trainee Advanced Care Practitioners and medical students have also joined the ward rounds this year as an educational experience.

Educational sessions

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

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

Future developments

Recruitment to the band 5 and 7 pharmacy positions.

The antimicrobial ward rounds could be expanded so that more patients on antimicrobials are reviewed but this is limited by Consultant Microbiologist and Antimicrobial Pharmacist availability.

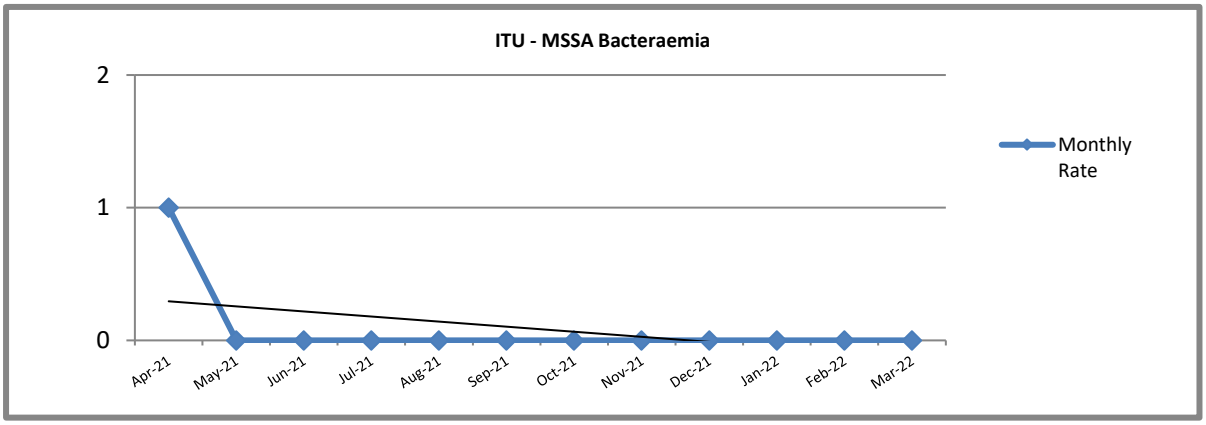
Within pharmacy there is a plan to train and rotate junior Pharmacists through the antimicrobial ward round to expand their knowledge of antimicrobials and AMS.

Microguide (an App based version of our formulary) is set for launch by August 2022.

Critical Care Surveillance

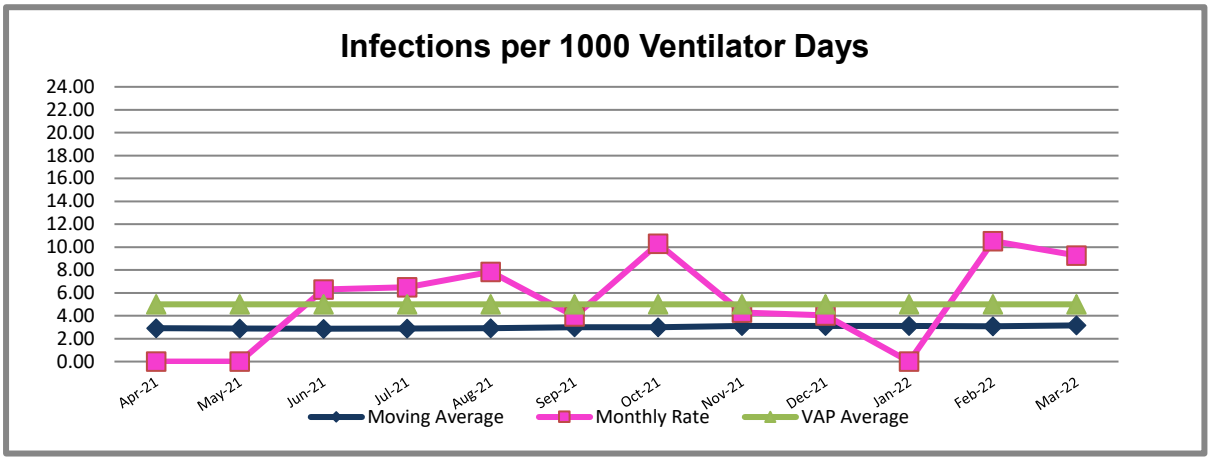
The Critical Care Unit conducts enhanced surveillance of bloodstream infections and ventilator associated pneumonias. MSSA bacteraemia cases were monitored, and one intravascular line associated intravascular case was observed.

Figure 35 Critical Care MSSA Bacteraemia Surveillance



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

Figure 36 Ventilator Associated Pneumonia Surveillance



Targets and Outcomes

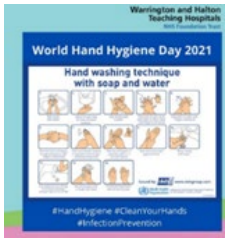
Activities

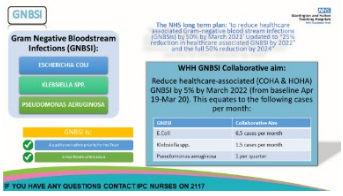
The Infection Prevention and Control Team has been involved in several initiatives within the Trust to promote the importance of infection prevention and control. These included: -

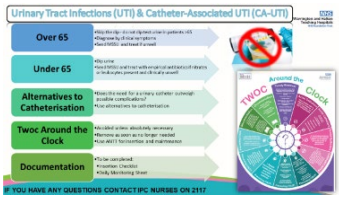
- Hand hygiene awareness raising events
- Unannounced spot checks
- Global hand hygiene day
- Matron/Facilities Walkabouts
- World Antibiotic Awareness Week
- Response to complaints
- Response to FOI requests

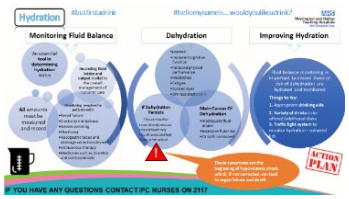
Awareness raising events

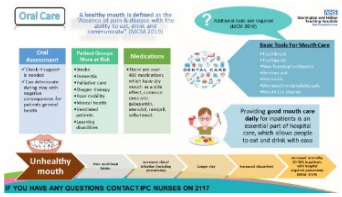
The team had a proactive approach to awareness raising events using Trust wide safety brief, good morning WHH and desktop messages.

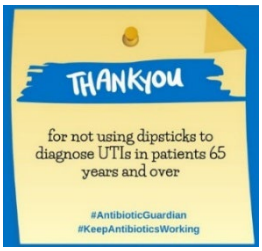


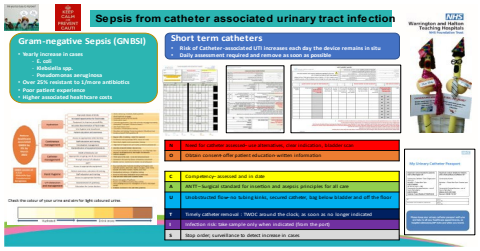












Updated policies and guidelines

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

Other Policies and Documents

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

- IPC Policy
- Hand Hygiene Policy
- ANTT Policy
- Group A Streptococcus Policy
- Standard Precautions Guidelines
- Personal Protective Equipment Guidelines
- Uniform and WorkWear Policy
- Ventilation Policy approved
- Notification Policy approved
- Major Outbreak of Infection Guidelines

- Clostridium difficile – toolkit for case investigation
- MSSA bacteraemia - post infection review toolkit
- MRSA bacteraemia - post infection review toolkit
- Assurance framework – Infection Prevention and Control Team reporting structure
- Infection Control Sub-Committee Work Plan 2019/20
- IPC Board Assurance Framework (Covid-19)

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

Contribution to other initiatives

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

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

- Northwest Boroughs Partnership Mental Health Trust Infection Control Committee

Training Activities

The Infection Prevention and Control Team continue to provide a structured annual programme of education. This includes an Infection Control eLearning package for all staff. Training attendance figures were monitored monthly with details shown in table 8

Table 8 Infection Control Training compliance

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

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

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

- Trust corporate induction: all new starters via eLearning
- Mandatory training: all staff
  - Patient facing staff – annual
  - Non-patient facing staff – 3 yearly

Other training was provided to:

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

Medical Students

- Infection Prevention and Control
- Various infection/microbiology topics

Ad hoc clinical based teaching

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

- Clostridium difficile management
- CPE screening
- Isolation priorities
- Linen Management
- MRSA screening and suppression therapy
- Outbreak Management
- Personal protective equipment
- Sharps Safety
- Viral gastroenteritis outbreak management

Conclusion

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

The successive waves of the Covid-19 pandemic created additional challenges on top of an already demanding role. The team members worked over and above to provide a high output of education, guidance, and positive outcomes for the Trust. It is to their great credit that all team members stepped up to meet the additional requirements for education, production of policy documents, service reviews and meeting attendance alongside a proactive agenda to address C. difficile and bloodstream infections from MRSA/MSSA and GNBSI.

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

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

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

3. ACTIONS REQUIRED/RESPONSIBLE OFFICER

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

4. IMPACT ON QPS?

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

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

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

5. MEASUREMENTS/EVALUATIONS

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

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

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

- Delivery of the Infection Prevention and Control Strategy
- Education and training compliance figures
- Audit findings and non-compliance actions
- Progress with policy revisions

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

Compliance assessment against the Health and Social Care Act (2008), Code of practice on preventing infections and related guidance (2015) biannually.

Compliance assessment against the Covid-19 IPC Board Assurance Framework, bimonthly updates.

6. TRAJECTORIES/ OBJECTIVES AGREED

- C. difficile ≤ 37 cases
- MRSA bacteraemia cases - Zero tolerance to avoidable cases
- MSSA bacteraemia cases – no threshold
- Gram negative bloodstream infections
    - E. coli bacteraemia ≤ 57 cases
    - P. aeruginosa bacteraemia ≤ 6 cases
    - Klebsiella spp. bacteraemia ≤ 19 cases
- IPC Strategy Delivery

7. MONITORING/REPORTING ROUTES

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

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

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

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

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

8. TIMELINES

Financial year 2021/22

9. ASSURANCE COMMITTEE

Infection Control Sub-Committee

10. RECOMMENDATIONS

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

Kimberley Salmon-Jamieson
Chief Nurse /Deputy Chief Executive Officer
Director of Infection Prevention and Control (DIPC)
July 2022

Appendix 1 Annual Work Programme 2022/23

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

Governance													
	Target date	**Leads**	**A**	**M**	**J**	**J**	**A**	**S**	**O**	**N**	**D**	**J**	**F**	**M**
Review of ICSC Terms of Reference	Annual	Deputy DIPC												✓
Review of IPCT infrastructure and reporting lines	Annual	ADIPC				✓								✓
DIPC annual report	Annual	ADIPC												
Quarterly DIPC reports to Quality Assurance Committee (QAC)	Quarterly	ADIPC		✓			✓			✓			✓	
Quarterly DIPC reports to Trust Board	Quarterly	ADIPC		✓			✓			✓			✓	
Risk register review	Monthly	ADIPC	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
ICSC HLBP submission to PSCE; QAC; and H & S committees	Bimonthly	ADIPC	✓		✓		✓		✓		✓		✓	
RCAs/PIR of HCAI incidents: MRSA; CDT; COVID	Per case	LNs	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Infection Prevention Programme	3 / annum	LNs					✓			✓			✓	
Submission of C. difficile RCA findings to the CCG panel for review to assess for lapses in care	Quarterly	LNs / ADIPC		✓			✓			✓			✓	
Review of revised HCAI (GNBSI/C. difficile Objective for 2022/23)	Annual	ADIPC	✓											
IPCT team building session	Sep 2021	ADIPC						✓						
Review of progress against this work plan and the IC strategy	Biannual	ADIPC						✓						✓
Provision of commentary for Trust Quality Account	Annual	ADIPC	✓											
Code of Practice for prevention of HCAIs – compliance assessment	Biannual	ADIPC						✓						✓
Review of HCAI prevention action plans C. difficile; GNBSI; Staphylococcus aureus	3 / annum	ADIPC				✓			✓			✓		
Revise investigation toolkit for GNBSI	Mar	ADIPC												✓
Review toolkit for investigation of MSSA bloodstream infections	Mar	ADIPC												✓
Review toolkit for investigation of Clostridium difficile cases	Mar	ADIPC												✓
Review toolkit for Nosocomial Covid-19 cases (8-14 days and 15+ days)	Mar	ADIPC												✓
Committee/Group meeting attendance														
Antimicrobial Stewardship Group Meetings	Quarterly	AMSG Lead CMM	✓			✓			✓			✓		
Bed meetings	Daily	IPCNs	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
CCG CDT review panel meetings	Quarterly	ADIPC		✓			✓			✓			✓	
CDT MDT	Weekly	IPCNs	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Decontamination Group	Quarterly	ICD / ADIPC				✓			✓			✓		
Patient Flow Meetings/Event Planning Group	Monthly	ADIPC	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
GNBSI operational group – external	Bimonthly	TBC	✓			✓				✓				✓
GNBSI Expert Faculty – internal	Monthly	CMM/ Deputy DIPC/ ICD	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

	Target date	Leads	A	M	J	J	A	S	O	N	D	J	F	M
HCAI Network UKHSA	TBC	TBC												
Health and Safety Sub-committee	TBC	ADIPC												
Health Protection Forum WBC	TBC	IPC Matron												
ICSC	Monthly	IPCT	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
HCAI data submission to Communications team	Monthly	ADIPC	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
HCAI Prevention Plan for next financial year	Annual	ADIPC												✓
ICU/IPCT meetings	TBC	Deputy DIPC	✓			✓			✓			✓		
Incident meetings	As required	IPCT												
Infective Endocarditis MDT	Weekly	CMM	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
IPCT meetings	Weekly	IPCT	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
IPS meetings	Biannual	IPCNs												
Medical Devices group	Quarterly	IPCNs	✓			✓			✓			✓		
Nursing & Midwifery Forum	Monthly	ADIPC/IPC Matron	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Nutritional steering group	Monthly	TBC												
NWB ICC	TBC	Deputy DIPC												
Patient Safety and Clinical Effectiveness Committee	Monthly	ADIPC	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Patient Experience Sub-Committee	Monthly	IPC Matron	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Quality and Assurance Committee	Bimonthly	ADIPC		✓		✓		✓		✓		✓		✓
Safer sharps group meeting	Monthly	IPCN	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Ventilation Assurance Group	Quarterly	ICD / ADIPC												
Ward A9 MDT	Weekly	CMM	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Water safety group	Quarterly	ICD / ADIPC												
Workplace Health & Wellbeing Meetings	Biannual	TBC												
Surveillance														
Compliance with mandatory reporting of MRSA; MSSA; C. difficile; GNBSIs (E. coli, Klebsiella and Pseudomonas)	Monthly	IPCNs/ ADIPC	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Mandatory reporting data validation and timely sign off	Monthly	ADIPC	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Covid-19 outbreak reporting	Per incident	IPCNs	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
MSK compliance with Mandatory orthopaedic surveillance	Quarterly	LN MSK	✓			✓			✓			✓		
Zero tolerance to MRSA bacteraemia cases	Monthly	ALL												
SSSI	Quarterly	LN DD	✓			✓			✓			✓		
HCAI surveillance reports – weekly to Chief Nurse, Associate Chief Nurses, Lead Nurses, and Matrons	Weekly	IPC Admin	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Surveillance of HAI alert organisms (MRSA, VRE, CDT etc.)	Daily	IPCNs	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
HCAI reporting for Trust dashboards with commentary	Monthly	ADIPC	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
HCAI reporting to ICSC dashboards	Monthly	ADIPC	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Pseudomonas surveillance in Augmented care area (ICU: NNU : K25)	Fortnightly	IPCNs	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
VRE surveillance	Fortnightly	IPCNs	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

	Target date	Leads	A	M	J	J	A	S	O	N	D	J	F	M
Complete Quarterly Mandatory Laboratory returns and submit to PHE	Quarterly	Deputy DIPC	✓			✓			✓			✓		
Antibiotic ward rounds daily on ICU	Daily	CMMs	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Antibiotic ward rounds	Weekly	CMMs	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Environmental cleanliness monitoring														
Environmental cleanliness monitoring	Monthly	Facilities Manager	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Matron and IPC Walkabouts/ Covid Roadshows	Monthly	Matrons /IPCNs	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
First Impressions – SEE Walkabouts	TBC	IPC Matron												
Mock CQC inspections	TBC	Matrons	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Estates PAM assessment	Annual	ADE												✓
Legionella Assessments and compass flushing reports	TBC	ADE	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Implementation of revised NHS Cleaning standards and Cleanliness Charter	Monthly	HoF	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
	Target date	**Lead**	**A**	**M**	**J**	**J**	**A**	**S**	**O**	**N**	**D**	**J**	**F**	**M**
Audit														
Audit Programme (IPC led) against standard precautions with reporting to ICSC	Annual	IPCNs	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Hand hygiene audits	Weekly	LNs	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
MRSA pre-operative screening audit	Quarterly	LN DD	✓			✓			✓			✓		
MRSA screening compliance audits	Monthly	IPCNS	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Support areas requiring improvements identified on the Quality Metrics programme	Monthly	IPCNs	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Policy /guideline/SOP/leaflet reviews														
CJD Instrument Handling	Jun	IPCNs												
CJD Nursing Management	Jun	IPCNs												
Tuberculosis	Jun	IPCNs												
Scabies	Jun	IPCNs												
MRSA	Jun	IPCNs												
Measles	Jun	IPCNs												
Surveillance and data collection (local)	Sep	IPCNs												
Glycopeptide resistant enterococci MDRO	Sep	IPCNs												
Admission/transfer and discharge of infectious patients and risk assessment	Sep	IPCNs												
Specimen Handling	Sep	IPCNs												
Pandemic Influenza	Sep	IPCNs												
Mattress inspection SOP	Sep	IPCNs												
Chickenpox	Dec	IPCNs												
Clostridium difficile	Dec	IPCNs												
Viral Gastroenteritis	Dec	IPCNs												
Care of deceased patients	Dec	IPCNs												
Spillage of blood and body fluids	Dec	IPCNs												
Decontamination and single use devices	Dec	IPCNs												

	Target date	Leads	A	M	J	J	A	S	O	N	D	J	F	M
Meningitis and Meningococcal Disease	Mar	IPCNs												
Closure of rooms wards, departments, and premises to new admissions	Mar	IPCNs												
Viral haemorrhagic fevers	Mar	IPCNs												
Safe handling and disposal of waste	Mar	IPCNs												
Isolation of immunosuppressed patients	Mar	IPCNs												
Awareness raising events														
Global Hand washing Day	Jun	IPCNS		✓										
GNBSI and ANTT	Oct	IPCNS							✓					
Uniform and workwear promotion	TBC	All												
October IC week – Topic Boards	Oct	IPCNs							✓					
Trust wide Safety Brief – IPC promotion	Oct	ADIPC							✓					
November World Antibiotic Awareness Week	Nov	IPCNs								✓				
Seasonal flu campaign with OHWB	Dec	OHWB							✓	✓	✓	✓		
Covid PPE refresher training	TBC	TBC												
World TB Day	Mar													✓
Education														
Provide Mandatory training for IPC supporting areas with low compliance figures	Monthly	IPCNS	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Mandatory training sessions as per timetable	Monthly	IPCNs	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Induction training sessions as per timetable	Monthly	IPCNs	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Single Point Lessons as requirement identifies	Monthly	IPCNs	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

D = deferred
✓= Planned
✓= Completed

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/22/07/100**	
SUBJECT:	**Infection Prevention and Control Board Assurance Framework Compliance Report**	
DATE OF MEETING:	27th July 2022	
AUTHOR(S):	Lesley McKay, Associate Chief Nurse, Infection Prevention + Control	
EXECUTIVE DIRECTOR SPONSOR:	Kimberley Salmon-Jamieson, Chief Nurse + Deputy Chief Executive	
LINK TO STRATEGIC OBJECTIVE:	SO1 We will.. Always put our patients first delivering safe and effective care and an excellent patient experience.	✓
	SO2 We will.. Be the best place to work with a diverse and engaged workforce that is fit for now and the future.	✓
	SO3 We will ..Work in partnership with others to achieve social and economic wellbeing in our communities.	✓
EXECUTIVE SUMMARY	To provide the Quality Assurance Committee with assurance on actions in place to meet legislative requirements relating to the prevention and control of infection linked directly to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.	
PURPOSE: (please select as appropriate)	Information	Approval / To note ✓ / Decision
RECOMMENDATIONS:	The Trust Board is asked to receive and note the report.	
PREVIOUSLY CONSIDERED BY:	**Committee**	Quality Assurance Committee
	Agenda Ref.	QAC/22/07/181
	Date of meeting	5th July 2022
	Summary of Outcome	The compliance assessment was approved.
FREEDOM OF INFORMATION STATUS (FOIA):	**Release in Full**	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None	

SUBJECT	IPC Board Assurance Framework	AGENDA REF:	BM/22/07/100

1. BACKGROUND/CONTEXT

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

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

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

Legislative requirements relating to Covid-19 include: -

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

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

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

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

2. KEY ELEMENTS

Please see Appendix 1 for compliance assessment.

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

3) ACTIONS REQUIRED/RESPONSIBLE OFFICER

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

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

4) IMPACT ON QPS?

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

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

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

5) MEASUREMENTS/EVALUATIONS

- Incident reporting
- IPC BAF Action plan monitoring
- Environmental Action Plan monitoring
- Nosocomial case monitoring and outbreak detection and reporting

6) TRAJECTORIES/OBJECTIVES AGREED

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

7) MONITORING/REPORTING ROUTES

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

8) TIMELINES

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

9) ASSURANCE COMMITTEE

- Infection Control Sub-Committee

10) RECOMMENDATIONS

The Quality Assurance Committee is asked to receive the report.

APPENDIX 1 Infection Prevention and Control Board Assurance Framework Compliance Assessment 06 2022

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

APPENDIX 1 Infection Prevention and Control Board Assurance Framework Compliance Assessment 06 2022

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

APPENDIX 1 Infection Prevention and Control Board Assurance Framework Compliance Assessment 06 2022

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

APPENDIX 1 Infection Prevention and Control Board Assurance Framework Compliance Assessment 06 2022

1. Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks their environment and any other users may pose to them.				**RAG**
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure that:				
	- RSV dashboards discussed at the IPC/Paediatric Surge planning meetings			
There are check and challenge opportunities by the executive/senior leadership teams of IPC practice in both clinical and non-clinical areas	- Matron and IPC Walkarounds - Senior nursing team checks that action cards are being completed - Executive Team walkabouts - Ward Accreditation with IPC reviewer membership - Challenge occurs at the following meetings: - Tactical - Silver IPC Cell - Quality Assurance Committee - Infection Control Sub-Committee - Senior Executive Oversight Group - Covid NED Group - Increased Microbiology support/ briefings delivered to medical cabinet - Surface wipes and alcohol-based hand rubs are provided for all non-clinical areas			
Resources are in place to implement and measure adherence to good IPC practice.	PPE supply is monitored at tactical Group meetings PPE audit programme in place Health and Safety Team audit programme Signage is displayed on donning and doffing as an aide memoire for staff.			

