TRUST BOARD - 29 July 2020

ITEMS FOR APPROVAL

ITEMS FOR NOTING FOR ASSURANCE

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/20/07/75**	
SUBJECT:	**Complaints Annual Report**	
DATE OF MEETING:	29 July 2020	
AUTHOR(S):	Layla Alani, Deputy Director Governance	
EXECUTIVE DIRECTOR SPONSOR:	Kimberley Salmon-Jamieson, Chief Nurse + Deputy Chief Executive	
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	SO1 We will.. Always put our patients first through high quality, safe care and an excellent patient experience. SO2 We will.. Be the best place to work with a diverse, engaged workforce that is fit for the future. SO3 We will ..Work in partnership to design and provide high quality, financially sustainable services.	x x
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF):		
EXECUTIVE SUMMARY *(KEY ISSUES):*	This annual report includes a summary of formal complaints raised by patients or their relatives between 01 April 2019 and 31 March 2020. • In 2019/20 the Trust significantly improved the timeliness in response to complaints. • 441 complaints were received during the reporting period, a decrease of 14 from 2018/19. • Of the 441 complaints 420 were closed during the reporting period of which 101 were Upheld, 145 were Partially Upheld, and 157 were Not Upheld • In March 2020 the NHS responded to the Coronavirus (Covid19) pandemic. National guidance was issued advising how to respond to complainants during this period. This resulted in 17 low and moderate complaints being closed. • Following triage, 9 complaints were considered to be Serious Incidents. • 59 complaints were open at the time of reporting, with no breached timeframes. • 5 PHSO cases are currently being investigated; and • 1114 PALS cases have been received. These figures are correct on the date of reporting (4 June 2020)	
PURPOSE: *(please select as appropriate)*	Information / Approval / To note x / Decision	
RECOMMENDATION:	Trust Board members are asked to note the report	
PREVIOUSLY CONSIDERED BY:	**Committee**	Quality Assurance Committee
	Agenda Ref.	QAC/20/07/96

	Date of meeting	7 July 2020
	Summary of Outcome	The Quality Assurance Committee were asked to note the report.
FREEDOM OF INFORMATION STATUS (FOIA):	Choose an item.	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	Choose an item.	

REPORT TO BOARD OF DIRECTORS

SUBJECT	Annual Complaint Report

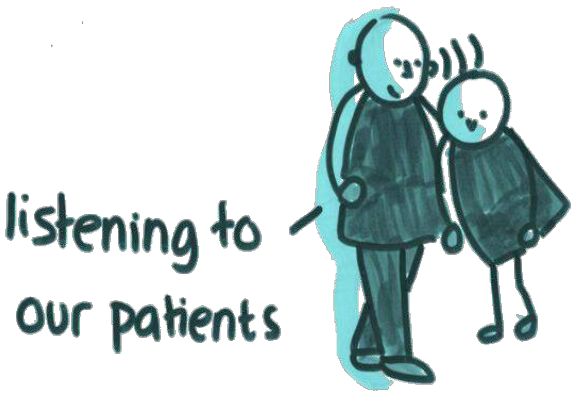
1. BACKGROUND/CONTEXT

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 continued on:

- Reducing the backlog of complaints in the Trust.
- Improving the timeliness of responses to complainants.
- Implementing the revised Complaints policy and a new process across the Trust to ensure that the patient, their relatives and carers receive an efficient and responsive complaints service.
- Focus upon learning working collaboratively with CBUs to improve standards of care and complaints responses where necessary.
- Training staff to ensure that they understood their role in relation to the Trust's new complainants policies and processes and good complaints handling,
- A Quality Assurance Group led by the Trust Chairman was developed to review the quality of our complaints responses and to promote accountability of leading the complaints agenda at senior management level within the clinical services.

- Improving how the Trust responds to PALS concerns.
- On addressing the concerns of dissatisfied complainants and PHSO referrals.
- Improving the system (Datix) used to log complaints, to make it more accessible and create an environment of visible data, and
- Improving the sharing of learning from complaints and compliance of actions arising through audits.

The successes in 2019/20 have included:

- The backlog of complaints is clear.
- The timeliness of complaints has improved from 29% in Q1 2019/20 to 100% in Q4 2019/20 following a quality improvement project. Timeliness of complaints will continue to be part of the Trust's Quality Account priorities in 2020/21 for complaints responses to meet the Trust target of 90%.
- 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 has now had all Clinical Business Unit (CBU) leads present a complaint and discuss their processes for complaints handling and learning.
- The Trust PALS office is now established in the main foyer and has provided an environment that supports patients and the public to present and discuss their concerns.
- The Datix reporting system is now embedded and complaints and PALS data is circulated through dashboards to the CBU's and wards.
- The Trust has embedded lessons learned audits, to ensure that learning from complaints and Serious Incidents are implemented.

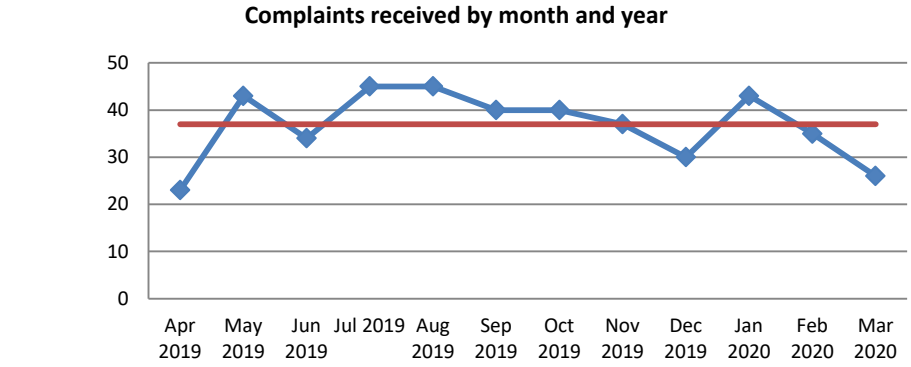
We are guests in our patients' lives

Don Berwick

2.1 Complaints received

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

441 complaints were received during the reporting period, a decrease of 14 from 2018/2019 (455). The graph below details the amount of complaints opened over the specified time period.



	Apr 2019	May 2019	Jun 2019	Jul 2019	Aug 2019	Sep 2019	Oct 2019	Nov 2019	Dec 2019	Jan 2020	Feb 2020	Mar 2020
Data	23	43	34	45	45	40	40	37