APPENDIX 1 Infection Prevention and Control Board Assurance Framework Compliance Assessment 06 2022

1. Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks their environment and any other users may pose to them.				**RAG**
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure that:				
This must include all care areas and all staff (permanent, agency and external contractors)				
The application of IPC practices within this guidance is monitored, e.g.: - hand hygiene - PPE donning and doffing training - cleaning and decontamination	Weekly hand hygiene audits Covid-19 PPE audits (for aerosol and non-aerosol generating procedures) are in place for all clinical areas	Centralised information on PPE training Level 2 clinical IPC training 78% at the end of April 2022.	UK HSA training videos are included in annual mandatory training programmes. Trajectories set by CBU, 2 taught sessions per week, eLearning option	
The IPC Board Assurance Framework is reviewed, and evidence of assessments are made available and discussed at Trust board.	Bimonthly review or sooner if updated Board meeting agenda Board meeting minutes			
The Trust Board has oversight of ongoing outbreaks and action plans.	- Information on outbreaks included in daily executive summary and discussed at the daily Senior Executive Oversight Group Meeting - Learning from Outbreaks included in Nosocomial Board Paper 01 2021 - Nosocomial learning action plan in place reviewed at Silver IPC cell meetings - Covid-19 RCA findings fed back to CBUs with drill down to			

APPENDIX 1 Infection Prevention and Control Board Assurance Framework Compliance Assessment 06 2022

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

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

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

2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections				**RAG**
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure that:				
A minimum of twice daily cleaning of: - patient isolation rooms - cohort areas - donning & doffing areas - 'Frequently touched' surfaces e.g., door/toilet handles, patient call bells, over bed tables and bed rails - where there may be higher environmental contamination rates, including toilets/commodes particularly if patients have diarrhoea	- Twice daily cleaning in place - Ring the bell it's time for Clinell campaign - Domestic staff record when they have cleaned areas - Enhanced cleaning – all areas, including non-clinical, supplied with desk wipes - Increased cleaning frequency in all public areas including toilets, communal spaces, lifts - Cleaning of workstations is included in the Environmental Action Plan - Domestic staff time cleaning activity when areas are vacant - Increased cleaning included in ICU Bioquell pod SOP - Review of guidance to reduce cleaning in low-risk elective procedure areas and return to use of detergents **Error! Hyperlink reference not valid.**			
A terminal/deep clean of inpatient rooms is carried out:	- Terminal cleaning and decontamination polices in place including guidance on			

2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure that:				
- following resolutions of symptoms and removal of precautions - when vacated following discharge or transfer (this includes removal and disposal/or laundering of all curtains and bed screens)	environmental disinfectant required to decontaminate the environment. Decontamination included in the Covid-19 policy - All policies are used in conjunction with any updates provided by COVID-19 national guidance - Terminal Cleaning Guidelines 2018 - Decontamination Policy 2019 - 4 additional HPV machines purchased and in use - CEO meeting and Chief Nurse/Deputy CEO and ADIPC meeting with domestic staff - Associate Director of Estates is a member of Silver IPC cell - Terminal cleaning standards sign off checklist			
- following an AGP if room vacated (clearance of infectious particles after an AGP is dependent on the ventilation and air change within the room)	- Ventilation Group and Ventilation Policy	Ventilation and air changes per hour in all areas is not unknown	Discussion on down time following areas where AGPs are performed based on air changes/hour where known and time extended in areas where mechanical ventilation is not available	

2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections				**RAG**
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure that:				
Reusable non-invasive care equipment is decontaminated: - between each use - after blood and/or body fluid contamination - at regular predefined intervals as part of an equipment cleaning protocol o before inspection, servicing, or repair equipment.	- Included in Decontamination Policy which incorporates single use and single patient use guidance - Cleaning monitoring audits - Decontamination audits - Policy and certification process to confirm cleaning prior to service inspection or repair - Dynamic mattresses are cleaned off site by contractual arrangements - Green I am clean indicator tape for items cleaned/ decontaminated at ward level			
Compliance with regular cleaning regimes is monitored including that of reusable patient care equipment.	Robust audit programme with timely feedback for corrective action as per the national cleanliness standards			
As part of the Hierarchy of controls assessment: ventilation systems, particularly in, patient care areas (natural or mechanical) meet national recommendations for minimum air changes refer to country specific guidance.	Theatre ventilation audits	Trust-wide audit and Action plan required	Requirement for Estate overview discussed at Ventilation Group and action plan to be developed to address non-compliant areas	
The assessment is carried out in conjunction with organisational estates teams and or specialist advice from ventilation group and or the organisations, authorised engineer	Trust is supported by an Appointed Authorising Engineer/Ventilation. Guidance sought on all capital projects with sign off of plan.			

APPENDIX 1 Infection Prevention and Control Board Assurance Framework Compliance Assessment 06 2022

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

3. Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
Arrangements for antimicrobial stewardship are maintained - previous antimicrobial history is considered - the use of antimicrobials is managed and monitored	- Consultant Medical Microbiology daily Ward Round in Critical Care - Ward based Pharmacist support - Prescribing advice available by telephone (in and out of hours 24/7)	Point prevalence Audit scores in the region of 92%. Some wards have lower than 90% compliance for more than 1 quarter	Business case approved to strengthen stewardship resources Change approach to auditing to provide more meaningful data	

Compliance assessment against version 1.8

3. Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
to reduce inappropriate prescribing to ensure patients with infections are treated promptly with correct antibiotic.	- Pharmacist prescribing support on all inpatient wards - Infection Control Doctor presentations to Medical Cabinet - Formulary reviewed as evidence/ guidelines are updated - Antibiotic prescribing guidelines for COVID suspected patients have been published - Antimicrobial Management Steering Group Meetings - Quarterly - C difficile outliers ward rounds - Quarterly Point Prevalence audits with concerns discussed at Medical Cabinet and Infection Control Sub-Committee – Process reviewed and point prevalence audits reduced to biannual with more focussed audits in areas where improvement is required - Antimicrobial Stewardship is included in the IPC Strategy 2022 - 2023			
Mandatory reporting requirements are adhered to, and boards continue to maintain oversight	- Mandatory reporting of HCAIs has continued to be completed timely			

3. Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
	- Data on HCAIs is included on the Quality Assurance Committee and Trust Board and Infection Control Sub-Committee Dashboards - DIPC reports HCAI data at Trust Board - Information on Data Capture System - Distribution of HCAI surveillance data weekly - Annual UK HAS HCAI reports and monthly dashboards			
Risk assessments and mitigations are in place to avoid unintended consequences from other pathogens.	- Infection control risk assessments completed on admission and updated in light of microbiology results - Electronic patient record alerting system - IPC Policies/guidelines - IPC on call service			

4. Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion.				**RAG**
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
Visits from patient's relatives and/or carers (formal/informal) should be encouraged and supported whilst maintaining the safety and wellbeing of patients, staff, and visitors	Risk assessment in place Compassionate visiting supported Visiting restrictions lifted and returned to pre-pandemic visiting times 1st June 2022			
National guidance on visiting patients in a care setting is implemented	- Restricted visiting implemented 17 March 2020; Visiting fully suspended from 26 March 2020; Compassionate visiting arrangements agreed 09 April 2020. Paper on visiting arrangements taken to SEOG - Visiting the dying guideline in place with training provided by the Palliative Care Team - Trust wide Communication via email on visiting restrictions then cessation - Environmental Safety Plan includes site lock down to restrict access - Compassionate visiting arrangements agreed for the following patient groups where close family and friends visiting may be admitted: - Patients in critical care - Vulnerable young adults - Patients living with Dementia		• Guidance regularly updated in-line with national guidance • Visitor risk assessments • Pre-visit symptom screening checklist • Visitor information leaflet • Family Liaison Officer team • Virtual visiting/ iPad • Visiting restrictions lifted and returned to pre-pandemic visiting times 1st June 2022	

4. Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion.				**RAG**
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
	- Autism - Learning difficulties - Loved ones who are receiving end of life care - Signage at entrances - Information on Trust website - FLOgrams - Trial wards agreed to re-introduce visiting week commencing 7 June 2021 limiting numbers and visiting time period of 1 hour - Visiting permitted with booked and timed slot on Christmas Day and Boxing Day with control measures in place on symptom checks and where possible Lateral Flow Device Test (with negative result) - Visiting guidance updated to meet current national guidance – 2 visitors per patient, timed slots, for 1 hour - Visiting restrictions lifted and returned to pre-pandemic visiting times following Guidance on 1st June 2022			

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

4. Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion.				**RAG**
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
Visitors with respiratory symptoms should not be permitted to enter a care area. However, if the visit is considered essential for compassionate (end of life) or other care reasons (e.g., parent/child) a risk assessment may be undertaken, and mitigations put in place to support visiting wherever possible.	Visitor Risk assessment Sign-in sheet symptom checker Visiting restrictions lifted and returned to pre-pandemic visiting times following Guidance on 1st June 2022			
Visitors are not present during AGPs on infectious patients unless they are considered essential following a risk assessment e.g., carer/parent/guardian.	FFP3 Fit testing for visitors to ICU			
Implementation of the Supporting excellence in infection prevention and control behaviours Implementation Toolkit has been adopted C1116- supporting-excellence-in-ipc-behaviours-imp-toolkit.pdf (england.nhs.uk)	Campaign posters received and roll out plan devised	Images of WHH staff selected for campaign use Wellbeing support area established	Roll out completed January 2022	

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

5. Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people				**RAG**
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
Infection status of the patient is communicated to the receiving organization, department or transferring services, when a possible or confirmed seasonal respiratory infection needs to be transferred.	- SBAR transfer form in place - Covid-19 Alert added to Lorenzo for all patients with a positive SARS-CoV-2 swab - Covid-19 status included on SBAR form - Covid-19 has been added to e-discharge summary template - Pre-admission information provided to patients being admitted electively - Policy for patients being discharged to care homes	Review of guidance published 17/01/22 Stepdown of infection control precautions and discharging COVID-19 patients and asymptomatic SARS-CoV-2 infected patients - GOV.UK (www.gov.uk) Limited number of side rooms	Liaison with Patient Flow Team throughout each day to optimise side room use, based on transmission risks	
Staff are aware of agreed template for screening questions to ask.	ED triage tool Senior staff in ED Triage Covid screening sign in sheet			
Screening for COVID-19 is undertaken prior to attendance wherever possible to enable early recognition and to clinically assess patients prior to any patient attending a healthcare environment	Visitor risk assessment Review of guidance to perform testing on admission in low-risk elective procedure areas **Error! Hyperlink reference not valid.**		UKHSA Guidance agreed for site specific and lower risk procedures including Halton Ward B4 and Endoscopy Pre-admission testing for low risk elective procedures using Lateral Flow device testing introduced	
Front door areas have appropriate triaging arrangements in place to cohort patients with possible or confirmed COVID-19/ other respiratory infection symptoms and segregation of cases to minimise the risk of cross-infection as per national guidance.	Triage tool and molecular Point of Care testing is in use in ED and Maternity. ED Triage tool included a question on travel history	Out of hours Cover for results from 10pm until am where POC test was negative, but PCR result is positive	To be discussed	

5. Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
	Positive results are sent by text message to Infection Prevention and Control (IPC) Nurses, who review and put IPC advice in place. PCR testing is also undertaken on admission Respiratory/non-respiratory pathway SOP Infection Risk Assessment in EPR Symptom screening checklist Virtual Ward Pathways			
Triage is undertaken by clinical staff who are trained and competent in the clinical case definition and patient is allocated appropriate pathway as soon as possible.	Senior staff triage in ED			
There is evidence of compliance with routine patient testing protocols in line with trust approved hierarchies of control risk assessment and approved	Compliance reviewed during outbreaks and at nosocomial RCA review meetings BI reporting systems shows swabs due to be taken daily. Daily oversight by senior nursing team to support compliance with admission, day 3 and day 5 testing Weekly testing stepped down 04/2022	Audit of compliance required	Process for reporting of Lateral Flow Device testing numbers to be confirmed	
Patients with suspected or confirmed respiratory infection are provided with a surgical facemask (Type II or Type IIR) to be	Patient information leaflet circulated in January 01/2022 promoting use of face masks for in patients	Some patients exempt from face mask use and some patients decline	Communication circulated on 27/01/22 that use of Face masks in healthcare settings remains in place Clear curtains between inpatient beds	

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

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

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

5. Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
	symptom screening in place on arrival - Virtual appointments where practicable - Temperature checking and symptom screening in place in OPD/ Vaccination centre			

6. Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
Appropriate infection prevention education is provided for staff, patients, and visitors.	IPC Mandatory training programme Signage for visitors and support provided by staff on duty	Level 2 clinical IPC training 78% at the end of April 2022.	Trajectories set by CBU, 2 taught sessions per week, eLearning option	
Training in IPC measures is provided to all staff, including: - the correct use of PPE including an initial face fit test/and fit check each time when wearing a filtering face piece (FFP3) respirator and - the correct technique for putting on and removing (donning/doffing) PPE safely.	Fit Testing programme UK HSA training videos shown during mandatory training sessions			

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

6. Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
Gloves are worn when exposure to blood and/or other body fluids, nonintact skin or mucous membranes is anticipated or in line with SICPs and TBPs.	Standard precautions and PPE guidelines			
The use of hand air dryers should be avoided in all clinical areas. Hands should be dried with soft, absorbent, disposable paper towels from a dispenser which is located close to the sink but beyond the risk of splash contamination as per national guidance	- Hand air dryers not in place in clinical areas - Access to hand hygiene facilities (stock of liquid soap, hand gel and paper towels is included in the auditing template) - Removal of hand driers in public toilets (none in clinical areas) has taken place as part of the environmental action plan - Hand towel dispensers have been installed and waste collection schedule put in place			
Staff maintaining physical and social distancing of 1 metre or greater wherever possible in the workplace	Guidance on social distancing re-enforced Risk assessment templates updated to reflect the removal of the requirement for social distancing June 2022			

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

6. Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
for hospital/organisation onset cases (staff and patients/individuals)	Local prevalence data included in Tactical Group agendas BI reports with UpToDate position Datix reporting of hospital onset case, Outbreak reporting as per the NHSE/I HOCI SOP Regional benchmarking using the Cheshire and Merseyside Nosocomial pack UKHSA CCDC attends Infection Control Sub-Committee Silver Infection Control Cell meetings chaired by the DIPC All Covid-19 positive results are communicated by text alert to the IPCNs. Patient records are flagged, and IPC advice documented			
Positive cases identified after admission who fit the criteria for investigation should trigger a case investigation. Two or more positive cases linked in time and place trigger an outbreak investigation and are reported.	IPC Team monitor incidence and report outbreaks via the web-based reporting system in line with the NHSE/I northwest HOCI SOP Datix reports are completed for all hospital onset cases and where an Outbreak is declared. RCA investigations are completed and reviewed to identify learning and harm. Where concerns are identified regarding harm, referral			

6. Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
	is made to the Governance Team for further review. PowerPoint feedback reports on learning from incidents shared with each CBU for 2020/2021			

7. Provide or secure adequate isolation facilities				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
That clear advice is provided, and monitoring is carried out of inpatients compliance with wearing face masks (particularly when moving around the ward or healthcare facility) providing it can be tolerated and is not detrimental to their (physical or mental) care needs.	Patient information leaflet circulated in January 01/2022 promoting use of face masks for in patients Signage on display advising use of face masks Facemasks no longer required for patients, and guidance implemented from 13th June 2022	Some patients exempt from face mask use and some patients decline National restrictions on face mask use lifted on 27/01/22 for public spaces	Communication circulated on 27/01/22 that use of Face masks in healthcare settings remains in place Clear curtains between inpatient beds Communication from CEO 13/06/2022	
Separation in space and/or time is maintained between patients with and without suspected respiratory infection by appointment or clinic scheduling to reduce waiting times in reception areas and avoid mixing of infectious and non-infectious patients.	Symptom screening on arrival at clinics Pre-attendance advice not to attend if symptomatic.			

7. Provide or secure adequate isolation facilities				**RAG**
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
Patients who are known or suspected to be positive with a respiratory pathogen including COVID-19 where their treatment cannot be deferred, their care is provided from services able to operate in a way which minimise the risk of spread of the virus to other patients/individuals.	Appointment scheduling to avoid cross over of Covid/non-Covid patients			
Patients are appropriately placed i.e., infectious patients in isolation or cohorts.	Monitoring of Covid testing for patient placement Isolation Policy Isolation of Immunosuppressed Patients Guidelines Side room audit tool Additional side room capacity created with pods inserted in - ED x1 - ICU x5 - B18 x4 Additional side rooms created on Wards - A2 - A3 - A6 - A9 - C21	Demand for side rooms exceeds capacity	Liaison with Patient Flow Team throughout each day to optimise side room use, based on transmission risks	
Ongoing regular assessments of physical distancing and bed spacing, considering	Environmental action plan Clear curtains			

7. Provide or secure adequate isolation facilities				**RAG**
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
potential increases in staff to patient ratios and equipment needs (dependent on clinical care requirements).				
Standard infection control precautions (SIPCs) are used at point of care for patients who have been screened, triaged, and tested and have a negative result	SOP for respiratory/non-respiratory pathways and PPE requirements Standard IPC precautions Guidelines IPC audit programme in place IPC Mandatory training programme Facemasks no longer required, and guidance implemented from 13th June 2022			
The principles of SICPs and TBPs continued to be applied when caring for the deceased	Care of deceased patients' guidelines			

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

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

8. Secure adequate access to laboratory support as appropriate				**RAG**
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
There is regular monitoring and reporting that identified cases have been tested and reported in line with the testing protocols (correctly recorded data)	- LION BIS used to monitor testing in line with guidance and follow-up of omitted tests on admission/ day 3 /day 5/ weekly from day 5 - Documentation of IPC advice on receipt of positive results - RCA requests for cases ≥ day 8 of admission, with monitoring system in progress - Daily data validation process for Sit Rep sign-off and external reporting - IPC Team Spreadsheet with RCA follow up of all cases ≥ day 8 of admission - Turn around times are monitored at Silver Cell IPC meetings			
Screening for other potential infections takes place	Other routine admission screening (CPE, MRSA, VRE) in place			
That all emergency patients are tested for COVID-19 and other respiratory infections as appropriate on admission.	All patients being admitted to the Trust have Covid admission tests taken in ED using point of care (Abbot ID Now) testing and PCR swab Point of Care Testing supports ED and inpatient placement			
That those inpatients who go on to develop symptoms of respiratory infection/COVID-19	Covid is considered as a differential diagnosis for inpatients developing respiratory symptoms	A small number of RCA investigation findings	Discussion took place at Medical Cabinet to advise timely testing for Covid when	

8. Secure adequate access to laboratory support as appropriate				**RAG**
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
after admission are retested at the point symptoms arise.		identified missed testing opportunities	inpatients develop Hospital acquired pneumonia Guidance added to the Trust Antibiotic Formulary to test for Covid-19 in any patients who develop HAP	
That all emergency admissions who test negative on admission are retested for COVID-19 on day 3 of admission, and again between 5-7 days post admission.	Daily monitoring system in place to achieve full screening compliance for admission, day 3 and day 5 swabs Weekly screening implemented Lateral Flow Device testing implemented in June 2022 for day 3 and day 5 inpatient testing	RCAs are identifying a very small number of routine samples are being missed	- Daily senior nurse oversight to ensure compliance - Electronic systems support identification of patients who have not been screened as per routine testing protocol - Additional control measures put in place to ensure compliance including reminders via daily safety brief, emails to senior staff, electronic monitoring system - PowerPoint presentation on RCA learning fed back to CBUs with drill down of learning at individual ward level	
That sites with high nosocomial rates should consider testing COVID-19 negative patients daily.	- Community prevalence increasing >1400 per 100k/7-day rate January 2022 - Reduced nosocomial case numbers - Increased testing in outbreak areas as advised be the Infection Control Doctor - Daily testing has been implemented on wards during Covid-19 outbreaks			

8. Secure adequate access to laboratory support as appropriate				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
That those being discharged to a care home are tested for COVID-19, 48 hours prior to discharge (unless they have tested positive within the previous 90 days), and result is communicated to receiving organisation prior to discharge.	Discharge screening in place with results shared accordingly prior to patient discharge Discharge to care home SOP in place including process to check results prior to discharge			
Those patients being discharged to a care facility within their 14-day isolation period are discharged to a designated care setting, where they should complete their remaining isolation as per national guidance	Named community facility for care of patients who require continued isolation for Covid-19			
There is an assessment of the need for a negative PCR and 3 days self-isolation before certain elective procedures on selected low risk patients who are fully vaccinated, asymptomatic, and not a contact of case suspected/confirmed case of COVID-19 within the last 10 days. Instead, these patients can take a lateral flow test (LFT) on the day of the procedure as per national guidance.	SOP revised to reflect pre-admission Lateral Flow device testing.			

9. Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
The application of IPC practices is monitored and that resources are in place to implement	IPC Audit Programmes - Hand hygiene			

9. Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
and measure adherence to good IPC practice. This must include all care areas and all staff (permanent, agency and external contractors).	- PPE - High Impact Intervention Audits - Ward audit programme Escalation in auditing schedule where concerns are identified and during outbreaks			
Staff are supported in adhering to all IPC policies, including those for other alert organisms.	- PPE Champions in place supported by training - Clinical advice for management of patients with suspected infections continued - IPC on call service to provide advice 7 days per week - PPE donning and doffing included in Induction and Mandatory training sessions - IPC Team visit areas to discuss concerns raised in relation to national guidance - Alert organisms are flagged on Lorenzo - IPCNs review patients with Alert organisms and provide advice to clinical teams - Discussion with Patient Flow Team on side room prioritisation - Pseudomonas surveillance in place in ICU, NNU			

9. Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
	- Prioritisation of side rooms for infections transmitted by the respiratory route and returning travellers from abroad - Isolation and CPE screening for patients admitted by inter-hospital transfer - Signage is displayed on donning and doffing as an aide memoire for staff - Covid-19 PPE booklet			
Safe spaces for staff break areas/changing facilities are provided.	Break rooms are Covid secure risk assessed. Spot checks on social distancing are carried out Removal of the requirement for social distancing June 2022			
Robust policies and procedures are in place for the identification of and management of outbreaks of infection. This includes the documented recording of an outbreak.	- Daily surveillance in place of ≥ day 8 cases and location tested to promptly identifying clusters and initiate outbreak investigation accordingly - Occupational Health and Wellbeing Team monitor for clusters of staff cases - Outbreak meeting agendas, minutes and action plans			

9. Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
	- Outbreak reporting reference numbers from NHSE/I via web-based reporting system - Emails to UKHSA; CCG; CQC, WHH Communications Team - Daily HOCI reporting template completed by Ward Managers and submitted to IPC/ Matron for review and action - Datix reporting			
All clinical waste and linen/laundry related to confirmed or suspected COVID19 cases is handled, stored, and managed in accordance with current national guidance.	- Guidance included in Covid-19 Policy. Early guidance adhered to when initial classification of a HCID. Waste was quarantined and disposed of by incineration - Guidance included in the Coronavirus Policy - Used linen is processed as infected via red alginate stitched bag stream - Linen Policy - Waste segregation, handling, and disposal guidelines - Waste is disposed of via orange waste stream as per updated national guidance			

9. Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
	- Waste segregation included in mandatory training - All waste bins have colour coded lids and signage to denote waste category			
PPE stock is appropriately stored and accessible to staff who require it.	- Stock control in place - In and out of hours access protocol in place - Specialist PPE equipment office with access available 7 days/week - National distribution to maintain stock levels			

10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
Staff seek advice when required from their IPCT/occupational health department/GP or employer as per their local policy.	SOP for staff and household member Covid-19 testing			
Bank, agency, and locum staff follow the same deployment advice as permanent staff.	Bank, agency, and locum staff follow the same deployment advice as permanent staff			
Staff who are fully vaccinated against COVID-19 and are a close contact of a case of COVID-19 are enabled to return to work without the need to self-isolate (see Staff	SOP in-place to allow return to work in line with NHSE/I guidance			

10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection				**RAG**
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
isolation: approach following updated government guidance)				
Staff understand and are adequately trained in safe systems of working, including donning, and doffing of PPE.	Included in mandatory IPC training. Level 2 compliance eat the end of April 22 = 78%	Some CBUs with less than 85% training compliance	IPCN offer to provide additional training sessions. 2 taught sessions per week and eLearning option	
A fit testing programme is in place for those who may need to wear respiratory protection.	Fit Testing programme is in place.			
Where there has been a breach in infection control procedures staff are reviewed by occupational health. Who will: lead on the implementation of systems to monitor for illness and absence. Infection prevention and control board assurance framework - facilitate access of staff to antiviral treatment where necessary and implement a vaccination programme for the healthcare workforce - lead on the implementation of systems to monitor staff illness, absence and vaccination against seasonal influenza and COVID-19 - encourage staff vaccine uptake.	Outbreak meeting discussions on exposed staff Datix reports on workplace exposure incidents	Review of updated guidance published 17/01/22 COVID-19: management of staff and exposed patients or residents in health and social care settings - GOV.UK (www.gov.uk)		
Staff who have had and recovered from or have received vaccination for a specific respiratory pathogen continue to follow the infection control precautions, including PPE, as outlined in national guidance.	Covid-19 SOP			

10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
A risk assessment is carried out for health and social care staff including pregnant and specific ethnic minority groups who may be at high risk of complications from respiratory infections such as influenza and severe illness from COVID-19. A discussion is had with employees who are in the at-risk groups, including those who are pregnant and specific ethnic minority groups. that advice is available to all health and social care staff, including specific advice to those at risk from complications Bank, agency, and locum staff who fall into these categories should follow the same deployment advice as permanent staff. A risk assessment is required for health and social care staff at high risk of complications, including pregnant staff.	- An integrated self-risk assessment tool has been produced for all staff to identify if they are 'at-risk'. - Following identification (through the tool or the personal information held on individuals), and a subsequent detailed risk assessment is completed for all staff who are within an 'at-risk' group, compliance Sep-21 at 94% and is reported daily - Chief People Officer and Chief Executive Officer and Chairman attended the BAME Staff Network Group in June 2020 to receive feedback - Individual letters have been sent to BAME members of staff, outlining support available - Named midwife contact within Maternity Department provides advice for pregnant staff - All staff who are considered clinically extremely vulnerable are supported by robust workforce support and the Trust are in the process of having one			

10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
	to one discussion to agree support and adjustments - All staff working at home have been provided with a 'working from home pack', including access to mental health support - Enhanced Occupational Health Service to 7 days per week with additional staffing both administration and clinical. Service resumed to 5 day working - An enhanced wellbeing offer has been developed, linked to learning from Wuhan, Italy, and the British Psychological Society - Electronic system in place for Covid-19 Workforce risk assessment - Access to face to face counselling - Wellbeing Wednesday emails			
Vaccination and testing policies are in place as advised by occupational health/public health.	Health Clearance Policy			
Staff required to wear FFP3 reusable respirators undergo training that is compliant with HSE guidance, and a record of this training is maintained and held centrally/ESR records	- Fit testing programme, including quantitative and qualitative testing, in place - Qualitative Fit testing SOP - Quantitative Fit testing SOP			

10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection				**RAG**
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
	- Records are added to a central database - Powered Hoods are offered as an alternative where it has not been possible to fit close fitting face masks Only EN 149:2001 compliant masks are accepted as fit for use for Aerosol Generating procedures			
Staff who carry out fit test training are trained and competent to do so.	Programme of Fit Testing in place which is only carried out by trained Fit testers An accredited Fit2Fit company or the Department of Health virtual training provided staff training			
All staff required to wear an FFP3 respirator have been fit tested for the model being used and this should be repeated each time a different model is used.	- Programme of Fit Testing in place - Compliance with Fit testing is monitored. Paper submitted to QAC in February 2021 - Programme of Fit Testing continues with an ambition to ensure staff are Fit Tested against 2 types of FFP3 respirators. Data on 08/10/2021 - Total Number on Database: 3848			

10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection				**RAG**
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
	- Total Number passed on at least 1 current supported mask: 2422 - Total Number passed on at least 2 current supported masks: 554			
All staff required to wear an FFP3 respirator should be fit tested to use at least two different masks	- Programme of Fit testing in progress	- Staff tested against only 1 mask	- Continuous Availability of Fit Testing to achieve the requirement to be fit tested against 2 masks	
A record of the fit test and result is given to and kept by the trainee and centrally within the organisation.	- Database with Fit testing details including those staff requiring specialist respiratory equipment which is updated as additional fit testing is completed	- Data not held on ESR	- Action in place to review use of ESR for recording Fit Testing records - Trust-wide data held on a spreadsheet	
Those who fail a fit test, there is a record given to and held by employee and centrally within the organisation of repeated testing on alternative respirators and hoods.	- Spreadsheet with Fit testing details included	- Data not held on ESR	- Action in place to review use of ESR for recording Fit Testing records	
That where fit testing fails, suitable alternative equipment is provided. Reusable respirators can be used by individuals if they comply with HSE recommendations and should be decontaminated and maintained according to the manufacturer's instructions.	- Alternative respiratory protection is offered i.e., powered hood - Staff are redeployed to green pathway areas or amber areas where aerosol generating procedures are not performed - Provision of specialist PPE equipment is recorded including			

10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection				RAG
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
	advice on decontamination of re-usable PPE			
Members of staff who fail to be adequately fit tested a discussion should be had, regarding re deployment opportunities and options commensurate with the staff members skills and experience and in line with nationally agreed algorithm.	- Alternative respiratory protection is offered i.e., powered hood - Staff are redeployed to green pathway areas or amber areas where aerosol generating procedures are not performed - Provision of specialist PPE equipment is recorded including advice on decontamination of re-usable PPE	-	-	
A documented record of this discussion should be available for the staff member and held centrally within the organisation, as part of employment record including Occupational health.	- Provision of specialist PPE equipment is recorded	- Documented evidence of discussion and central holding of this record	- Process under review to capture this data	
Boards have a system in place that demonstrates how, regarding fit testing, the organisation maintains staff safety and provides safe care across all care settings. This system should include a centrally held record of results which is regularly reviewed by the board.	- Spreadsheet with Fit testing details included - Compliance with Fit testing is monitored. Paper submitted to QAC - Email updates provided weekly by the Fit Testing Team Coordinator	- Data not held on ESR	- Action in place to review use of ESR for recording Fit Testing records - Information on Fit testing figures is reported at Tactical meetings and included at Senior Executive Oversight Group Meetings - Report to QAC 02/2021	
Consistency in staff allocation should be maintained, reducing movement of staff and the crossover of care pathways between	- Staffing reviews undertaken for all COVID areas			

10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection				**RAG**
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
planned/elective care pathways and urgent/emergency care pathways as per national guidance.	- Staff movements managed by the senior nursing team at daily meetings - Senior Nurse presence 7 days per week 8am-8pm to support staffing management - Planned elective areas have designated teams, who are not moved to any other area in the Trust - Where it is necessary to move staff between different areas to support patient safety, this is discussed with the Infection Control Team. - This cross over has not occurred between Elective and Emergency Care pathways			
Health and care settings are COVID-19 secure workplaces as far as practical, that is, that any workplace risk(s) are mitigated maximally for everyone.	- Risk assessment in place to reduce risk - Agile working policy includes home working - Staying Covid-19 secure signage listing mitigation in place			
Staff absence and well-being are monitored and staff who are self-isolating are supported and able to access testing	- Managers have been supported to record absence in 'real time'. Daily and weekly absence reporting is in place - Data reported at Tactical meetings			

10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection				**RAG**
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
	- Staff self-Isolation SOP in place from 08/2021 to enable staff to return to work, if they meet a risk assessed criteria from non-household Covid-19 contact - HR advisors support wellbeing meetings for long-term absence - Return to work advice includes requirement for 2 negative Lateral Flow Device tests from day 6 and day 7			
Staff who test positive have adequate information and support to aid their recovery and return to work	- A COVID-19 Occupatinal Health advice line has been created, to provide a range of advice and guidance to the workforce - The OH Service has also developed the co-ordination and advice service for staff testing (for symptomatic staff) - Enhanced Occupational Health Service to 7 days per week with additional staffing both administration and clinical. Service returned to 5 days - Occupational Health and Wellbeing advise staff of test results and provide further wellbeing support as and when required	- Test and Trace Service hours of operation	- Notifications from Test and Trace are received in the Control Room and forwarded to the Occupational Health and Infection Control Teams for action	

10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection				**RAG**
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	
Systems and processes are in place to ensure:				
	- Retesting is in place as appropriate and is set out in Staff Testing SOP - Occupational Health e-mail to staff and their manager with return-to-work guidance			

APPENDIX 2 Action Plan for IPC BAF 06 2022

Ref No	Action required	Target / review date	Date met	Supporting action	Lead	Supported by	Evidence/ Current position	RAG status
Criterion 1 Systems are in place to manage and monitor the prevention and control of infection								
Criterion 2 Provide and maintain a clean and appropriate environment								
1	A systematic review of ventilation and risk assessment is undertaken to support location of patient care areas for respiratory pathways	**July 22**		Requirement for discussion on audit findings at Ventilation Group and plan to agree actions	ADE	IPCT ICD	Site audits completed Action plan required to address areas of non-compliance	
Criterion 3 Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance								
Criterion 4 Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion.								
Criterion 5 Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people								
2	Audit of compliance with routine patient testing protocols in line with Trust approved hierarchies of control risk assessment and approved	**May 22**			IPCT	Informatics	BI report on testing provides information on tests outstanding for completion. Process for reporting of Lateral Flow Device testing compliance numbers to be confirmed	
3	Prioritisation patients with excessive cough and sputum production for placement in single rooms whilst awaiting testing.	**May 22**			PFT	IPCT	Patients are prioritised based on risk assessment by mode of infection transmission	

Ref No	Action required	Target / review date	Date met	Supporting action	Lead	Supported by	Evidence/ Current position	RAG status
Criterion 6 Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection								
Criterion 7 Provide or secure adequate isolation facilities								
Criterion 8 Secure adequate access to laboratory support as appropriate								
4	Revision to pre-admission PCR / Lateral Flow Device testing.	**May 22**	**June 22**		Planned Care Group Triumvirate	IPCT	Proposal to implement on the day Lateral Flow Device testing for day case surgery Halton ward B4 and both site Endoscopy Units.	
Criterion 9 Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections – Nil Concerns								
Criterion 10 Have a system in place to manage the occupational health needs and obligations of staff in relation to infection								
5	All staff required to wear an FFP3 respirator should be fit tested to use at least two different masks	**Sep 22**		Continuous Fit Testing Programme	DCN		Figures reported to Trust Board	

RAG Legend	
Action not commenced	
Action in progress	
Action completed	

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

Completed actions

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

Ref No	Action required	Target / review date	Date met	Supporting action	Lead	Supported by	Evidence/ Current position	RAG status
7	Consider daily testing of COVID-19 negative patients when there are high nosocomial rates should consider testing daily.	Feb 22	Feb 22	Increased testing in wards during outbreaks	CMM		Outbreak case detection	
8	Prompt tracing of Covid-19 contacts where this occurs	May 22	Apr 22	Publication approval reference: C1630 – isolation of Covid-19 contacts no longer required if asymptomatic	CMM/ ADIPC		Covid-19 exposed contact letter updated Completed as far as reasonably practicable	

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/22/07/101**	
SUBJECT:	**Digital Board – Summary Report**	
DATE OF MEETING:	27th July 2022	
AUTHOR(S):	Tom Poulter, Chief Information Officer	
	Sue Caisley, Deputy Chief Information Officer Alison Jordan, Associate Director of Information	
EXECUTIVE DIRECTOR SPONSOR:	Paul Fitzsimmons, Executive Medical Direct	
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	SO1 We will.. Always put our patients first delivering safe and effective care and an excellent patient experience.	X
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): **(*Please DELETE as appropriate)***	**#1114** FAILURE TO provide essential and effective Digital Services CAUSED BY increasing demands upon resources (e.g. cyber defences), new technology skillsets (e.g. Cloud), unfit solutions (e.g. Maternity), end-of-life solutions (e.g. Telephony), poor performance (e.g. Lorenzo EPR)RESULTING in a potentially reduced quality of care, data quality, a potential failure to meet statutory obligations (e.g. Civil Contingency measures) and subsequent reputational damage. **#1079** Failure to provide an electronic patient record (EPR) system that can accurately monitor, record, track and archive antenatal (including booking information, intrapartum and postnatal care episodes. Caused by an IT system (Lorenzo) which is not maternity specific, currently does not have a robust internet connectivity, inaccurate input of data, inadequate support to cleanse data and no intra-operability between services, for example by the health visitor services. Resulting in the inability to capture all required data accurately, to have a robust electronic documentation process in cases of litigation or adverse clinical outcome, poor data quality and inadequate communication with allied services, such as health visitors who are then uninformed of women within the system requiring antenatal assessment. This can also result in women being allocated to the wrong pathway and the wrong payment tariff. **#1372** FAILURE TO deliver the future Electronic Patient Record solution through the Strategic Procurement project in line with the Trust's time, budget and quality requirements CAUSED BY - A failure to develop an affordable business case due to baseline costs, strong existing benefits & lack of new cash releasing benefits - A failure to garner ICS and NHSE support to progress the EPR business case - A failure to deliver Managed Convergence in line with emergent national policy and the ICS Convergence strategy (in development) RESULTING IN (sequentially) – a continuation of the Trust's challenges with the incumbent EPR, Lorenzo (as identified in the Strategic Outline Case), potential for a costly extension to the existing Lorenzo contract or the highly retrograde step of returning to paper systems as Lorenzo will be at end of life at or before the end of the tactical contract extension delay.	
EXECUTIVE SUMMARY *(KEY ISSUES):*	The Digital Board met on 11th July 2022. This report provides a summary of papers received from key stakeholders, with the following assurance status for key delivery areas: • Paperless Programme	

	Substantial Assurance • Vendor Management Moderate Assurance • Information and Business Intelligence Substantial Assurance • IT Services Moderate Assurance • Digital Compliance and Risk Substantial Assurance • Electronic Patient Record Moderate Assurance • Clinical Safety and Risk Review Substantial Assurance • eRostering Moderate Assurance • Regional "place" Digital Programme (Warrington Together) Moderate Assurance • MIAA report on Clinical Safety Moderate Assurance Items to escalate to FSC: • Following approval of Digital Optimisation Group to Digital Board, the Lorenzo (Paperless Care) programme will continue to run with cycled BAU release management. The Trust has stepped away from first of type innovation projects e.g. NHS 111 integration. The Digital Board gives assurance that we are safe, and there is no impact on EPR plans. • Ongoing PACS risk WHH continue to work with Philips to complete actions relating to antivirus software, which could result in a fine of 4% of turnover. Phillips have committed a deadline of July 2022 for work to be completed. • Medirota is currently being provided with no charge; this period will shortly be coming to an end, and this will provide a cost pressure. It is not believed to be an appropriately robust system going forwards, and an options appraisal will be presented to Execs, also detailing that remaining with MediRota or choosing another system will require funding. Minutes of the Digital Board meeting are attached as Appendix A to this report for reference.

PURPOSE: ***(please select as appropriate)***	Information	Approval	To note	Decision
RECOMMENDATION:	The Trust Board is asked to note the report for assurance.			
PREVIOUSLY CONSIDERED BY:	**Committee**	Finance & Sustainability Committee		

	Agenda Ref.	FSC/22/07/120
	Date of meeting	20 July 2022
	Summary of Outcome	The meeting was cancelled and Chair's action taken to note the report for assurance.
FREEDOM OF INFORMATION STATUS (FOIA):	Partial FOIA Exempt	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	Section 43 – prejudice to commercial interests	

SUBJECT	Digital Board Update	AGENDA REF:	BM/22/07/101

1. BACKGROUND/CONTEXT

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

2. KEY ELEMENTS

1.1 Digital Programme
Substantial Assurance

The Paperless Care Programme continues to make excellent progress seeing 2 project go live since last reporting period.

GP Connect integration with GP Record
GP Connect makes patient medication and allergy information available within Lorenzo to all appropriate clinicians when and where they need it, to support direct patient care, leading to improvements in both care and outcomes.
Inpatient Lateral Flow Device Testing
As part of a national directive to move to day 3 and day 5 testing by Lateral Flow Device, a new electronic form has been developed with support from Infection Control.

The reconfiguration of Digital Optimisation Group new ToR and reporting format will be in place in Q2.

The Digital Optimisation Group completed an impact assessment with regards to the implications for BAU and Strategic EPR plans. The group agreed on the impact assessment complete regarding Dedalus to replace Lorenzo with Orbis _U. The Trust has stepped away from first of type innovation projects e.g. NHS 11 integration. The Digital Board gives assurance that we are safe, and there is no impact on EPR plans.

1.2 Vendor Management
Moderate Assurance

2.21SP1 EFB07 – Live 14th June.
2.22 delivery 8th July – Testing commenced – Go Live 14th September. Benefits to be updated at future meeting.
2.23 Testing scheduled for October 23 – scope currently being developed, expected to be complete March 2023.

There are 2 open PAN's both affecting WHH, one is regarding care management and the other is regarding ePMA, both have regular detection script to correct any WHH patient records as mitigation in place.

There are 2 open CNS's both affecting WHH, CSN-059 has a script in place and awaiting delivery and CNS-065, the fix is planned for release in September 2022.

1.3 Information and Business Intelligence
Substantial Assurance

The Cheshire &Mersey Information and Business Intelligence group are reviewing the daily, weekly, monthly returns with a view to reduce the number of returns required per Trust. The requirement for weekend reporting ceased weekend 11 June 2022. Reporting on the following Monday must include weekend data.

There are currently no risks on the Digital Analytics Risk Register that reports to the Risk Review Group.

The formal commencement of the ICS took place 1 July 2022. This supports in statute the already established collaborative working arrangements we have already with our PLACE partners and now more widely across C&M. From an Information and BI perspective the ICS is working to develop a command centre that will, once established provide the ability to report into ICS who will then collate system wide data to support good health and social care outcomes for our service users.

1.4 IT Services Update
Moderate Assurance

There are 28 IT Services Projects for 22\23, 10 out of 12 of June's RFC's have been completed successfully, 1 is pending following CAB approval and 1 is awaiting CAB approval. High assurance on Windows 10, Windows server migrations and antivirus controls. Moderate assurance on data centre, network and end user computer patching, this is because the network patching has fell slightly behind due to competing workload and limited resources. IT have now started an action plan to migrate 68 Trust servers onto Windows 2019 server operating system. We have 3 systems that have been challenging to migrate

- Historic Meditech data
- OLD Intranet (The Hub)
- Trust Tie

Meditech is due for completion at the end of September 22, delayed due to the volume of data that needs migrating, a firewall change to complete the Tie migration, completion date pushed back to end of July 22. Digital Analytics have collated the information currently stored on the old SharePoint, all systems need completing by 10th January 2023 as Microsoft extended support runs out.

On the 5th of July 2022, Lorenzo and eOutcome was down site wide. After investigation there was a SQL application database error on the Fraxinus server. Fraxinus resolved. Downtime total was 1.5hr.

To note: PACS/Windows Defender Antivirus work is ongoing, recently we had an outage on PACS following a Windows patching schedule. Philips technical engineer investigated and discovered errors on node 1 relating to firmware updates for the node and storage. Discussions have been held with Philips to establish a timetable to resolve the issues discovered on node 1.

1.5 Digital Compliance and Risk
Substantial Assurance

The Trust internal vulnerability score reached an all-time high of 75 before settling at 36. Newly found vulnerabilities in Apple iTunes, VMWare Tools, Windows, and Google Chrome. There was 0

High Care CERT reported last month by NHS Digital. The score has increased by 10 points in the Trust's BitSight score (780 (advanced)). Industry comparison states WHHT better than 90% of the healthcare/wellness group. 2 medium risks have been resolved since last month. There are some Trust assets that require

priority attention as they have outstanding Critical Care CERT's. Local risk assessment shows that the risk to the trust is lower than stated in the report due to local mitigations in place. Work on the evidence for the ISDN Accreditation continues, proposed a new date and waiting on the accreditation team for approval of suggested dates.

1.6 Strategic Electronic Patient Care Management System (EPCMS)
Moderate Assurance

The programme is developing the business case for EPCMS which will need to be approved by the Trust Board, supported by the ICS/ICB and then approved by NHS E/I prior to procurement re launch November 2022.
There have been ongoing discussions with the ICS with regards to the capital funding allocation process and how this can support the forecast capital expenditure for EPCMS.

Following approval of EPCMS Project Board Option 2 'Place Based OBS Evaluation Approach' and Option 4 'Start a new procurement with explicit links to convergence and interoperability' will be taken forward into the update OBC to August FSC/Trust Board.

Currently timetable remains unchanged; to have a new EPR system by November 2024. However, achieving this timeframe will be challenging and is subject to a timely relaunch and fast-tracking external OBC/FBC approval.

1.7 Clinical Safety and Risk Review
Substantial Assurance (for Lorenzo)

No new Product Alert or Customer Safety Notices were issued during June.

1.8 eRostering Programme
Moderate Assurance

There will be an executive paper produced with the options; Medirota is not suitable for all specialities. Allocate and Annual Leave need to be aligned. Deb Mallett is working on the paper, which will be going to Executives. This will be added to the High-level review that remaining with MediRota or another system will require funding.

1.9 Regional "Place" Digital Programme
Moderate Assurance

Warrington Together DEG established a task and finish group to complete the Warrington Place baseline assessment against the NHSX WGLL standards. This was completed with the caveats of internal governance.

The Programme is currently working on:

- eXchange – publishing discharge summary letters, and clinic letters.
- Share2Care – has been through regional review, had a demonstration of preferred solution, GraphNet, now plans to be developed to agree scope and requirements for the business

case to be put to the Place for a Share2Care Record, enables sharing of letters, pathways, gives patients access to their record, allows communication across clinical portal.

- PHR – Amity is preferred option though PKB/Zesty are also options

Requested funding for a dedicated Programme Manager from Place to initiate and drive the programme of work supported by place partners.

1.10 MIAA report on Clinical Safety
Moderate Assurance

Clinical safety staff in the Trust need to work as efficiently as they can, need a process and strategy. Introduction of new systems need to be part of their process. Communications need refining, this links to the new systems work, and existing critical/essential systems need to be reviewed for their clinical systems.

3. ACTIONS REQUIRED/RESPONSIBLE OFFICER

The following items were discussed at Digital Board and are highlighted for the attention of FSC. There are no specific actions required.

- The Lorenzo programme will continue to run with cycled BAU release management which will have no impact on the Paperless Care Programme projects. The Trust has stepped away from first of type innovation projects e.g. NHS 111 integration.

- Ongoing PACS risk WHH continue to work with Philips to complete actions relating to antivirus software, which could result in a fine of 4% of turnover. Phillips have committed a deadline of July 2022 for work to be completed.

- Medirota is currently being provided with no charge; this period will shortly be coming to an end, and this will provide a cost pressure. It is not believed to be an appropriately robust system going forwards, and an options appraisal will be presented to Execs, also detailing that remaining with MediRota or choosing another system will require funding.

4. RECOMMENDATIONS

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

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/22/07/102**	
SUBJECT:	**Clinical Recovery Oversight Committee (CROC) Chair's Annual Report 2021-22**	
DATE OF MEETING:	27th July 2022	
AUTHOR(S):	Terry Atherton, Non-Executive Director & Chair of F&SC	
LINK TO STRATEGIC OBJECTIVE: (*Please select as appropriate*)	SO1 We will.. Always put our patients first delivering safe and effective care and an excellent patient experience.	✓
	SO2 We will.. Be the best place to work with a diverse and engaged workforce that is fit for now and the future	
	SO3 We will ..Work in partnership with others to achieve social and economic wellbeing in our communities.	
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): (*Please DELETE as appropriate*)	**#224** Failure to meet the four hour emergency access standard and incur recordable 12 hour Decision to Admit (DTA) breaches, caused by capacity constraints in the Local Authority, Private Provider and Primary Care capacity resulting in potential risks to the quality of care and safety to patient, staff health and wellbeing, Trust reputation, financial impact and below expected patient experience.. **#1215** Failure to deliver the capacity required caused by the ongoing COVID-19 pandemic and potential environmental constraints resulting in delayed appointments, treatments and potential harm **#1273** Failure to provide timely patient discharge caused by system-wide Covid-19 pressures, resulting in potential reduced capacity to admit patients safely. **#1289** Failure to deliver planned elective procedures caused by the Trust not having sufficient capacity (Theatres, Outpatients, Diagnostics) resulting in potential delays to treatment and possible subsequent risk of clinical harm **#1125** Failure to achieve constitutional access standards caused by the global COVID-19 Pandemic resulting in high attendances and occupancy, non-compliance for RTT, Diagnostics, Cancer and ED Performance	
EXECUTIVE SUMMARY ***(KEY ISSUES):***	This report seeks to deliver assurance to the Trust Board that the Clincal Recovery Oversight Commitee has met its Terms of Reference and has gained assurance throughout the reporting period of the Trust's performance.	
PURPOSE: ***(please select as appropriate)***	Information / Approval ✓ / To note / Decision	
RECOMMENDATION:	The Trust Board is asked to review the document and ensure it meets its purpose.	
PREVIOUSLY CONSIDERED BY:	**Committee**	Clinical Recovery Oversight Committee
	Agenda Ref.	CROC/22/07/82
	Date of meeting	19th July 2022 (Chair's Actions)
	Summary of Outcome	Approved
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None	

CLINICAL RECOVERY OVERSIGHT COMMITTEE

AGENDA REFERENCE:	CROC/22/07/82			
SUBJECT:	Committee Chairs Annual Report 2021-22			
DATE OF MEETING:	19th July 2022			
ACTION REQUIRED:	To note			
AUTHOR(S):	Daniel Moore, Chief Operating Officer			
EXECUTIVE DIRECTOR SPONSOR:	Daniel Moore, Chief Operating Officer			
LINK TO STRATEGIC OBJECTIVE	SO1: We will ... Always put our patients first through high quality, safe care and an excellent patient experience.			
EXECUTIVE SUMMARY:	This report seeks to deliver assurance that the Committee has met its Terms of Reference and has gained assurance throughout the reporting period of the Trust's performance. The report was approved by Chair's actions following the previous meeting.			
PURPOSE: (please select as appropriate)	Information	Approval ✓	To note	Decision
RECOMMENDATION:	The Committee is asked to note report			
PREVIOUSLY CONSIDERED BY:	**Committee**	Not Applicable		
	Agenda Ref.			
	Date of meeting			
	Summary of Outcome			
NEXT STEPS: ***State whether this report needs to be referred to at another meeting or requires additional monitoring***	***Submit to Trust Board***			
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None			

SUBJECT	Annual Report of the Clinical Recovery Oversight Committee 2021-22

1. BACKGROUND/CONTEXT

The Committee is required to report annually to the Board outlining the work it has undertaken during the year, and where necessary, highlighting any areas of concern. This paper presents the Clinical Recovery Oversight Committee Annual Report which covers the reporting period 1 April 2021 to 31 March 2022.

The purpose of the Clinical Recovery Oversight Committee is to be accountable to the Board of Directors (the Board) for providing oversight and assurance on all aspects of quality and performance in relation to:

- Referral to Treatment (RTT)
- Patient Cancer Pathways
- Diagnostics including Endoscopy and Outpatients
- Progress of Clinical Harm Reviews (CHR)

In addition it reviews and monitors the Trust's operational performance against its annual plan and any necessary corrective planning and action.

The Committee initially established as a temporary committee during the COVID-19 pandemic and is accountable to the Board to ensure triangulation of matters detailed above under the purview of the Quality Assurance Committee and the Finance & Sustainability Committee. It was decided to move to establish the board on a permanent basis with Board consent to provide oversight, scrutiny and assurance of the restoration and recovery of elective services.

Terms of Reference

Following initial approval of the Committee's Terms of Reference in March 2021, they were updated and approved by the Trust Board in October 2021 to ensure they continued to remain fit for purpose.

Core Members

- Non-Executive Chair of Finance & Sustainability Committee
- Non-Executive Chair of Quality Assurance Committee
- Non-Executive member of Quality Assurance Committee
- Chief Nurse & Deputy CEO
- Executive Medical Director
- Chief Operating Officer
- Deputy Director of Governance
- Deputy Chief Finance Officer
- Associate Director of Planned Care

Frequency of Meetings and Summary of Activity

In light of the COVID-19 pandemic, the meetings were held virtually via MS Teams on a fortnightly basis during April to June 2021 and then monthly from July to March 2022 with Board consent.

The Committee met virtually 13 times during the year (meetings were stood down in July 2021, December 2021 and January 2022 due to operational pressures). See appendix 1 for Record of Attendance).

A summary of the activity covered at these meetings follows (see appendix 2 for workplan)

Reporting

In terms of reporting to the Clinical Recovery Oversight Committee, the following key reports were submitted in 2021-22.

Harm Profile Update – standing item

The Harm Profile update sets out an overview of the number of reviews undertaken against the corresponding waiting list priority code in line with regional and national guidance. The report set out and tracks the number of reviews undertaken and compliance against the Clinical Prioritisation & Scheduling Standard Operating Procedure (SOP). This report updated on any harm to patients because of their time waiting on the Trust Waiting Lists.

Review of Waiting Lists and Clinical Harm Review report – standing item

The committee received updates from the Medical Director in relation to regional processes on undertaking clinical harm reviews and how that benchmarked with the Trust process

Waiting List update: RTT; Priority Code Waiting Times; Cancer; Diagnostics – standing item

The Waiting List Report detailed elective recovery performance across:

- Referral To Treatment waiting times.
- The national waiting time priority codes P2, P3, P4, P5 and P6
- Regional bench mark data from Cheshire and Mersey providers
- The number patients waiting over 104 weeks
- The number of patients waiting over 78 weeks
- The number of patients waiting over 52 weeks
- Restoration of the Diagnostic DMO1 6 week waiting time standard for Radiology, Cardiorespiratory and Endoscopy procedures.
- Restoration of Cancer Waiting Time targets, including the number of patients waiting more than 104 and 62 days.
- Restoration of the New Outpatient and Follow Up waiting times
- Achievement of Patient Initiated Follow up (PIFU) services.

- The number of outpatients being done virtually.

2022-23 Planning Progress – standing item

Progress updates were received by the committee as to the various operational planning rounds and performance guidance. This included the planning for H1 (April to September) and H2 (October to March) in 2021-22.

Access to Recovery Fund – standing item

The Committee received updates from the Deputy Chief Finance Officer in relation to the national framework for achieving Elective Recovery Funding. The update included monthly updates on whether the standard was achieved and the associated income value. Specific updates were received in February and March 22 into spend against national bid monies supporting Elective Recovery to achieve H2 activity levels.

Cheshire & Merseyside Elective Restoration update – standing item

A verbal update was received each meeting highlighting any important benchmarking of performance within the Cheshire and Merseyside region. This update also included any opportunities for services to benefit from mutual aid or regional initiatives on waiting list relief.

Risk Register – every other meeting

The committee received updates of the risks on the Corporate and BAF risk registers relating to elective recovery. This included risks: 1215, 1273, 1331, 1332, 1125, 224 and 1135

Other issues considered / Reviewed during the year

In October 2021 and March 22, the committee received and considered a report on an Outpatients Deep Dive, following concerns of outpatient activity not achieving the H2 targets. The Clinical Recovery Oversight Committee noted the content of the report and the capacity risks identified in some key services that will impact compliance with the ERF target.

In March 2022 the committee received an update to the Trusts progress and implementation of the national My Planned Care project aimed at supporting patients with information about the waiting time and options for their elective care.

Issues Carried Forward / Escalated

Each Clinical Recovery Oversight Committee meeting considers whether any business matters discussed should be escalated to the Trust Board. The following were raised by the committee.

- The delay in 2ww for Breast Symptomatic patients because of workforce and demand pressures
- The impact of successive waves of Covid19 on elective recovery
- The number of instances of harm found by the Harm Review process

The Committee will continue its work to ensure oversight and assurance of Elective recovery and the reduction of waiting times in line with local and national guidance.

The Committee continued to receive and consider Sub Committee minutes, namely:

- The Clinical Services Oversight Committee (CSOG)

Summary
The Committee encourages frank, open and regular dialogue between regular attendees to the meetings. I would like to thank all members of the Committee, along with Directors, staff, internal and external advisors for their responses, support and contributions during the year.

Terry Atherton
Chair of Clinical Recovery Oversight Committee
June 2022

Appendix 1

CLINICAL RECOVERY OVERSIGHT COMMITTEE ATTENDANCE RECORD April 2021- March 2022

	2021													2022		
	14th April	27th April	13th May	25th May	8th June	22nd June	8th July	23rd July	18th August	14th Sept	12th Oct	16th Nov	14th Dec	18th Jan	15th Feb	15th March
Terry Atherton, Non-Executive Director (Chair)	✓	✓	✓	✓	✓	✓	Meeting cancelled due to site pressures	✓	✓	✓	✓	✓	Meeting cancelled due to site pressures	Meeting cancelled due to site pressures	✓	✓
Margaret Bamforth Non-Executive Director, Board Maternity Safety Champion	✓	✓	✓	✓	✓	A		✓	✓	✓	A	✓			✓	✓
Cliff Richards, Non-Executive Director	✓	✓	✓	✓	✓	✓		A	A	✓	✓	✓			✓	✓
Kimberley Salmon-Jamieson, Chief Nurse + Deputy CEO/Mat Safety Champion	A/D	✓	A	✓	✓	✓		✓	A	A	A	A			A	✓
Layla Alani, Deputy Director Integrated Governance	A	✓	✓	✓	✓	✓		A	✓	✓	A	✓			X/D	A
Alex Crowe, Executive Medical Director	✓	✓	A	✓	✓	✓		✓	✓	A	✓	A				
Paul Fitzsimmons, Executive Medical Director wef November 2021															✓	A
Anne Robinson, Interim Medical Director												✓			ANR	ANR
John Culshaw, Trust Secretary	✓	✓	✓	✓	✓	✓		✓	✓	A	✓	✓			A	✓
Jane Hurst, Deputy Director Finance & Commercial Development	✓	✓	✓	✓	✓	✓		✓	✓	✓	✓	✓			✓	✓
Daniel Moore Chief Operating Officer	✓	✓	A	✓	✓	✓		✓	✓	✓	✓	✓			✓	✓
John Goodenough, Deputy Chief Nurse	X / D	ANR	ANR	ANR	ANR	ANR		ANR	X/D	ANR	ANR	ANR			A	ANR
Valerie M Doyle, Associate Director – Planned Care	ANR	ANR	X / D	✓	✓	A		A	A	A	✓	A			✓	✓
In attendance																
Donna Hargreaves, Executive Assistant to Chief Nurse + Deputy CEO and Chief Operating Officer	✓	✓	✓	✓	✓	✓		A (CM)	✓	✓	✓	✓			✓	✓
Janice Howe, Public Governor		✓	✓	✓	✓	✓		A	✓	✓	✓	✓			✓	x
Tom Coalbran, RTT Business Manager				✓		✓		A	ANR	ANR	ANR	ANR			x	ANR
Grant Patterson, Grant Thornton, Auditors				✓	x	x		x	x	x	x	x			x	x
Zak Francis, Grant Thornton, Auditors				✓	x	x		x	x	x	x	x			x	x
Guy Hanson, Service Manager Theatres (for agenda item CROC/21/09/104 – Theatre productivity & theatre capacity)				✓						✓					ANR	ANR
Zoe Harris, Director of Operations and Performance, Deputy COO (for agenda item CROC/09/105 – Outpatients Deep Dive)				✓						✓	✓	✓			ANR	✓

Appendix 2 - Cycle of Business 2021-2022

		2021															2022
	Exec Lead	14.4.21	27.4.21	13.5.21	25.5.21	08.6.21	22.6.21	08.7.21	23.7.21	06.8.21	18.8.21	14.9.21	12.10.21	09.11.21	14.12.21	18.01.22	15.02.22	15.03.22
INTRODUCTION & ADMINISTRATION																		
Apologies for Absence	Chair	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Declarations of Interest	Chair	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Minutes of the last meeting	Chair	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Matters Arising and Action Log	Chair	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Rolling attendance log and cycle of business	Chair	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
GOVERNANCE & COMPLIANCE																		
Committee Terms of Reference – to review in six months	Trust Sec	✓											✓					✓
Committee Cycle of Business – to review in six months	Trust Sec		✓										✓					✓
Minutes/High Level Briefing from Thursday meeting of Clinical Services Oversight Group	Assurance		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Committee Effectiveness Review – six months	Chair/T Sec												✓					✓
Committee Effectiveness Review – annual	Chair/T Sec																	
Risk Register – every other meeting	Trust Sec					✓		✓		✓		✓		✓		✓		✓
PERFORMANCE																		
Harm Profile Update	Chief Operating Officer	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Review of Waiting Lists and Clinical Harm Review report	Chief Operating Officer	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Waiting List update: RTT; Priority Code Waiting Times; Cancer; Diagnostics.	Chief Operating Officer	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Outpatients Deep Dive – provide update in March 2022	Chief Operating Officer												✓					✓
PLANNING																		
Clinical Prioritisation & Scheduling Standard Operating Procedure (SOP) – for information	Chief Operating Officer		✓															
Speciality Overview	Chief Operating Officer	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
		2021																
	Exec Lead	14.4.21	27.4.21	13.5.21	25.5.21	08.6.21	22.6.21	08.7.21	23.7.21	06.8.21	18.8.21	14.9.21	12.10.21	09.11.21	14.12.21			
Access to Recovery Fund – monthly update	Deputy Director Finance & CD			✓		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
TO NOTE FOR ASSURANCE																		
Cheshire & Merseyside Elective Restoration update	Chief Operating Officer	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
CLOSING																		
Key issues to the Board	Chair	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Any Other Business	Chair	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Next Meeting Date & Time	Chair	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/22/07/103**	
SUBJECT:	**Complaints Annual Report**	
DATE OF MEETING:	27th July 2022	
AUTHOR(S):	Layla Alani, Director Governance	
EXECUTIVE DIRECTOR SPONSOR:	Kimberley Salmon-Jamieson, Chief Nurse & Deputy Chief Executive	
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	SO1: We will... Always put our patients first through high quality, safe care and an excellent patient experience.	x
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): **(*Please DELETE as appropriate)***	**#1215** Failure to deliver the capacity required caused by the ongoing COVID-19 pandemic and potential environmental constraints resulting in delayed appointments, treatments and potential harm **#1273** Failure to provide timely patient discharge caused by system-wide Covid-19 pressures, resulting in potential reduced capacity to admit patients safely. **#1272** Failure to provide a sufficient number of beds caused by the requirement to adhere to social distancing guidelines mandated by NHSE/I ensuring that beds are 2 metres apart, resulting in reduced capacity to admit patients and a potential subsequent major incident. **#1275** Failure to prevent Nosocomial Infection caused by asymptomatic patient and staff transmission or failure to adhere to social distancing guidelines resulting in hospital outbreaks **#1289** Failure to deliver planned elective procedures caused by the Trust not having sufficient capacity (Theatres, Outpatients, Diagnostics) resulting in potential delays to treatment and possible subsequent risk of clinical harm. **#115** Failure to provide adequate staffing levels in some specialities and wards. Caused by inability to fill vacancies, sickness. Resulting in pressure on ward staff, potential impact on patient care and impact on Trust access and financial targets. **#1134** Failure to provide adequate staffing caused by absence relating to COVID-19 resulting in resource challenges and an increase within the temporary staffing domain **#1233** Failure to review surgical patients in a timely manner and provide a suitable environment for surgical patients to be assessed caused by CAU being bedded and overcrowding in ED resulting in poor patient experience, delays in treating patients and increased admission to the surgical bed base. **#1108** Failure to maintain staffing levels, caused by high sickness and absence, including those affected by COVID-19, those who are extremely vulnerable, those who are assessed as only able to work on a green pathway, resulting in inability to fill midwifery shifts. This also currently affects the CBU management team.	
EXECUTIVE SUMMARY *(KEY ISSUES):*	This annual report includes a summary of formal complaints raised by patients or their relatives between 1 April 2021 and 31 March 2022.	

	• 289 new complaints were received during the reporting period, a decrease of 107 from 2020/21 where 396 were received. This is in line with an increase in PALS where early and local resolution has proved encouraging. • In 2021/22 the Trust closed 307 complaints during the reporting period of which 80 were Upheld, 148 were Partially Upheld and 79 were Not Upheld. • Following triage, 14 complaints were considered to be Serious Incidents (8) or Concise Investigations (6). When compared to the previous reporting period, this is a static position. • 49 complaints were open at the time of reporting, with no breached timeframes. • 5 PHSO cases are currently being investigated. • There has been a 33.6% increase in PALS concerns when comparing 2020/21 to 2021/22 (1565 vs 2091). This is a positive position as concerns are being resolved ahead of a formal complaint being required. These figures are correct on the date of reporting (24 May 2022).			
PURPOSE: ***(please select as appropriate)***	Information	Approval	To note x	Decision
RECOMMENDATION:	The Board of Directors are asked to note the contents of this report.			
PREVIOUSLY CONSIDERED BY:	**Committee**	Quality Assurance Committee		
	Agenda Ref.	QAC/22/06/152		
	Date of meeting	4th July 2022		
	Summary of Outcome	To share with the Trust Board		
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	Section 22 – information intended for future publication			

REPORT TO BOARD OF DIRECTORS

SUBJECT	Complaints Annual Report	AGENDA REF:	BM/22/07/103

1. BACKGROUND

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

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

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

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

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

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

The following key principles must be applied:

- Complaints and concerns will be dealt with in a fair, flexible and conciliatory manner, encouraging open communication between all parties.
- High standards of conduct are expected from all staff at all times to ensure that service users/representatives will be treated respectfully, courteously and sympathetically.
- The requirement to maintain confidentiality during the complaints process will be absolute (unless indicated otherwise).
- All patients and their families will be advised how they can raise a concern or make a formal complaint via information leaflets available on all wards and clinical service units and the internet.

- All people who make complaints will be advised of the various independent support agencies that are available to assist them in making their complaint.
- As far as possible, people who make complaints will be involved in decisions about how their complaints are handled and considered.
- The Trust will aim to resolve complaints within the Trust as part of local resolution (first stage of the national complaints procedure) wherever possible.
- Complainants receive a meaningful apology when appropriate.
- The Trust will identify appropriate learning and implement change as the result of a complaint where appropriate.
- The Trust will co-operate with other organisations when a complaint involves other outside organisations.
- No person who makes a complaint will be discriminated against on the grounds of religion, gender, race / ethnicity, disability, age or sexual orientation or because they have made a complaint.

2. KEY ELEMENTS

During the last financial year work has focused on:

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

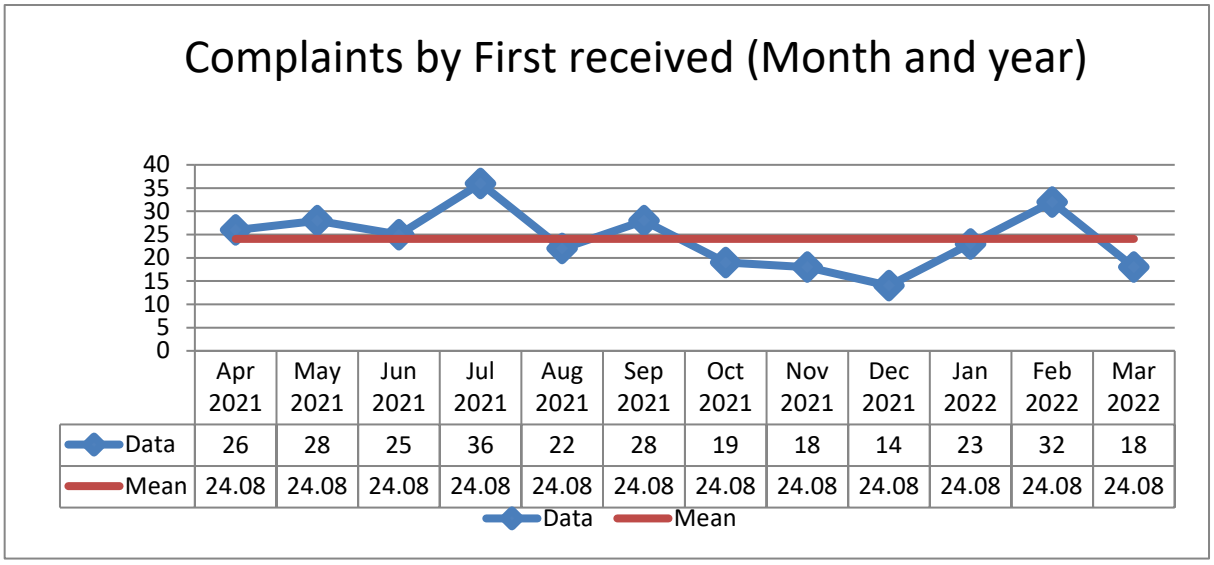
The successes in 2021/22 have included:

We are guests in our patients' lives

- Timeliness of complaints has consistently exceeded the Trust's target of 90%. WHH continue to have 0 breached complaints.
- The PALS service has improved timeliness of responses to concerns, with the average response time now being 2.2 working days, which is under the Trust's response target of 3 days.
- Working collaboratively with the Trust's Patient Experience Team to identify what matters most to our patients and considering how the PALS and Complaints Team can continually improve services for our patients.
- The Trust Quality Assurance Group has continued to meet since being established in July 2017. Led by the Trust Chairman, the Complaints Quality Assurance Group ensures all Clinical Business Unit (CBU) leads present a complaint and discuss their processes for complaints handling and learning.
- The number of reopened complaints received has reduced from 42 in 2020/21 to 24 in 2021/22. The percentage of reopened complaints has reduced from 10.6% in 2020/21 to 8.3% in 2021/22.

2.1 Complaints received

289 complaints were received during the reporting period, a decrease of 107 from the previous year (396). The graph below details the number of complaints opened from 1 April 2021 to 31 March 2022. In 2021/2022 the Trust received an average of 24 complaints per month. This was less than the average for 2020/21 which was an average of 33 complaints per month. This was impacted by the Covid-19 pandemic. In July 2021, the Trust received the highest number of complaints for the 2021/22 financial year (36). NB: the Trust has driven for more concerns to be resolved at local level, via the PALS route.



	Apr 2021	May 2021	Jun 2021	Jul 2021	Aug 2021	Sep 2021	Oct 2021	Nov 2021	Dec 2021	Jan 2022	Feb 2022	Mar 2022
Data	26	28	25	36	22	28	19	18	14	23	32	18
Mean	24.08	24.08	24.08	24.08	24.08	24.08	24.08	24.08	24.08	24.08	24.08	24.08

2.2 Complaint themes

Formal complaints can be received for a variety of reasons. Table A shows the themes noted for the reporting period. Table B denotes themes from 2020/21 as a comparison. Whilst an improved position is noted in relation to attitude and behaviour work continues to be focused to deliver further improvement with this indicator also referenced within PALS data.

Table A

Theme	21/22
Clinical treatment	123
Attitude and behaviour	61
Communication (oral)	36
Admissions / transfers / discharge procedure	35
Date for appointment	10
Personal records	6
Communication (written)	3
Test Results	2
Patient privacy / dignity	1
Cleanliness / laundry	1
Patient property / expenses	1
Failure to follow agreed procedures	1
Shortage / availability	1
Competence	1
Policy & Commercial Decisions of NHS Board	1
Date of admission / attendance	1

Table B

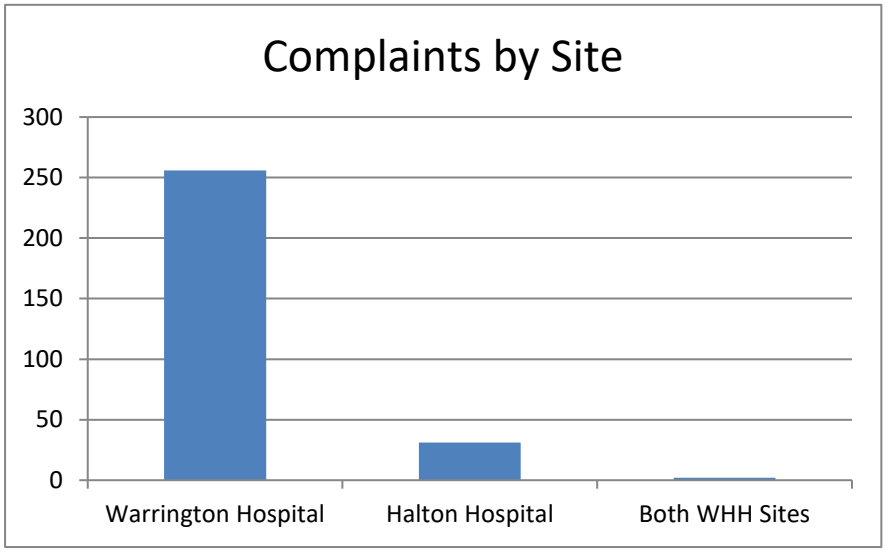
Theme	20/21
Clinical treatment	131
Attitude and behaviour	102
Communication (oral)	52
Admissions / transfers / discharge procedure	36
Personal records	17
Communication (written)	15
Date for appointment	13
Test results	6
Competence	4
Cleanliness / laundry	3
Patient property / expenses	3
Failure to follow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

The most common cause for people to complain was associated with clinical treatment or care provided. When comparing the percentage of complaints relating to clinical treatment from 2020/21 to 2021/22, there has been a 6.1% decrease in the percentage of complaints received relating to this theme. It should be noted that whilst this has increased across the PALS themes reported there has been no requirement for a formal complaint to be raised. This indicates that there have been improvements in clinical treatment meeting patients' expectations and it is often communication that has been the most significant factor.

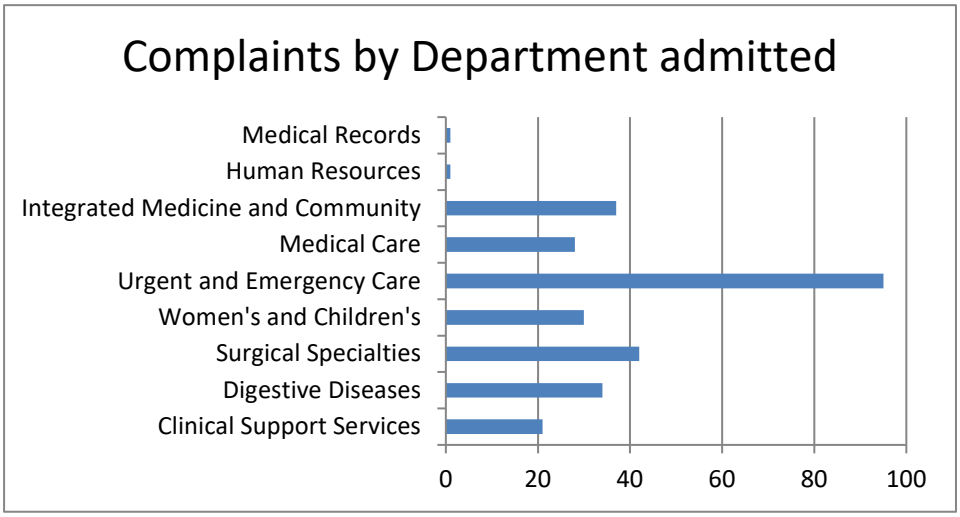
In 2021/22, the percentage of complaints relating to attitude and behaviour as the primary theme has reduced significantly by 40.1% (102 in 20/21 vs 61 in 21/22). This is reflective of the work undertaken across the Trust to improve customer service. This work was relaunched in 2021/22 as 'First Impressions work'. This included tailored training packages being delivered to those areas noted to have the largest number of complaints associated with attitude and behaviour. The decrease of 53.6% of attitude and behaviour complaints received for the Urgent and Emergency Care Clinical Business Unit (CBU) has shown a positive impact though this work continues as the theme remains within the data reviewed for PALS. Again, these concerns have not required escalation to formal complaints which is a positive measure.

2.3 Complaints received by Locations/Service

The graph below details that the Warrington hospital site reported more complaints (369) than the Halton site (31). This is to be expected as it is the larger site with significantly more activity and acute care delivery.



The following graph details the 289 complaints received by the Trust in the reporting period by Clinical Business Unit (CBU) and Trust wide service:



Urgent and Emergency Care received the most complaints followed by Surgical Specialities. When comparing 2020/21 data to complaints received from 2021/22 for Urgent and Emergency Care, there was a reduction from 120 complaints reported in 2020/21 to 95 in 2021/22 (20.8%). When comparing 2020/21 data to complaints received from 2021/22 for Surgical Specialities, there was a reduction from 52 complaints reported in 2020/21 to 42 in 2021/22 (19.2%).

In the previous year's report, it was reported that the Women's and Children's CBU had seen a 40% increase in complaints received from 2019/20 to 2020/21. This position has now significantly improved with a 50.8% decrease in complaints received in 2021/22 (30) compared with 2020/21 (61). This is representative of the improvement work undertaken by the CBU, which included:

- Collaborative working with the Complaints Team, CBU and Patient Experience Team via monthly meetings to review trends, themes and discuss patient stories.
- All services in the CBU participated in the NHS England Quality Improvement Programme, Always Events. The aim of this was to improve patient experience across the CBU. Areas of

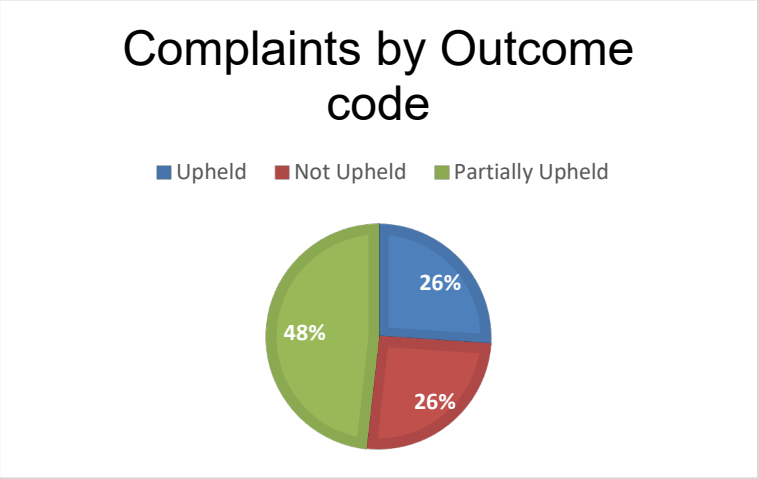
focus included communication, language use and choice, and information to support leaving hospital

- Staff attendance to the Customer Service course

2.4 Complaints Outcomes

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

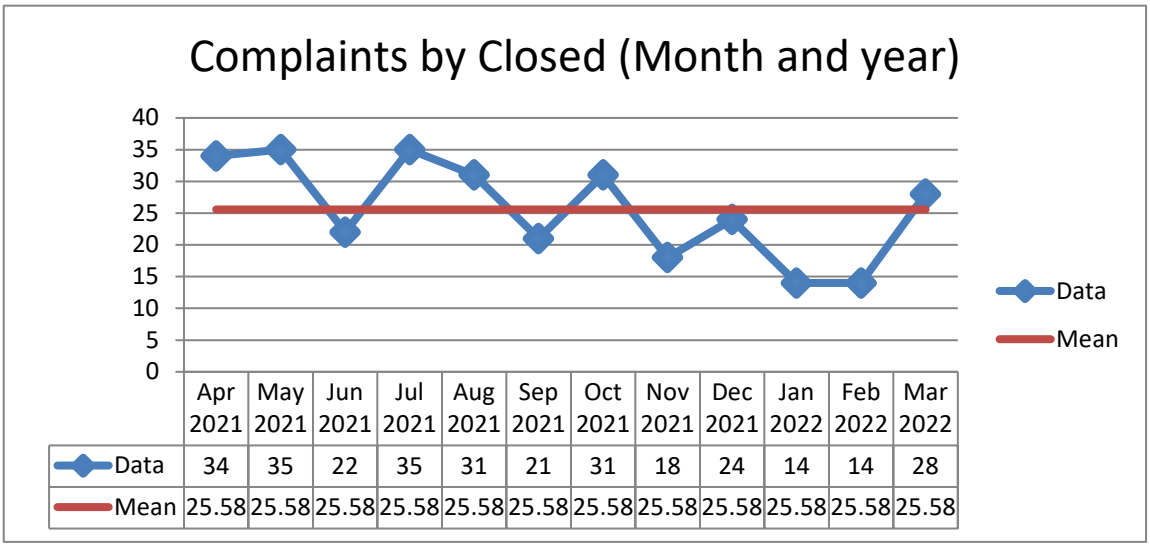
The chart below shows the outcome of closed complaint during the reporting period. The percentage of upheld complaints was lower in the 2021/22 reporting period (26%) than in the 2020/21 reporting period (33%). The majority of complaints in the 2021/22 reporting were partially upheld (48%) which has increased from the 2020/21 reporting period (37%). The percentage of not upheld complaints has decreased by one percentage point in the 2021/22 reporting period (26%) when compared with the 2020/21 reporting period (27%). The decrease in upheld complaints and increase in partially upheld complaints indicates that, complaint investigations are concluding that care provision has been appropriate albeit with learning identified.



2.5 Complaints Resolved

In the reporting period the Trust closed 307 complaints (this is due to closing those that were received in the previous reporting period). The graph below shows the closed complaints over time. As noted in the below graph, the number of complaints closed was lowest in January and February 2022, due to the reduced number of complaints that had been received in December 2021 and January 2022 at WHH.

Timeliness of responding to complaints



	Apr 2021	May 2021	Jun 2021	Jul 2021	Aug 2021	Sep 2021	Oct 2021	Nov 2021	Dec 2021	Jan 2022	Feb 2022	Mar 2022
Data	34	35	22	35	31	21	31	18	24	14	14	28
Mean	25.58	25.58	25.58	25.58	25.58	25.58	25.58	25.58	25.58	25.58	25.58	25.58

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

	2021									2022		
CBU	April	May	June	July	August	September	October	November	December	January	February	March
Clinical Support Services	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Digestive Diseases	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Estates and Facilities	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Human Resources	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Integrated Medicine and Community	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Medical Care	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Surgical Specialties	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Urgent and Emergency Care	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Women's and Children's	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Grand Total	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**

2.6 Referrals to Parliamentary Health Service Ombudsman

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

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

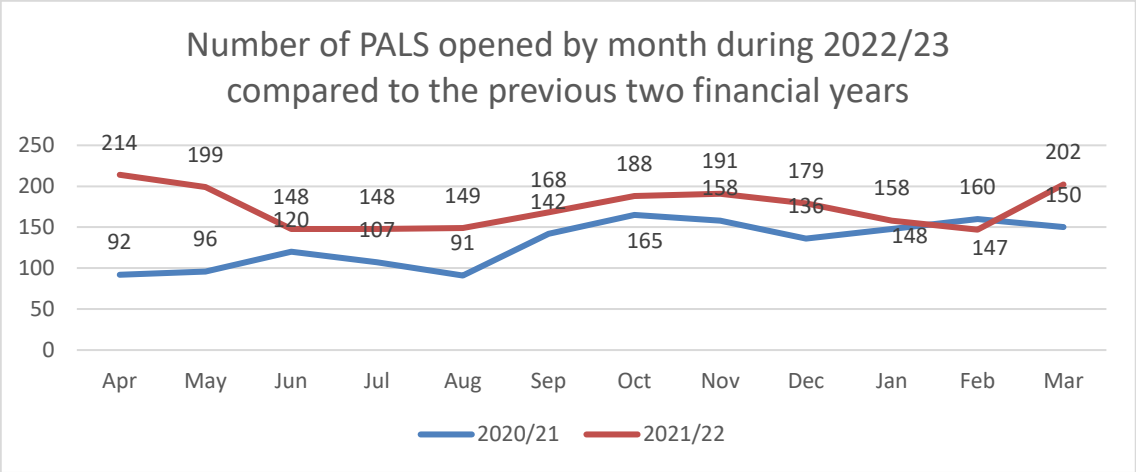
The PHSO have concluded two investigations within the reporting period. These were both partially upheld, in relation to how the Trust communicated with the patients involved and their relatives. The PHSO made recommendations for apologies to be offered by the Trust to the complainants for any undue distress caused by the communication issues identified and the Trust complied with these recommendations. The Trust currently has five ongoing PHSO complaints.

2.7 Learning from Complaints

You Said….	We Did….
A patient developed a Deep Veinous Thrombosis (DVT) post-operatively after the decision was made not to continue to patient on clexane.	A review of the Trust's DVT policy has been commenced. The review will look at the current policy with available local and national guidance to ensure that the policy in place at the Trust follows recognised best practice in the prescription of prophylactic anticoagulant medication. The review is expected to be completed by June 2022.
A patient who is deaf attended the emergency department. Proper support was not offered and the patient had to rely upon her daughter to communicate.	The patient's experience was discussed with the ED Team to reiterate the systems in place to support deaf patients. This includes the use of Language Line and using clear masks or visors to allow patients to lip read. The concerns were also shared with the Trust's Patient Experience Team who have explained that a 6-week course in BSL for beginners is being implemented in March 2022 across the Trust. An Accessible Information Standards policy has also been created to give staff greater direction on accommodating the different communication needs of our patients.
A mother raised concerns regarding the lack of clarity in information given to her around how to prepare her baby for an MRI scan.	The letters sent to parents when a baby is due to have an MRI scan is in the process of being updated to include detailed information on what steps parents should take to help make sure their baby is comfortable and prepared for the scan. This update will be completed by June 2022.

2.8 Patient Advice and Liaison Service (PALS)

In the 2021/22 reporting period, PALS received 2091 enquiries, which is a 33.6% increase from 2020/21 when PALS received a total of 1565 enquiries. The increase in PALS activity and decrease in formal complaints activity indicates that PALS are successfully resolving concerns at an informal stage. The below graph shows the difference between PALS received for each month in 2020/21 against those received for each month in 2021/22.



Tables A and B below show the top 5 themes for PALS during the 2020/21 and 2021/22 reporting periods. Tables C and D show the top 5 CBUs in receipt of PALS during the 2020/21 and 2021/22 reporting periods.

Tables A and B:

2020/21	
Communication (oral)	518
Clinical treatment	253
Date for appointment	224
Communication (written)	138
Attitude and behaviour	132

2021/22	
Communication (oral)	624
Clinical treatment	404
Communication (written)	255
Date for appointment	210
Attitude and behaviour	204

Tables C and D:

2020/21	
Surgical Specialties	290
Integrated Medicine & Community	235
Urgent and Emergency Care	231
Digestive Diseases	216
Medical Care	201

2021/22	
Medical Care	430
Urgent & Emergency Care	379
Surgical Specialities	337
Digestive Diseases	246
Women's & Children's	214

Whilst we have seen a reduction in the number of formal complaints received for the themes of clinical treatment, communication and attitude and behaviour, there has been an increase in the number of PALS received for these themes. This is attributed to an increase in the number of PALS enquiries received across the Trust for all CBUs. The increase in enquiries is multifactorial. Following the introduction of the face to face PALS service in 2021/22, as anticipated, the numbers of new PALS received increased.

Concerns relating to communication difficulties with wards as a result of the visiting restrictions that continued to be in place in 2021/22 also contributed to the rise in the number of communication related PALS being received. Examples of such concerns included relatives experiencing longer telephone waiting times when trying to obtain an update and enquiries in relation to when restrictions would be eased. The delays resulting from waiting list backlogs, increased hospital attendances and admissions gave rise to enquiries about the standard of clinical treatment and appointment date enquiries. Whilst clinical treatment, communication and attitude and behaviour have shown to be themes for PALS concerns there has been a significant shift in them becoming formal complaints.

In July 2021, the Trust recruited two dedicated PALS Officers. Previously, the role had been undertaken by the Complaints Team as a dual role. The introduction of the additional PALS Officers and split between the roles of Complaints and PALS Officers has meant that PALS cases are now allocated to a dedicated handler, which means that patients and relatives raising concerns are receiving an improved continuity in service.

3. SUMMARY AND ACTIONS REQUIRED

Throughout the Covid 19 pandemic which continued through 2020/21 and 2021/22, the Trust maintained the timeliness of responses to formal complaints, as previously set as part of the Trust's Quality priorities in 2019/20. Further work was undertaken in 2021/22 to improve the timeliness of responses to PALS concerns. In quarter 4 2021/22 this had improved to 2 working days, a further improvement from the 3.3 working days reported for the same quarter the previous year.

As set out in our 2020/21 report, the complaints team monitored both the timeliness and quality of the complaints' responses provided. In 2021/22 the number of reopened complaints reduced to 29 from 42 in 2020/21, indicating that the quality of responses continues to improve. The complaints team continues to report into the Patient Experience Sub-Committee and continues to report learning in the quarterly Learning from Experience report, reported via the Quality Assurance Committee.

In 2022/2023, the existing focus will continue to provide assurance of sustainability with close working alongside the Patient Experience Team to triangulate learning alongside works to be undertaken as part of the Patient Safety Framework. This will include themes from incidents, claims and inquests. A programme of learning and engagement has been developed and is being implemented across the Trust to continue to support the quality of complaints responses

In collaboration with the Patient Experience Team, the complaints team will introduce a 'real time' service to ensure that patients and relatives receive appropriate support and resolve without the need for a PALS concern or complaint to be raised. This will be a focus in 2022/23.

4. RECOMMENDATIONS

The Trust Board is asked to note the report.

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/22/07/104**	
SUBJECT:	**Medicines Controlled Drugs and Annual Report**	
DATE OF MEETING:	27th July 2022	
AUTHOR(S):	Diane Matthew, Chief Pharmacist	
EXECUTIVE DIRECTOR SPONSOR:	Paul Fitzsimmons, Executive Medical Director	
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	SO1 We will.. Always put our patients first delivering safe and effective care and an excellent patient experience. SO2 We will.. Be the best place to work with a diverse and engaged workforce that is fit for now and the future SO3 We will ..Work in partnership with others to achieve social and economic wellbeing in our communities.	x
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): **(*Please DELETE as appropriate)***		
EXECUTIVE SUMMARY *(KEY ISSUES):*	This report provides an overview of Pharmacy, Medicines Optimisation and Medicines Safety activities in 2021/22 and recommends actions to be undertaken in 2022/23. In 2021/22 good progress was made against the actions identified in last year's annual report. A summary is provided in the background section which highlights progress made against a range of Pharmacy/Medicines transformation projects including IT projects, in particular the successful implementation of EPMA in ITU, the impact of Phase 1 funding and approval of Phase 2 funding to support ED and admissions medicines safety activities (medicines reconciliation, critical medicines supply) and the release of money from reserves to support and extend antimicrobial stewardship activities. Funding was made available to provide piperacillin/ tazobactam infusion bags. These were sourced from an approved Hospital Supplier to support earlier administration of this antibiotic to in ED & the respiratory ward. Aseptic services are currently provided by external Hospital and Commercial suppliers. It is expected that funding will be made available centrally for region/ICS to establish Hub Models. If so, the Trust will need to consider its future aseptic service's needs, the risks/benefits of different delivery options to identify preferred approach(es) to delivery and take part in such discussions. Medicines information service delivery has been supported by recruitment of a temporary Medicines Information Pharmacist. Workload in this area increased and the Team also	

	put in a good performance with Yellow Card reporting in Quarter 3. Medicines procurement and supplies activities are highlighted. Trust activity increased in 2021/22 and this is shown with increases in medicines expenditure. In 2022/23 the system is expecting increased medicines expenditure due to increased activity and unit costs. Secondary care reliance on generic medicines is highlighted along with the increasing risk of generic medicines supply shortages. A degree of instability can occur briefly when new contracts are implemented, the extent and duration of stock shortages has increased and is of concern. Production of Medicines related NICE Guidelines and new medicine's introductions were reduced during the pandemic, in 2021/22 normal services resumed and senior appointments to the Pharmacy Department in 2021/22 has ensured this work continued and standards were maintained. Other medicines safety initiatives have continued including the polypharmacy and de-prescribing, cross-sector project, extension of the ETCP communications to Community Pharmacy which is now a 2022/23 CQUIN and the Medicines Improvement Group workstream which includes an ongoing commitment to reducing harm from omitted critical medicines. The omitted medicines reporting tool is part of a Quality Improvement Project intended to support medicines administration and reduce omitted medicines, in particular critical medicines. This project is already identifying ways of improving working at ward and pharmacy levels. Incident reporting of medicines was maintained at a level similar to that in the preceding years 2018/19=1065, 2019/20=1186, 2020/21=1107, 2021/22=XXX with a no harm rate of reporting of XX%. This is comparable with the level seen within other Trusts. 2021/22 saw an increase in the use of rapid incident reviews and those that involved a medicines component have been supported by the Medicines Safety Officer and other senior pharmacists. Controlled Drugs incidents and Audits have highlighted a need to focus on improving record keeping and improvements here will continue to be supported by the Medicines Improvement Group and Ward Medicines Champions.

	Learning from incidents was effectively disseminated via Trust communication channels including delivery at medical handovers where appropriate. A brief overview of activities to support the COVID-19 management program such as COVID-19 vaccination, the provision of COVID-19 medicines to inpatients and more recently the COVID-19 medicines community patient delivery is also provided. Attention of the Committee is drawn to a deviation that has arisen with the Home Office controlled drug licence which supports the supply of controlled drugs to other healthcare providers. A licence lapse occurred. When this became apparent, the Executive Team and Board acted promptly, affected services were suspended and alternative providers found. Services will resume when the Home Office approves the licence. In 2022, the current chief pharmacist is retiring. A new chief pharmacist has been appointed and a transition period will occur in late July 2022. The Trust CDAO will need to be changed and the CQC informed of the named individual. Licences held will require review and changes to the people named on these licences. The work associated with this is underway.			
PURPOSE: ***(please select as appropriate)***	Information X	Approval	To note	Decision
RECOMMENDATION:	The Trust Board is asked to note the report for assurance.			
PREVIOUSLY CONSIDERED BY:	**Committee**	Quality Assurance Committee		
	Agenda Ref.	QAC/22/06/157		
	Date of meeting	7 June 2022		
	Summary of Outcome	The paper was noted for assurance.		
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None			

REPORT TO BOARD OF DIRECTORS

SUBJECT	Medicines and Controlled Drugs Annual Report	AGENDA REF:	BM/22/07/104

1. BACKGROUND/CONTEXT

The terms medicines management or medicines optimisation describe the processes and behaviours that drive the way in which medicines are selected, procured, delivered, prescribed, administered, and monitored. The Care Quality Commission regulatory framework 'Fundamental Standards of Quality and Care' includes medicines management within the 'Safe' domain, serving to maintain its position as a high-priority governance issue for health provider organisations. In their 'Market Report' (2012), the CQC identified medicines management as representing one of the areas of highest non-compliance across health and adult social services care sectors.

The Chief Executive delegates responsibility for medicines management within the Trust and contributions to medicines management within the wider health economy, to the Chief Pharmacist, as indicated within Standards for Better Health (SfBH) and by the Care Quality Commission (CQC)). Medicines Management has two components, safe and secure handling of medicines (SfBH Core Standard C4d) and clinical and cost effectiveness (SfBH Core Standard C5a&d).

Improving medicines management controls is part of the national agenda and is included in the NHS Litigation Authority (NHSLA) standards, as well as the Standards for Better Health Core Standards and the CQC acute hospitals portfolio review.

The Chief Pharmacist discharges medicines management responsibilities through the pharmacy services and through membership of medicines related committees within the Trust and wider health economy, in particular through the Trust Medicines Governance Committee and the Area Prescribing Committee.

The Chief Pharmacist is the Trust designated accountable officer for controlled drugs and is required to take organisational responsibility for controlled drugs, ensure that arrangements for identifying and investigating concerns and monitoring and reporting arrangements are in place and ensure that the Trust has systems in place to notify the CQC if the accountable officer changes. Due to retirement, this will need to occur before the end of July 2022.

A range of pharmacy services are delivered to the Trust and other NHS and non-NHS organisations by around 129 FTE professional and support staff. Pharmacy and medicines optimisation activities include:

Medicines procurement; homecare procurement and monitoring; distribution, prescribing, dispensing and administration of medicines; management of aseptically prepared products including total parenteral nutrition/specials/chemotherapy; clinical pharmacy; enhanced technical services to wards; anticoagulation services; individual patient counselling and group education sessions; medicines information (healthcare professionals) and medicines helpline services (patients).

Pharmacy delivers a range of medicines-related clinical governance services such as education and training, antimicrobial stewardship, immunoglobulin demand management and database upkeep, patient group direction stewardship, patient safety, clinical audit, risk management, policy development and professional support to the Medicines Governance Committee.

Pharmacy has responsibilities in relation to the following IT systems: Pharmacy JAC System, the e-Chemotherapy iQEMO system, medicines deployment units in Lorenzo, DAWNAC system for anticoagulation, e-Ordering.

The Medicines Governance Committee, reports to the Trust Patient Safety and Clinical Effectiveness Committee and provides assurance that there are appropriate systems in place for safe, effective, and evidence-based medicines related practices within the organisation. This multi-professional committee is chaired by Paul Scott, Consultant Anaesthetist and Surgical Specialities Clinical Director, is serviced by the Pharmacy Department, and is attended by representatives from the Warrington and Halton Localities and the Midlands and Lancashire CSU.

Good progress has been made with the 2021/22 action plan which included the following areas of work:

- **completion of the EPMA roll out to all wards** – *there is one remaining area, the neonatal unit where we are aiming to go-live in Q3, 2022.*
- **implementation of GP Connect** – *Problems were identified that required GP system suppliers to develop fixes. GP Connect was re-tested in May 2022 and unfortunately the fixes haven't worked. The associated weekly meetings are being re-introduced in the hope that the problems will be resolved soon. GP Connect html provides different clinician support and is being tested in early June 2022. It is expected that this will go-live very soon.*
- **implementation of electronic outpatient prescribing** – *A paper has been written for/will be presented to the Home Office, if approved this will support the roll out of outpatient prescribing which will progress this year*
- **implementation of EPMA Parts 3 & 4:** dose range checking, dose calculator, integration of Lorenzo with the JAC Pharmacy System-*The required Pharmacy System upgrade was completed, further developments are needed in order to implement EPMA Part 4. Dose range checking and the dose calculator will be focussed on until then.*
- **re-submission of the pharmacy transformation business case for phases two and three**: *Phase two has been approved, staff recruitment has progressed well, and the new staff will arrive between May and October*
- **review of aseptic services and submission of an Options Paper**: *A paper was presented at the Capital Planning Group for funds to undertake a scoping exercise. A paper requesting funding for ready to use piperacillin/tazobactam infusion bags for ED and B18 (respiratory) was approved and implemented*
- **improvements in the use of antibiotics/antifungals through effective antimicrobial stewardship strategies:** *A paper requesting release of money held in reserves for antimicrobial stewardship was approved and recruitment is underway*
- **improvements in Trust performance against the medication questions in the National Inpatient Survey:** *Awaited*
- **the cross-sector polypharmacy-deprescribing project:** *Meetings held regularly, and the project is progressing*
- **activities to reduce harm arising from omitting critical medicines**: *An omitted medicines report was developed and shared with ward teams. A Quality Improvement Program has been commissioned. Pharmacy and Digestive Diseases Wards are working together to raise awareness of omitted medicines and complete PDSA cycles to improve. Learning to be rolled out across the rest of the Trust. A critical medicines flag is being added to critical medicines so that these omissions can more easily be reported separately. This initial work may be completed in June 2022*

2. OVERVIEW OF PHARMACY AND MEDICINES OPTIMISATION SERVICES

Aseptic Services

In Lord Carter of Cole's NHS Procurement and Efficiency report[1] published in February 2016, he stated that the NHS could save at least £800million through transforming hospital pharmacy services and medicines optimisation and made recommendations for transforming hospital pharmacy services and medicines optimisation. Within the report there was a recommendation that Aseptic Service provision required review and new ways of thinking to improve delivery and maximise efficiencies.

Haematology, ophthalmology, rheumatology, gastroenterology, upper and lower GI, urology, gynaecology, and paediatric specialties are reliant on the continuity of the Trust's aseptically prepared specialist products (cytotoxics, biologics and total parenteral nutrition). These are currently procured using a variety of approved hospital, homecare, and private sector providers.

	2018/19	2019/20 Comparator Year	2020/21	2021/22
Transactions	1931	1602	1423↓	1691↑
Value	£85,807	£91,652	£137,739↑	£136,272↑
Adult TPN	1079	825	1254↑	1118↑
Neonatal TPN	320	272	273↔	360↑
Ophthalmic preparations	112	116	128↑	203↑
Urology preparations	175	187	35↓	192↑
Gynaecology preparations	136	127	92↓	132↑
Antiviral infusion (CMV)	14	15	6↓	28↑
Tazocin Infusion	0/17480	0/37740	0/36540	2387/45111

The Trust has a known gap in relation to the provision of pre-prepared parenteral products. Over the last 2 years, some products have been sourced for ICU,

[1] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/499229/Operational_productivity_A.pdf

respiratory and ED areas. It has been highlighted that there is greater access to pre-filled syringes than infusion bags and this needs to be factored into the future strategy for purchasing syringe drivers and pumps.

Delivered actions: In 2021/22, a business case was produced and approved for the purchase of piperacillin/tazobactam infusion bags for ED & B18 and a paper was presented to the capital planning group proposing the allocation of money to undertake a review of the Trust's aseptic services requirements**.**

In 2022/23 The Trust should consider what it requires from and the contribution it will make to an aseptic services Hub model. The ICS should consider the bid it may wish to make for development funds that are proposed for aseptic services.

Medicines Information Services

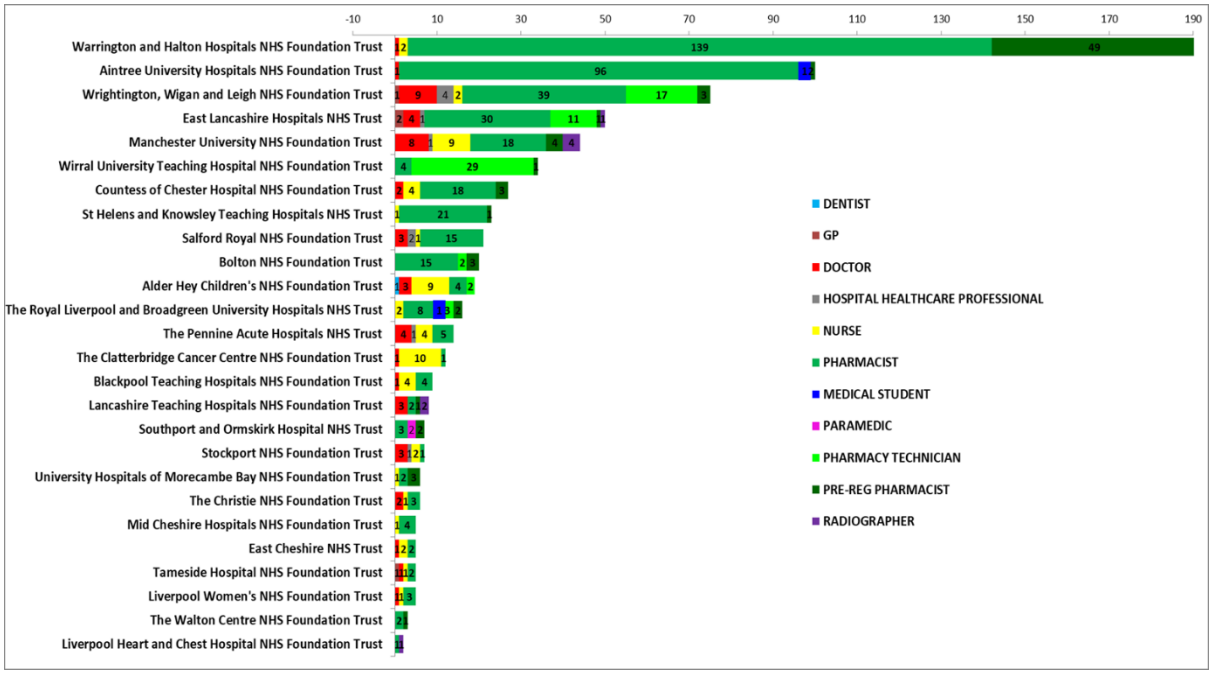
The WHH medicines information service is audited on behalf of Specialised Pharmacy Services by the Northwest Medicines Information service.

The Medicines Information Pharmacist attends and feeds back from the Area Prescribing Committee Formulary and Guidelines Group and supports the Medicines Governance Committee work program by reviewing NICE Guidelines and compiling a monthly report assessing impact/actions based on identified medicines content.

The Medicines Information service supports healthcare professionals with evidence-based answers to medication related problems and a medicines hotline service provides support for patients. Around 45% of enquiries are raised by patients and 55% by healthcare professionals. MI enquiries increased in 2020/21 and that trend has continued in 2021/22.

KPI	2018/19	2019/20	2020/21	2021/22
MI Enquiries	435	553	600↑	722↑
MI enquiries answered within timescales (%)	94%	99%	99%	100%↑
Level 1 enquiries (%)	40%	55%	52%	54%↑
Level 2 enquiries (%)	55%	42%	42%	41%
Level 3 enquiries (%)	5%	3%	6%	5%
ADR yellow cards from MiDatabank	18	66	50	11↓

Quarter 3 2021/22 ADR Reporting Data for North-West Hospitals



Delivered action: The Department was successful in recruiting Iram as an acting Medicines Information Pharmacist, who facilitated an increase in the Trust's ADR reporting enabling us to achieve the reporting top spot regionally in Q3 2021/22. Iram has now left the Trust and we welcome Kate back, very soon.

Procurement and Supply Services

Pharmacy has a focus on cost containment by prompt introduction of contract changes and minimising waste. Assessing and recycling Trust medicines that are suitable for use is one of the important ways this is achieved. Although the overall number of credit transactions reduced in 2021/22, the overall value of stock returned increased.

KPI	2018/19	2019/20	2020/21	2021/22
Value of stock issued	£16,231,554	£15,851,356↓	£15,430,601↓	£18,194,226↑
Value of stock returned	£ 787,477	£ 856,232 ↑	£ 892,554↑	£ 1,056,935 ↑
Net value of stock issued	£15,439,271	£14,995,578↓	£14,538,058↓	£17,137,291↑
Value of homecare	£ 3,777,990	£ 2,861,958 ↓	£ 2,865,629↓	£ 2,895,666↓

TRANSACTION TYPE	2018/19	2019/20	2020/21	2021/22
Inpatient	27,999	29,837↑	38,258↑	36296↑
Outpatient/ED	31,264	39,742↑	36,437↓	40,997↑
TTO	77,042	79,292↑	68,186↓	86,641↑
Clinic	134	11	17	364↑
Day case	5,041	6,633↑	5,903↓	5,034↓
One stop	52,176	57,863↑	62,749↑	59,029↑
Bulk issue	111,662	126,862↑	123,790↓	122,870↓
Credit	24,071	27,887↑	26,483↓	19,265↓
Other	938	1069↑	1310↑	958↓
Total	**330,327**	**369,196↑**	**363,133↓**	**371,454↑**

Overall expenditure was higher in 2021/22 compared with the two previous years. The increase in emergency and elective admissions has contributed to an increase in expenditure on some medicines, medicines shortages have also inflated prices.

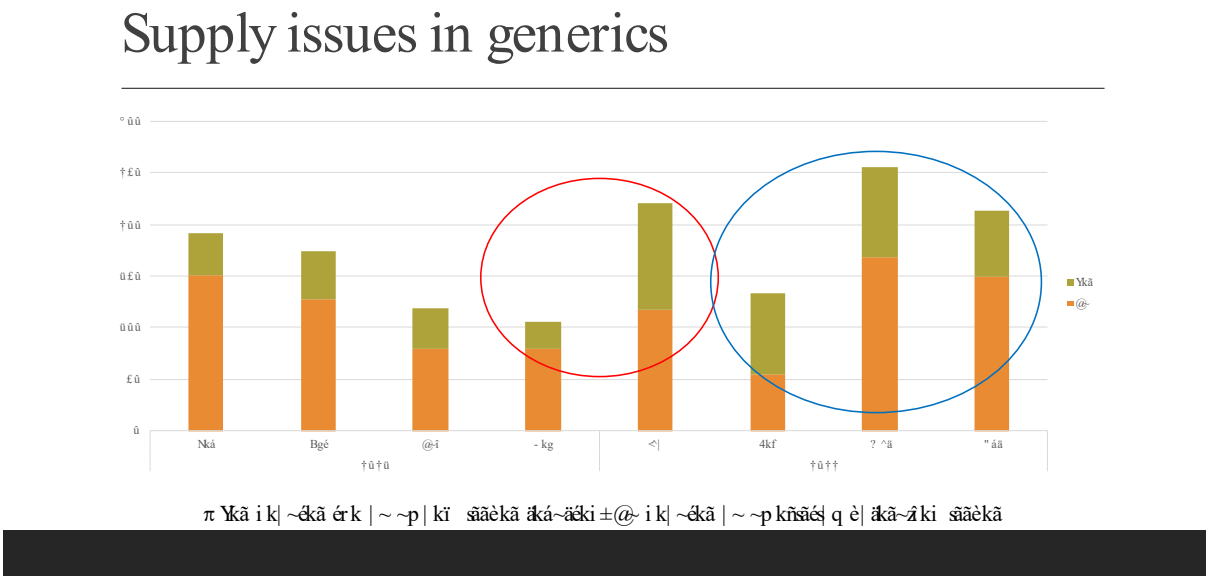
Increases in expenditure have occurred across the majority of BNF codes. The procurement of ready to use agents is the right approach to take from a purchasing for safety and efficiency perspective but does add on-costs. Some of the medicines used as part of the Recovery Trial such as remdesivir and tocilizumab and the newer COVID medicines sotrovimab, Paxlovid and molnupiravir are also high-cost drugs. The reduction in the homecare spend reflects the impact of prescribing biosimilar agents, numbers of patients requiring such treatments continue to rise. HIV spend has been removed from the homecare data as this service is no longer provided by the Trust.

BNF Code & description	% Change in spend (20/21 vs 19/20)	% Change in spend (21/22 vs 19/20)
01 Gastrointestinal	-40%	80%
02 Cardiovascular	9%	37%
03 Respiratory	-1%	16%
04 Central nervous system	9%	17%
05 Infection	-45%	-25%
06 Endocrine	-11%	-15%
07 Obstetrics & Gynaecology & Urinary	-34%	-14%
08 Malignant Disease	20%	12%
09 Nutrition and blood	5%	24%
10 Musculoskeletal & Joint Disease	4%	11%
11 Eye	-8%	34%
12 Ear Nose & Oropharynx	-23%	-8%

13 Skin	-7%	3%
14 Immunology & Vaccines	-28%	47%
15 Anaesthetics	-3%	21%
Water for nebulisation/ humidification	46%	19%
Haemo-filtration fluids	98%	-5%
Enteral nutrition	-35%	92%

Challenges with Maintaining the Continuity of Supply of Medicines:
Over 85% of medicines used in hospital are generic lines. Challenges with maintaining supplies of generics, continue to be faced; January to April 2022 is showing a higher number of reported new issues compared with September to December 2021 and there are clear signs that wave 13 framework in 2022 is having a higher number of supply issues for a longer period of time than at the start of the wave 12 framework in 2020. The EU White Paper on the Effectiveness of Public Procurement of Medicines in the EU (February 2022) highlights issues that are

affecting competition and limiting access to medicines. This document makes a number of recommendations that are relevant to the UK also. Partnership working, sharing supplies, moving the medicines to where they are needed, sharing data continue to be methods utilised to counter the impact of shortages.



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Ward Pharmacy Services

In late 2019, the Trust introduced a Pharmacy admissions service within the emergency department in order to support patient medication safety improvements through timely medicines reconciliation, reduction in omitted and delayed medicines and also to optimise the use of medicines. Phase One of the ED admissions service was rolled out in stages between November 2019 and January 2020. This was initially provided a 9am to 5:30pm Dispensary service at weekends and bank holidays, one ITU shift daily across 7 days, two ED shifts at weekends and a late ED shift on Fridays and Mondays.

Table of Medicines Reconciliation Data for all inpatients (adults and children) with a length of stay greater than 24 hours showing the impact of introducing weekend / extended ED admission services and of service changes and activity changes during COVID-19

Medicines reconciliation (MR) figures include adult, children and maternity admissions and are generated from Lorenzo **discharge** data. National Guidance only applies to adult services however the Trust also monitoring medicines reconciliation data for children.

Medicines	YEAR			
Reconciliation Data	2018/19	2019/20	2020/21	2021/22
No. patients with MR within 24hr of admission	5725	8391	15412	14751↓
%	26%	37%	78%	68%↓
No. patients with MR within 48hr of admission	9760	11764	17223	18673↑
%	45%	52%	87%	86%↔
No. patients with MR during admission	14388	16797	17669	19574↑
%	66%	75%	89%	91%↑
Total No. patients with LOS>24hr	21673	22474	19745	21548↑

The medicines reconciliation data for 2019/20 reflects the modest impact of introducing a medicines reconciliation service in ED part-way through the year in December 2019.

The data for 2020/21 shows the additional improvement in medicines reconciliation figures arising as a result of moving out of ED due to the rapid flow of patients into inpatient beds and instead deploying staff to undertake medicines reconciliation activities across all medical and surgical wards. This resulted in a more equitable

service provision for patients improved both the medicines reconciliation numbers and percentages within 24 hours and overall and provided wards with an enhanced Pharmacy service that is now sought after. With additional medical deployed on

wards at weekends during 2020/21 it was difficult to move the Pharmacy staff back into ED knowing that this would impact upon medicines reconciliation figures and in turn patient safety.

In 2021/22 the number of patients who received a medicines reconciliation (MR24) within 24 hours dropped slightly by 4% but the percentage of patients seen dropped more significantly from 78% to 68%. This reduction in percentage reflects the increased numbers of patients with a LOS>24hours that were admitted/discharged in 2021/22 compared with 2020/21 (21548 versus 19745, an increase of 9%). The number of patients who received a medicines reconciliation within 48 hours (MR48) increased overall by 8% and the percentage of patients seen was similar to the previous year at 86%. The total number of patients with an MR during the inpatient stay increased from 17669 to 19574, an increase of 11%.

The increase in Trust inpatient activity coupled with a high turnover of Pharmacy staff during 2021/22 impacted on the MR24h performance but not on the MR48h or total MR data. Recruitment has taken place, and this will enable improvement to occur in the MR24h KPI.

Pharmacy Intervention Audit Data

While undertaking MRs is a vital patient safety initiative in relation to patients receiving their correct regular medication on admission, medication review is not a process unique to admission. All Pharmacy interventions and clinical advice provided from admission to discharge drive medication/patient safety. Timely medicines reviews and interventions provide the Trust with greater assurance that medicines will not harm patients during their inpatient stay.

Table of the Proportion of medication orders reviewed that result in an intervention from Point Prevalence Data Collected over a Number of Years

Year	Number of interventions/total medication orders (%)
2015	**12.8% (489/3811)**
2016	**14.5% (221/1529)**
2017	**11.8% (212/1792)**
2018	**14.6% (342/2349)**
2021	**11.3% (303/2664) (EPMA in place)**

A wide range of interventions arise during the course of one day, the table below shows the frequency of different intervention types (2021 intervention audit data)

Intervention Type	Number of Interventions Recorded	Percentage (%)
DHx - Unintentional omission - requested medicines to be prescribed	61	20.2
Review dose / frequency	57	18.9
Requested duration/stop date	46	15.2
Other	34	11.3
Identified need for medicine not currently prescribed	27	8.9
Review formulation	13	4.3
Contraindication - Other	8	2.6
VTE Risk Assessment Requested	8	2.6
DHx - Unintentional prescribing - requested medicines to be discontinued	7	2.3
Drug Duplication	6	2.0
Patient Counselling	6	2.0
Requested formulary change	5	1.7
Requested resolution to previously identified med rec issues	5	1.7
Review route of administration	4	1.3
Incorrect drug	3	1.0
Legal issue - CD Rx not signed/dated	3	1.0
Legal issue - CD Rx quantity incorrect	3	1.0
Requested TDM	3	1.0
Contraindication - Interaction	2	0.7
Legal issue - OP Rx not signed/dated	1	0.3

Table Showing the Breakdown of the Intervention Type 'Other'

Row Labels	Number of Interventions Recorded	Percentage (%) of 'Other' category interventions	Percentage (%) of Total interventions (all types)
'Other' *unable to group*	9	26.5	3.0
Weight Requested	8	23.5	2.6
Monitoring Requested	7	20.6	2.3
Advice provided	6	17.6	2.0
Discharge Letter Requested	3	8.8	1.0
VTE Discrepancy	1	2.9	0.3

The 2021 intervention audit report has been extensively analysed as this is the first audit since the implementation of EPMA. The report highlights improvements that can be made to improve prescribing and describes the resulting action plan that will be implemented.

Medicines Governance Services

Medicines Governance activities were scaled down during the COVID-19 escalation periods. Publication of NICE Guidance and the introduction of new medicines were much reduced, the Area Prescribing Committee meetings were suspended. Review / Approval of Guidelines and clinical trial documentation (RECOVERY trial) was

undertaken via email to Committee members as needed. The Medicines Governance Committee meetings resumed briefly between waves one and two and re-commenced in February 2021.

Medicines Governance activities:

1. New product review and introduction (non-NICE & NICE)
2. Published NICE Guidelines/Technology Appraisals assessment and review
3. Review & internal communication of monthly NHSE Communications with actions as appropriate
4. Area Prescribing Committee and Trust Formulary reviews
5. Trust Guidelines/Patient Information Leaflets/Templates containing medication information assessment and review
6. Patient Group Directions-assessment & review
7. Unlicensed medicines risk assessments and assurance
8. Antimicrobial stewardship
9. VTE chemical prophylaxis
10. Risk register: Risks relevant to Medicines Governance
11. Controlled drug quarterly reports
12. Medicines Safety
    a. Quarterly Incident Reports
    b. MHRA Monthly Drug Safety Update: impact assessment
    c. NHSI Patient Safety Alerts involving medicines: relevance/impact assessment and
    d. Nurse/Pharmacist medicines safety activities
        i. Staff education and training
        ii. Support for staff who have made a medication error
        iii. Review of medication incidents
        iv. Partnership for Patient Protection work
        v. Audits

MEDICINES OPTIMISATION

Medicines related audits were completed during the 2021/22. This included Audits relating to Safe and Secure Handling of Medicines, Controlled Drugs, Antibiotic Point Prevalence and Pharmacist Interventions.

Other notable Medicines Optimisation activities:

1. The increased presence of pharmacists and pharmacy technicians on wards particularly at weekends has increased the opportunity to intervene and make recommendations promptly. (Extrapolating from Pharmacist Intervention Audits, around 30,000 patient safety interventions are undertaken by clinical pharmacy teams mainly in relation to inpatient activities).

2. Embedding the training program for ward pharmacy technicians to undertake drug histories
3. Use of the electronic transfer of discharge information to Community Pharmacy (the ETCP System that has been linked to the EPR and the TIE) - identification of patients on admission and during their inpatient stay who may benefit from support from their Community Pharmacist when discharged. This is linked to a 2022/3 CQUIN.
4. Implementing electronic prescribing and medicines administration in ITU in 2021.
5. Strong focus on the use of cost-effective medicines preparations (NHSI – Use of Resources Data – Model Hospital). The Trust continues to perform well against the majority of Model Hospital parameters.

As part of the 2022/23 action plan there will be continued effort with the following areas of work:

a. completion of the EPMA roll out to the final inpatient ward,
b. implementation of GP Connect and GP Connect html,
c. implementation of electronic outpatient prescribing,
d. implementation of EPMA Parts 3 & 4: dose range checking, dose calculator, integration of Lorenzo with the JAC Pharmacy System,
e. Pharmacy transformation phase two,
f. review of aseptic services,
g. improvements in the use of antibiotics/antifungals through effective antimicrobial stewardship strategies,
h. improvements in Trust performance against the medication questions in the National Inpatient Survey
i. the cross-sector polypharmacy-deprescribing project
j. activities to reduce harm arising from omitting critical medicines
k. the CQUIN program

MEDICINES/CONTROLLED DRUGS/SAFETY

Medication Safety Officer and Medication Incidents

The MSO completes and presents a quarterly report of Medication and Controlled Drug incidents at the Medicines Governance Committee. This report includes a summary of agreed actions/progress.

Topics/areas being monitored include:

1. Safe and secure handling of medicines, in particular controlled drugs
2. Omitted and delayed medicines
3. Critical medicines
4. Medicines frequently occurring in medication related incidents:
    a. Anticoagulants

b. Diabetic medication
c. Opiates
d. Antimicrobials

These are areas of interest for the omitted medicines work currently being undertaken.

Table showing Quarterly Medication Incident Data for 2018 to 2022

		Number of incidents by harm classification					
Year	Quarter	Total	Level 1 (No harm)	Level 2 (Minor harm)	Level 3 (Moderate harm)	Level 4 (Major harm)	Level 5 (Catastrophic)
18/19	Q1	194	174 (90%)	19 (10%)	1 (0.5%)	0	0
18/19	Q2	301	286 (95%)	14 (5%)	1 (0.3%)	0	0
18/19	Q3	268	268 (93%)	18 (7%)	0	0	1* (0.4%)
18/19	Q4	302	283 (94%)	20 (7%)	3 (1.0%)	0	0
19/20	Q1	268	240 (90%)	25 (9%)	3 (1.1%)	0	0
19/20	Q2	323	299 (93%)	24 (7%)	0	0	0
19/20	Q3	319	302 (95%)	17 (5%)	0	0	0
19/20	Q4	276	245 (89%)	30 (11%)	1 (0.4%)	0	0
20/21	Q1	203	186 (92%)	17 (8%)	0	0	0
20/21	Q2	358	336 (94%)	19 (5%)	1 (0.3%)	2 (0.6%)	0
20/21	Q3	278	251 (90%)	27 (10%)	0	0	0
20/21	Q4	268	245 (91%)	23 (9%)	0	0	0
21/22	Q1	323	285 (88%)	23 (7%)	4 (1%)		
21/22	Q2	289	243 (84%)	32 (11%)	4 (1%)	0	0
21/22	Q3	311	279 (90%)	26 (8%)	4 (1%)	2	0

*Patient death not deemed to be associated with the medication issue

The Medicines Improvement Group reports into the Medicines Governance Committee and is responsible for monitoring and progressing medication safety initiatives.

Pharmacy provides regular communications on medication safety at Safety Huddles and at Medical/Surgical Handover and provision of Safety Alerts where appropriate is an embedded process. Pharmacy has delivered several Topic of the Week sessions to communicate medication safety messages.

Following the reporting of incidents involving medicines in Datix, the Medication Safety Officer or another senior pharmacist attends rapid incident reviews, takes part in serious incident investigations and the production of reports/approval/delivery of agreed actions.

Learning from incidents

Medicines Safety Actions:

Education and training related initiatives involving a combination of collaborative working between the MSO, the Clinical Education Pharmacist and activities undertaken by members of the Pharmacy team include:

1. Encouraging use of EPMA intravenous fluid Sequences
2. Walkabouts and regular attendance at medical/surgical handovers for communication of medication matters
3. Presentation at meetings where CBU specific errors/EPMA updates/Critical medicines are discussed
4. FY1 training includes:
    - critical and omitted medicines training
    - Introduction to anticoagulation and discussion of incidents
5. FY2 training includes:
    - Refresh of anticoagulation knowledge and discussion of incidents
6. Resources to support safe practice of rotating medical staff
7. Support with reflection on medication related practice / incidents for the foundation programme
8. Provision of IV training and EPMA training to support redeployment of nursing staff
9. Safer Times newsletters to highlight impact of recent incidents
10. Prescriber Medicines Handbook, Physician Associate Handbook in development
11. Supporting timely completion of VTE risk assessments by providing a daily report for the Safety Briefing and highlighting missing risk assessments to the medical teams.

12. Utilising the 2021 intervention data and considering human factors to introduce improvements that prevent or reduce the likelihood of similar future incidents.

Controlled Drug Incidents 2021/22

CD Incident type	Q1 21/22	Q2 21/22	Q3 21/22	Q4 21/22	Total 21/22
Recording errors	17	15	22	19	73
Policy deviation not affecting patient	6	8	11	5	30
Administration error - patient taken	2	3	7	13	25
Policy deviation affecting patient	1	7	2	5	15
Prescribing error - before reaching patient	2	5	4	4	15
Running balance issue <5% discrepancy	2	2	1	5	10
Prescribing error - patient taken	2	3	1	3	9
Managed appropriately	0	3	3	1	7
Delivery error	1	3	0	2	6
Discharge procedure error - patient not affected	2	2	1	1	6
Administration error - before reaching patient	2	2	0	1	5
Discharge procedure error - patient affected	2	1	1	1	5
Running balance issue >5% and less than 10%	0	2	2	1	5
Spillages / breakages / damaged CDs	2	1	0	2	5
Running balance; >10% discrepancy	3	0	0	1	4
Stock error	1	0	1	2	4
Lost / stolen / missing drugs	0	1	1	1	3
Deliberate Overdose - no harm	0	1	0	1	2
Dispensing error - before reaching patient	0	0	2	0	2
Storage error	2	0	0	0	2
Administration error - omitted dosage	1	0	0	0	1
Dispensing error - patient received but not taken	0	1	0	0	1
Dispensing error - patient taken	0	1	0	0	1
Illicit use by patient	0	0	1	0	1
Manufacture error	0	1	0	0	1
Prescribing error patient received but not taken	0	0	0	1	1
SOP failure	0	0	1	0	1
Abuse by the patient	0	0	0	0	0
Administration error - patient received but not taken	0	0	0	0	0
Allegation professional receiving controlled drugs	0	0	0	0	0
Allegation professional selling-controlled drugs	0	0	0	0	0
CD cupboard unlocked	0	0	0	0	0
CD licence issue	0	0	0	0	0
Destruction error	0	0	0	0	0

Fraudulent attempt to obtain CDs by patient	0	0	0	0	0
Fraudulent attempt to obtain CDs by professional	0	0	0	0	0
Fraudulent Claims	0	0	0	0	0
GPhC issue	0	0	0	0	0
Lost / stolen / missing CD keys	0	0	0	0	0
Lost / stolen / missing CD prescriptions	0	0	0	0	0
Never event	0	0	0	0	0
Out of hours process failure - before reaching pa...	0	0	0	0	0
Out of hours process failure - patient received bu...	0	0	0	0	0
Out of hours process failure - patient taken	0	0	0	0	0
Out of hours process failure - patient taken	0	0	0	0	0
Out of hours process not affecting patient	0	0	0	0	0
Patient / public known to be selling CDs	0	0	0	0	0
Patient death	0	0	0	0	0
Police investigation	0	0	0	0	0
Removal of CDs by a third party, e.g., Police	0	0	0	0	0
Stolen CD drugs	0	0	0	0	0
Stolen CD keys	0	0	0	0	0
Stolen CD prescriptions	0	0	0	0	0
Theft / stolen / diversion in controlled drugs, pa...	0	0	0	0	0
Theft or potential theft of CDs, prescriptions, et...	0	0	0	0	0
Theft or potential theft of CDs, prescriptions, et...	0	0	0	0	0
Transcription error - before reaching patient	0	0	0	0	0
Transcription error - patient received but not tak...	0	0	0	0	0
Transcription error - patient taken	0	0	0	0	0
Whistle blowing	0	0	0	0	0
Wrong prescription given out	0	0	0	0	0
	48	62	61	69	240

There were 240 incidents reported that involved controlled drugs. The lowest number was recorded in Q1, and the highest number was recorded in Q4. Recording errors accounted for 73 of the 240 incidents reported (30%), Policy deviation not affecting patients was the second highest with 30 incidents (12.5%). There were no harm incidents recorded amongst the 240 incidents documented as being controlled drug incidents.

The Medicines Improvement Group has been focussing on work to reduce the recording errors. New controlled drug registers were introduced in December 2021. Work is needed to ensure the introduction of these is embedded. A quality

improvement project similar to that being used for omitted medicines is proposed. A review of the administration errors and policy deviations will also be undertaken in order to identify and implement changes that improve these areas.

In April 2022, a deviation occurred with the Home Office controlled drug licence which supports the supply of controlled drugs to other healthcare providers in that a licence lapse occurred. This was datix reported to the Executive Team and the Board and is under investigation. The Executive Team and Board acted promptly, affected services were suspended and alternative providers found. Services will resume when the Home Office approves the licence.

COVID 19 Vaccination Service

Warrington Hospital Hub Plus has performed over 72,000 COVID-19 vaccinations since it was established in December 2020. This service initially provided the two primary doses then continued to provide the third primary dose for immunosuppressed or compromised people, the first booster dose. When the spring booster dose was announced, it was agreed that the service would continue and is now preparing for the autumn booster program.

Working closely with the Vaccination Service Managers, Pharmacy provides strong Governance support for the Vaccination Service with involvement in procurement, cold chain management, control of the supply from Pharmacy into the Clinics including preparation of diluted products as appropriate.

1. Governance considerations for the Vaccination Service:
    - Provision of Clinical Leadership
    - Adherence to the legal framework
    - Staff training completion
    - Procurement and Supply management
    - Consenting processes
    - Safeguarding
    - Safe and secure storage, preparation, administration
    - Infection prevention and control
    - Waste management
    - Record keeping
    - Implementation/dissemination of National Protocol and procedural updates
    - Provision of expert advice to vaccinators

The Vaccination Service is deemed to be safe and effective and supportive of the Vaccination program within the wider Health Economy supporting training, Mutual Aid and assisting with the vaccination of high-risk individuals.

COVID Medicines Service

The Trust has processes in place to rapidly implement Interim Commission Decisions/Reports associated with the introduction or use of COVID medicines. Standard operating procedures are in place describing the use of remdesivir, tocilizumab and sotrovimab within the Trust.

Since December 2021, the Trust has provided support for the Community COVID medicines service, initially supplying sotrovimab to the Community IV nursing service and supplying molnupiravir directly to outpatients, more recently with reviewing the medication of patients eligible for the Community COVID medicines to determine whether or not drug interactions would contraindicate the use of Paxlovid or would require temporary adjustments in the medicines they take to allow the use of Paxlovid. Following the provision of a written assessment to the COVID Medicines Deployment Unit (CMDU) then supplying Paxlovid if appropriate.

Since December 2021, 65 patients have received molnupiravir, 49 patients have received Paxlovid (representing around 1/3 of patients reviewed for this treatment) and 110 patients have received sotrovimab through supplies provided by WHH. This has been successful in preventing worsening of symptoms and the admission of patients.

3. 2022/23 ACTION UPDATE

1. Continue to improve against Model Hospital parameters
   Areas for improvement and continued effort include:
   a. completion of the EPMA roll out to all wards
      Roll out to NNU is expected this summer and this will complete the roll out to inpatient wards
   b. implementation of GP Connect,
      Testing identified development work for the two major GP systems Symone and EMIS. Further testing took place **on 24/5/22 and highlighted that further work was needed. 'GP Connect html' testing is occurring in June 2022 and will be implemented if testing is successful.**
   c. implementation of electronic outpatient prescribing
      If approved recommended changes to remove the need for a wet signature could support this implementation
   d. implementation of EPMA Part 3 dose range checking + dose calculator
      Scheduled for 2022/23

e. Implementation of Part 4 closed loop medicines supply integrated with the Pharmacy Dispensing System
Required Wellsky upgrade completed, awaiting further developments to then do the final implementation stage
f. re-submission of the pharmacy transformation business case for phase two (working in ED)
Funding approved, recruitment progressing
g. review of aseptic services / submission of an Options Paper: ***Paper submitted to the Capital Planning Group; further work needed in light of possible Development funding***
Piperacillin/tazobactam ready-prepared infusions business case approved, implemented, and supporting staff with earlier administration in ED & B18
h. improvements in the use of antibiotics/antifungals through effective antimicrobial stewardship strategies,
Approval given to release money in reserves allocated to antimicrobial stewardship, recruitment progressing
i. improvements in Trust performance against the medication questions in the National Inpatient Survey - **awaited**
j. the cross-sector polypharmacy-deprescribing project - **ongoing**
k. activities to reduce harm arising from omitting critical medicines – **Quality Improvement Project commissioned involving pilot wards and the use of the Omitted Medicines Report. Critical medicines flag has been trialled and is supported by the pilot wards. This is being extended to other critical medicines and will support the introduction of a critical medicines report.**

2. Continue to monitor medication safety and implement safety measures where needed including actions arising from rapid incident reviews/serious incident reviews
3. Continue the work of the Medicines Improvement Group and implement the action plan
4. Incorporate required sustainability changes into the action plan

4. IMPACT ON QPS?

This report provides assurance in relation to actions and improve medicines safety.

5. MEASUREMENTS/EVALUATIONS

Medicines Information KPIs
Transaction data

- Medicines reconciliation data providing evidence of the impact of business cases made to improve delivery of ED/ward pharmacy
- Medication incident data showing patterns of incident reporting and level of harm to no harm incidents from 2018 to 2021 and learning from incidents
- Intervention audit data
- Omitted medicines data

6. TRAJECTORIES/OBJECTIVES AGREED

Work with IT on the EPMA and IT developments in accordance with the work program (2022/23 program)
Implement the Pharmacy Transformation Phase 2 – Service to ED
Participate in discussions relating to Aseptic Service Transformation in Cheshire and Merseyside
Antimicrobial Stewardship Strategy and Workstream implementation with Microbiology
Continue the Medicines Improvement Group Actions including:

a. Reducing harm from omitting critical medicines
b. Anticoagulation / VTE workstream
c. Actions associated with the Pharmacy Intervention Audit
d. Controlled drug incident reduction

Support the deliver the cross-sector polypharmacy de-prescribing work plan
Support the CQUIN program:

e. CCG1: Staff flu vaccinations
f. CCG2: Appropriate antibiotic prescribing for UTI in adults aged 16+
g. CCG5: Treatment of community acquired pneumonia in line with BTS care bundle
h. CCG6: Anaemia screening and treatment for all patients undergoing major elective surgery
i. CCG7: Timely communication of changes to medicines to community pharmacists via the Discharge Medicines Service
j. PSS3: Achieving progress towards Hepatitis C elimination within lead Hepatitis C centres

7. MONITORING/REPORTING ROUTES

Medicines Governance Committee
Patient Safety and Clinical Effectiveness Committee
Controlled Drugs Local Intelligence Network
Moving to Outstanding Meetings

8. TIMELINES

See objectives and trajectory above

9. RECOMMENDATIONS

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

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/22/07/106**			
SUBJECT:	**Workforce Race Equality Standard Report**			
DATE OF MEETING:	27th July 2022			
AUTHOR(S):	Rebecca Patel, Associate Chief People Officer Sofia Higgins, Equality Diversity and Inclusion Manager			
EXECUTIVE DIRECTOR SPONSOR:	Michelle Cloney, Chief People Officer			
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	SO1 We will.. Always put our patients first delivering safe and effective care and an excellent patient experience. SO2 We will.. Be the best place to work with a diverse and engaged workforce that is fit for now and the future SO3 We will ..Work in partnership with others to achieve social and economic wellbeing in our communities.			 X
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): **(*Please DELETE as appropriate)***	**#1134** Failure to provide adequate staffing caused by absence relating to COVID-19 resulting in resource challenges and an increase within the temporary staffing domain			
EXECUTIVE SUMMARY *(KEY ISSUES):*	This report provides an overview of the process for producing the 2022 Workforce Race Equality Standard (WRES) data and action plan, and highlights progress made since 2021 reporting was conducted. The timescales within the report are estimates based on previous years' schedules. The National WRES team have not articulated formal timescales, however the Trust anticipates that the schedule will be as indicated within the report.			
PURPOSE: *(please select as appropriate)*	Information	Approval	To note X	Decision
RECOMMENDATION:	The Trust Board is asked to note the development of the WRES action plan and also approve the WRES action plan for publication and submission to the national portal.			
PREVIOUSLY CONSIDERED BY:	**Committee**	Strategic People Committee		
	Agenda Ref.	**SPC/22/07/79**		
	Date of meeting	20th July 2022		
	Summary of Outcome	Noted		
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None			

REPORT TO BOARD OF DIRECTORS

SUBJECT	Workforce Race Equality Standard Report	AGENDA REF:	SPC/22/07/79

1. BACKGROUND/CONTEXT

The Workforce Race Equality Standard (WRES) is an important requirement for the Trust and is detailed in the NHS standard contract. The purpose of the standard is to ensure that members of the workforce who are from Black, Asian and Minority Ethnic (BAME) backgrounds have equal access to career opportunities and receive fair treatment in the workplace.

The Trust is expected to show progress against a number of indicators of workforce equality, including a specific indicator to ensure that the organisation is representative across all levels. The WRES measures are important as they demonstrate the experience that our organisation is providing for our racially diverse workforce and research shows that a motivated, included and valued workforce contributes to the delivery of outcomes such as reduced health inequalities, high quality patient care, increased patient satisfaction and improved patient safety.

2. KEY ELEMENTS

a. Reporting Requirements and Timescales

The Trust's WRES data is to be submitted to the national central government portal by 31st August 2022. As part of the reporting requirements, organisations are required to develop an action plan approved by Trust Boards and upload it to the Trust's website by 31st October 2022.

The Trust's WRES action plan and data, as indicated in **Appendix One** and **Appendix Two** has been developed and collated and shared with the Workforce EDI Sub-Committee in June 2022. The WEDISC endorsed the approach and development of the action plan. The action plan is required to go through the People governance structures within the organisation, through Strategic People Committee and Trust Board in September prior to the action plan being uploaded onto the Trust's external website.

b. WRES Progress Since 2021

The WRES action Plan is highlighted in **appendix two**, and for transparency 2019 data has been left in so that the committee can identify trends. This data column will be removed, and the action plan reformatted before data are published on the WHH website in line with WRES reporting requirements. Meanwhile, the *Narrative* column gives an analysis of the trends and inferences identified in the data, while the *2021/2 Actions* and *Timescales* columns show the completion status of the actions.

c. WRES Action Plan Development

The action plan in response to this year's data has been collrboatively developed with the organisation's Multi-Ethnic Staff Network (Building A Multi-Ethnic Environment), Union colleagues and members of the Workforce Equality, Diversity and Inclusion Sub-Committee. In addition to seeking views from members of staff, actions will continue to be developed and implemented on the basis of best practice from other organisations.

d. Monitoring and Reporting Routes

Progress against the WRES action plan will be monitored via the Workforce Equality, Diversity, and Inclusion Sub-Committee, with escalation to the Operational People Committee and assurance provided to the Strategic People Committee.

3. RECOOMENDATIONS

The Board is asked to:

- Note the WRES action plan and approach to development
- Note the WRES action plan

4. APPENDICES

Appendix One: WRES Indicator One Data Information
Appendix Two: WRES Action Plan

Appendix One: WRES Indicator One Data Information

		2020/21			2021/22			
DATA ITEM		WHITE %	BAME %	ETHNICITY UNKNOWN %	WHITE %	BAME %	ETHNICITY UNKNOWN %	**INCREASE/DECREASE ON PREVIOUS YEAR**
1a) Percentages of Non-Clinical workforce								
1	Under Band 1	0	0	0	91.6	8.33	0	↑
2	Band 1	93.54	6.4	0	92.85	7.14	0	↑
3	Band 2	97.46	2.8	0	92.63	7	0	↑
4	Band 3	98.02	1.58	0.39	97.11	2.16	0	↑
5	Band 4	96.22	2.36	1.42	96.52	2.61	0.87	↑
6	Band 5	97.33	2.6	0	95.51	4.49	0	↑
7	Band 6	90.63	9.37	0	94.83	5.17	0	↓
8	Band 7	94.44	5.55	0	92.65	7.35	0	↑
9	Band 8A	94.28	5.71	0	93.02	4.65	2.32	↓
10	Band 8B	100	0	0	100	0	0	-
11	Band 8C	100	0	0	95	4.76	0	↑
12	Band 8D	85.71	14.28	0	92.30	7.69	0	↓
13	Band 9	100	0	0	75	25	0	↑
14	VSM	100	0	0	87.5	12.5	0	↑
1b) Percentages of Clinical workforce of which Non-Medical								
15	Under Band 1	0	0	0	100	0	0	-
16	Band 1	100	0	0	100	0	0	-
17	Band 2	92.4	7.52	0	92.19	7.81	0	↑
18	Band 3	96.89	2.59	0.51	94.76	4.71	0.52	↑
19	Band 4	95.79	4.20	0	94.9	5.04	0	↑
20	Band 5	84.40	14.51	1.07	68	27	4.9	↑
21	Band 6	91.62	7.88	0.49	89.93	9.41	0.64	↑
22	Band 7	95.23	4.51	0.25	93.14	6.38	0.47	↑
23	Band 8A	96.96	3.03	0	92.91	6.29	0.78	↑
24	Band 8B	96	0	4	93.54	3.22	3.22	↑
25	Band 8C	100	0	0	100	0	0	-
26	Band 8D	100	0	0	100	0	0	-
27	Band 9	100	0	0	100	0	0	-
28	VSM	100	0	0	100	0	0	-

Appendix Two: WRES Action Plan

Metric Number	Standard	2019/20 Data	2020/1 Data	2021/2 Data	Narrative	2020/1 Actions	2021/2 Actions	Timescales
1	Percentage of staff in AfC paybands or medical and dental subgroups and very senior managers (including Executive Board members) compared with the percentage of staff in the overall workforce. The data for this Metric should be a snapshot as at 31 March 2021/2 (See Appendix 1)				Indicator 1(Appendix 1)- the most significant changes to staffing and progression for non-clinical staffing in 2021 are that there are now also colleagues of BAME heritage in positions at Bands 8C, 9 and VSM, leaving only Band 8B where a BAME staff member does not hold a position. Additionally, there have been increases at bands 2,3,4,5 and 7. For clinical staff, there have been increases from Bands 2 to 8B, with the most significant increase of 87 staff at Band 5. This leaves Bands 8C, 8D, 9 and VSM with no current BAME representation.	Introduce targeted marketing of employment opportunities to increase diversity.	Ongoing	Q4 January 2023
						Scope options relating to positive action and present to Strategic People Committee to approve for implementation .	Development and delivery of a positive action programme targeted at BAME Nursing and Midwifery.	Q2 August 2022
2	Relative likelihood of White staff being appointed from	1.48	0.83	0.80	The data demonstrates that white staff are still more likely than BAME to be	Develop and launch Equality in Employment		Development in Q2 and launch in Q3

Metric Number	Standard	2019/20 Data	2020/1 Data	2021/2 Data	Narrative	2020/1 Actions	2021/2 Actions	Timescales
	shortlisting compared to that of BME staff being appointed from shortlisting across all posts.				appointed from shortlisting, although this likelihood has decreased in comparison with the 2020/21 data which illustrates a slight improvement.	policy to cover practical guidance in relation to employing individuals with a range of protected characteristics.		December 2022
						Continue development and delivery of EDI managers training to include case studies from own workforce.		Ongoing
						Include equality, diversity and inclusion responsibilities in all line manager Job Description templates.		Complete
						Include equality, diversity and inclusion objective in all staff PDRs	Ongoing	Q2 Sep 2022
						Refresh recruiting	Develop and deliver	Q2 July 2022

Metric Number	Standard	2019/20 Data	2020/1 Data	2021/2 Data	Narrative	2020/1 Actions	2021/2 Actions	Timescales
						managers training to increase inclusivity of selection processes and increase diversity	multiple units of EDI related training specifically targeted at recruiting managers	
							Development and delivery of Equality Diversity and Inclusion training highlighting the Trust' obligations to the Public Sector Equality Duty.	Q2 July 2022
							Inclusive Recruitment and Inclusive Employer work to be carried out	Q4 March 2023
3	Relative likelihood of BME staff entering the formal disciplinary process, compared to that of White staff entering the formal disciplinary process.	1.05	3.84	1.07	The 2021/22 data highlights that there has been a significant decrease in the relative likelihood of BAME staff entering the formal disciplinary process in comparison with 2020/21. This has been a result of	Development and launch of Civility, Kindness and Respect campaign across organisation.		Q2 August 2022
						Review of		Complete

Metric Number	Standard	2019/20 Data	2020/1 Data	2021/2 Data	Narrative	2020/1 Actions	2021/2 Actions	Timescales
					clear strategic planning, oversight and monitoring to address this specific indicator.	Improving People Practices and Fair Processes for all report to inform operational actions		
						Senior HR review of cases in the data set. Outcomes and actions to be reported to SPC		Complete
						Senior HR review of cases relating to BAME staff		Ongoing
4	Relative likelihood of staff accessing non-mandatory training and CPD.	0.99	0.80	0.97	The data illustrates that there has been a slight decrease in comparison with 2020/21 for all staff accessing non-mandatory training and CPD.	Develop inclusive talent management programme / framework.	Ongoing	Q4 by 31st March 2023
						Promotion and implementation of BAME specific learning and development opportunities internally and externally.		In place and on-going.
5	Percentage of staff experiencing harassment, bullying or abuse from	White: 21.2% BAME:	White: 21.6% BAME:	White: 21.0% BAME:	The data demonstrates that there has been a slight increase in comparison with	Work with the BAME Staff Network,		Ongoing

Metric Number	Standard	2019/20 Data	2020/1 Data	2021/2 Data	Narrative	2020/1 Actions	2021/2 Actions	Timescales
	patients, relatives or the public in last 12 months.	29.9%	25%	25.6%	2020/21. It is recognised that there is still a higher percentage of BAME staff experiencing harassment, bullying or abuse from the public in the last 12 months compared with white staff.	Freedom to Speak Up Team and HR Team to enhance reporting of incidents		
						Deep dive of existing data from staff survey, incidents, Freedom To Speak Up and grievances to understand patterns		Complete
						Targeted work via HR Team and OD Team in specific areas highlighted via the analysis		Q4 March 2023
						Analysis of Staff Survey results from 2020 (available in January 2021) to ascertain any hotspot areas or staff groups.		Ongoing
6	Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months.	White: 18.3% BAME: 22.4%	White: 19% BAME: 26%	White: 17% BAME: 21.5%	The data demonstrates that there has been an improvement in comparison with 2020/21 in that less	Development of EDI calendar to encourage a culture of		Complete

Metric Number	Standard	2019/20 Data	2020/1 Data	2021/2 Data	Narrative	2020/1 Actions	2021/2 Actions	Timescales
					BAME staff are reporting experiencing harassment, bullying or abuse from staff in the last 12 months.	inclusion.		
						Organisational participation in local community culture events such as Warrington Mela[1] (dependent upon COVID-19 restrictions).		Ongoing
						Investigate, and implement membership of Race Charter at Work[2].		Q2 Sep 2022
						Organisational sign-up to Social Partnership Forum's "Call to Action" in relation to bullying and harassment and embed into trust-wide civility, kindness and respect campaign.		Complete
						Review the		Ongoing

[1] About | Warrington Ethnic Communities Association (weca.org.uk)
[2] How to set up an ERG for black and ethnic minority employees | CIPD

Metric Number	Standard	2019/20 Data	2020/1 Data	2021/2 Data	Narrative	2020/1 Actions	2021/2 Actions	Timescales
						opportunities to collect equality monitoring data as part of Freedom to Speak up.		
						Undertake further review of Freedom to Speak up, incidents and HR cases		Complete
						Discuss equality, diversity and inclusion as part of the regular health and wellbeing conversations.		Complete
7	Percentage of staff believing that trust provides equal opportunities for career progression or promotion	White: 90.7% BAME: 76.1%	White: 91.4% BAME: 82.3%	White: 64.3% BAME: 49.7%	The data shows that there has been a marked decrease in the percentage of BAME members of staff believing that the trust provides equal opportunities for career progression or promotion.	Promotion and implementation of BAME specific learning and development opportunities internally and externally.		In place and on-going
						Development and implementation of reciprocal mentoring	Cohort one is near completion.	Q3 December 2022

Metric Number	Standard	2019/20 Data	2020/1 Data	2021/2 Data	Narrative	2020/1 Actions	2021/2 Actions	Timescales
						programme.		
						Introduce targeted marketing of employment opportunities to increase diversity.		Ongoing
8	In the last 12 months have you personally experienced discrimination at work from any of the following? Manager/team leader or other colleagues	White: 4.5% BAME: 12.3%	White: 4.50% BAME: 10.70%	White: 5.0% BAME: 11.9%	The data demonstrates that there has been a decrease compared to 2020/21 with more BAME members of staff reporting personally experiencing discrimination at work from a manager, team leader or other colleagues.	Increase BAME representation as Freedom To Speak Up Champions.		Q4 31st March 2023
						Development of EDI Champion role.	EDI Leads now exist across the organisation	Complete
						Development, in partnership with the BAME Staff Network of line manager guidance for dealing with specific concerns from BAME members of staff.		Q3 October 2022
9	Percentage difference between the organisation's Board voting membership and its overall workforce.	White: +3.7% BAME: -9.70%	White: +11.0% BAME: -9.9%	White: +5.0% BAME: -3.7%	The data demonstrates that in comparison with 2020/21, there has been an improvement in relation to	Participation in the NHS Leadership Academy		Ongoing

Metric Number	Standard	2019/20 Data	2020/1 Data	2021/2 Data	Narrative	2020/1 Actions	2021/2 Actions	Timescales
	Note: Only voting members of the Board should be included				BAME voting membership and the overall workforce.	Shadow Board leadership programme.		
						Participation in bespoke EDI training for board members.	Ongoing	Q3 December 2022

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/22/07/106**			
SUBJECT:	**Workforce Disability Equality Standard Report**			
DATE OF MEETING:	27th July 2022			
AUTHOR(S):	Rebecca Patel, Associate Chief People Officer Sofia Higgins, Equality Diversity and Inclusion Manager			
EXECUTIVE DIRECTOR SPONSOR:	Michelle Cloney, Chief People Officer			
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	SO1 We will.. Always put our patients first delivering safe and effective care and an excellent patient experience. SO2 We will.. Be the best place to work with a diverse and engaged workforce that is fit for now and the future SO3 We will ..Work in partnership with others to achieve social and economic wellbeing in our communities.			 X
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): **(*Please DELETE as appropriate)***	**#1134** Failure to provide adequate staffing caused by absence relating to COVID-19 resulting in resource challenges and an increase within the temporary staffing domain			
EXECUTIVE SUMMARY *(KEY ISSUES):*	This report provides an overview of the process for producing the 2022 Workforce Disability Equality Standard (WDES) data and action plan, and highlights progress made since 2021 reporting was conducted. The timescales within the report are estimates based on previous years' schedules. The National WDES team have not articulated formal timescales, however the Trust anticipates that the schedule will be as indicated within the report.			
PURPOSE: *(please select as appropriate)*	Information	Approval	To note X	Decision
RECOMMENDATION:	The Trust Board is asked to note the development of the WDES action plan			
PREVIOUSLY CONSIDERED BY:	**Committee**	Strategic People Committee		
	Agenda Ref.	**SPC/22/07/80**		
	Date of meeting	20th July 2022		
	Summary of Outcome	Noted		
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: *(if relevant)*	None			

REPORT TO BOARD OF DIRECTORS

SUBJECT	Workforce Disability Equality Standard Report	AGENDA REF:	SPC/22/07/80

1. BACKGROUND/CONTEXT

The Workforce Disability Equality Standard (WDES) is an important requirement for the Trust and is detailed in the NHS standard contract. The purpose of the standard is to ensure that members of the workforce who have disabilities have equal access to career opportunities and receive fair treatment in the workplace.

The Trust is expected to show progress against a number of indicators of workforce equality, including a specific indicator to ensure that the organisation is representative across all levels. The WDES measures are important as they demonstrate the experience that our organisation is providing for our disabled workforce and research shows that a motivated, included and valued workforce contributes to the delivery of outcomes such as reduced health inequalities, high quality patient care, increased patient and workforce satisfaction, and improved patient safety.

2. KEY ELEMENTS

a. Reporting Requirements and Timescales

The Trust's WDES data are to be submitted to the national central government portal by 31st August 2022. As part of the reporting requirements, organisations are required to develop an action plan approved by Trust Boards and upload it to the Trust's website by 31st October 2022.

The Trust's WDES action plan and data has been developed and collated and shared with the Workforce EDI Sub-Committee in June 2022. The WEDISC endorsed the approach and development of the action plan. The action plan is required to go through the People governance structures within the organisation, through Strategic People Committee and Trust Board in September prior to the action plan being uploaded onto the Trust's external website.

b. WDES Progress Since 2021

The WDES action Plan is highlighted in **Appendix One**, and for transparency 2019 data has been left in so that the committee can identify any trends. This data column will be removed, and the action plan reformatted before the data is published on the Trust website, in line with WDES reporting requirements. Meanwhile, the *Narrative* column gives an analysis of the trends and inferences identified in the data, while the *2021/2 Actions* and *Timescales* columns show the completion status of the actions.

c. WDES Action Plan Development

The action plan in response to this year's data has been collaboratively developed with the organisation's Disability Awareness Staff Network, Union colleagues and members of the Workforce Equality, Diversity and Inclusion Sub-Committee. In addition to seeking views from members of staff, actions will continue to be developed and implemented on the basis of best practice from other organisations.

d. Monitoring and Reporting Routes

Progress against the WDES action plan will be monitored via the Workforce Equality, Diversity, and Inclusion Sub-Committee, with escalation to the Operational People Committee and assurance provided to the Strategic People Committee.

3. RECOMMENDATIONS

The Trust Board is asked to note the development of the WDES action plan

4. APPENDICES

Appendix One: WDES Action Plan 2022

Appendix One: WDES Action Plan

Metric Number	Standard	2019/20 Data	2020/1 Data	2021/2 Data	Narrative	2020/1 Actions	2021/2 Actions	Timescales
1	Percentage of staff in each of the AfC bands 1-9 and VSM (including executive board members) compared with the percentage of staff in the overall workforce	<u>Non-Clinical</u> Disabled staff: 3.07% Non-disabled staff: 60.37% Disability Unknown: 36.54% <u>Clinical</u> Disabled staff: 2.68% Non-disabled staff: 64.4% Disability Unknown: 33.85%	<u>Non-Clinical</u> Disabled staff: 3.4% Non-disabled staff: 60.60% Disability Unknown: 36% <u>Clinical</u> Disabled staff: 1.5% Non-disabled staff: 64.4% Disability Unknown: 32.4%	<u>Non-Clinical</u> Disabled staff: 3.92% Non-disabled staff: 65.69% Disability Unknown: 30.30% <u>Clinical</u> Disabled staff: 1.89% Non-disabled staff: 70.23% Disability Unknown: 27.88%	Data taken from the organisation's Electronic Staff Record demonstrates that disabled staff are over-represented in lower bands and under-represented across senior levels in comparison with the 2020/1 WDES data. It is important to note that there are also low numbers of staff declaring a disability so a focus should be made on improving self-declaration	Refresh and re-promotion of self-declaration ESR campaign from Chief People Officer	Continue with engagement from Communications Team	ongoing
						Design and deliver a reciprocal mentoring programme	To be brought inhouse and continued	Complete
						Organisational approach to positive action to be designed and documented in relation to recruitment and selection, and the talent management framework		Ongoing
						Undertake a review of line management experiences in progressing staff to understand		Complete

						cultural competence of managers.		
						Achieve Disability Confident Level 3		Complete
							Develop and launch a communication strategy to encourage more staff to record their disability status.	Q2 July 2022
2	Relative likelihood of non-disabled staff compared to disabled staff being appointed from shortlisting across all posts	0.83	1.80	0.80	The data from 2021/2 demonstrates that there has been a notable improvement in relation to the likelihood of disabled staff being appointed from shortlisting	Develop and launch Equality in Employment policy to cover practical guidance in relation to employing individuals with a range of protected characteristics	Embedded into new 2022 EDI policy. Inclusive recruitment is also complete and ongoing.	Complete
						Continue development and delivery of EDI managers training to include case studies from own workforce.		Ongoing

						Include equality, diversity and inclusion responsibilities in all line manager Job Description templates.		Complete
						Include equality, diversity and inclusion objective in all staff PDRs	Included in talent management framework – Scope for Growth.	Complete
						Update line manager induction process to include inclusive recruitment principles and best practice		Complete
3	Relative likelihood of non-disabled staff compared to disabled staff entering the formal capability process, as measured by	0	0	0	There has been no change since the 2020/21 WDES and no members of staff with a disability have been identified as entering the formal capability process.	Development and launch of Civility, Kindness and Respect campaign across organisation		Q2 August 2022
						Review of Improving People Practices and Fair Processes for all	Due to the new people plan and the HR OD review, this will continue to be	Ongoing

	entry into the formal capability procedure.					Report to ensure actions and recommendations highlighted in report are implemented within organisation.	developed and rolled out.	
4	Percentage of disabled staff compared with non-disabled staff experiencing harassment, bullying or abuse from: Patients / service users, there relatives or other members of the public Manager Other colleagues	<u>i. Patients / service users:</u> Disabled staff: 25.70% Non-disabled staff: 20.90% <u>ii. Managers:</u> Disabled staff: 13.10% Non-disabled staff: 8.40% <u>iii. Other colleagues:</u> Disabled staff: 21.10% Non-disabled staff: 13.20%	<u>i. Patients / service users:</u> Disabled staff: 22.40% Non-disabled staff: 16.50% <u>ii. Managers:</u> Disabled staff: 17.50% Non-disabled staff: 8.60% <u>iii. Other colleagues:</u> Disabled staff: 21.20% Non-disabled staff: 12.80%	<u>i. Patients / service users:</u> Disabled staff: 26.40% Non-disabled staff: 20.0% <u>ii. Managers:</u> Disabled staff: 19.30% Non-disabled staff: 9.10% <u>iii. Other colleagues:</u> Disabled staff: 26.70% Non-disabled staff: 15.30%	Harassment and bullying experienced by disabled staff increased in 2021/22 from the previous year	Work with the Disability Awareness Network, Freedom to Speak Up Team and HR Team to enhance reporting of incidents	This is currently facilitated at meetings such as WEDISC and will continue.	Ongoing
						Targeted work via HR Team and OD Team in specific areas highlighted via the analysis	Career development programme. Ongoing	Q4 March 2023
						Analysis of Staff Survey results from 2021 (available in January 2022) to ascertain any hotspot areas or staff groups		Q2 July 2022 Ongoing

	b) Percentage of Disabled staff compared to non-disabled staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it.	Disabled: 48% Non-disabled: 51.5%	Disabled: 49.20% Non-disabled: 50.20%	Disabled: 44.40% Non-disabled: 48.20%	The reporting of incidents has also decreased for both disabled and non-disabled staff.	Development and launch of Civility, Kindness and Respect campaign across organisation	Elements have been started. This is a cultural change. Ongoing.	Q2 August 2022
						Review the opportunities to collect equality monitoring data as part of Freedom to Speak up	Ongoing	Complete
						Deputy Chief People Officer to lead review of cases		Q4 March 2022
5	Percentage of disabled staff compared to non-disabled staff believing the Trust provides equal opportunities for career progression or promotion	Disabled: 85.8% Non-disabled: 91.5%	Disabled: 89.10% Non-disabled: 90.60%	Disabled: 52.30% Non-disabled: 66.20%	The Staff Survey data from 2021/22 in comparison with 2020/21 demonstrates a proportionate decrease in the percentage who feel that the Trust provides equal opportunities for	Work with Disability Awareness Network to develop documentation and learning opportunities to support implementation of EDI objectives		Q3 October 2022

					progression or promotion.	across the organisation		
						Promotion and implementation of specific learning and development support to disabled members of staff	Access to work, Neurodiversity.	Q2 August 2022
						Implement a career development support programme for under-represented groups.		Complete
6	Percentage of disabled staff compared to non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough	Disabled:27.9% Non-disabled:19.3%	Disabled:32.90% Non-disabled:19.30%	Disabled:31.8% Non-disabled:22.3%	The Staff survey data from 2021/22 in comparison with 2020/21 demonstrates that there has been a 1% decrease in disabled members of staff feeling pressure to come to work	Conduct a review of guidance for line managers in relation to mental health to support members of staff during recovery following the COVID-19 pandemic. Disability Awareness Network and the		Complete & Ongoing

	to perform their duties				despite not feeling well. There has been an increase in non-disabled staff feeling pressure to come to work when feeling unwell.	mental wellbeing hub to support review.		
						Work with Disability Awareness Network to develop guidance for line managers in relation to the management of physical disabilities to support members of staff	OH and DAN to work together to develop guidance.	Q4 March 2023
						Promote the discussion of equality, diversity and inclusion as part of the health and wellbeing conversations for the organisation		Ongoing
						HR to lead a review of the current Attendance Management Policy, with support from Disability		Complete

						Awareness Network.		
7	Percentage of disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work.	Disabled:39.2% Non-disabled: 54.6%	Disabled:43.0% Non-disabled: 53.8%	Disabled:36.30% Non-disabled: 46.70%	The Staff Survey results from 2021/22 show a decrease in the number of disabled members of staff feeling that the organisation values their work	Work with Disability Awareness Network to promote celebration of disability through EDI calendar and activities		In place and on going
8	Percentage of disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work.	Disabled:75%	Disabled:83.70%	Disabled:78%	The Staff Survey results from 2021/22 demonstrate a decrease in the number of disabled staff saying that adequate adjustments are being made.	Promotion of flexible working guidance for members of staff and line managers.		Complete and Ongoing
						Promotion of Access to Work to staff and line managers.		Q2 July 2022
						Develop and launch Equality in Employment policy to cover		Complete covered in EDI policy

						practical guidance in relation to employing individuals with a range of protected characteristics.		
9	9a) The staff engagement score for disabled staff compared to non-disabled staff, and the overall engagement score for the organisation.	Disabled: 6.7 Non-disabled: 7.2	Disabled: 7.3 Non-disabled: 8.6	Disabled: 6.4 Non-disabled: 7.1	The Staff Survey engagement score for 2021/22, demonstrates a decrease in the number of staff who feel engaged with the organisation.	Continue to develop the Disability Awareness Network by increasing membership and visibility within the organisation.		Ongoing
	9b) Has your trust taken action to facilitate the voices of disabled staff in your organisation to be heard?	Yes			The organisation has developed and launched a Disability Awareness Staff Network who provide the voices of disabled staff and support initiatives, policy and procedures reviews from a disabled staff perspective.	Promotion of disability awareness events as part of the wider EDI calendar		In place and ongoing
						Achievement of Disability Confident Level 3 for the organisation		Complete
						Deliver training and development opportunities to Network Chairs		Complete and ongoing

						and members.		
						Continuation of Reciprocal Mentoring programme		Ongoing
10	Percentage difference between the organisation's Board voting membership and its organisation's overall workforce, disaggregated: By voting membership of the board By executive membership of the board	Voting membership of the board: Disabled Staff: -2% Non-disabled staff: +42% Executive membership of the board: Disabled staff: -2% Non-disabled staff: -25%	Voting membership of the board: Disabled Staff: -2% Non-disabled staff: -9.89% Executive membership of the board: Disabled staff: -2.08% Non-disabled staff: -1.94%	Voting membership of the board: Disabled Staff: -8.70% Non-disabled staff: -9.44% Executive membership of the board: Disabled staff: -4.35% Non-disabled staff: 1.81%	In terms of the representation of the Board in relation to the wider workforce, the voting membership of the Board has increased.	Participation in the NHS Leadership Academy Shadow Board leadership programme		Complete
						Participation in bespoke EDI training for board members, including Cultural Competence Training.		Ongoing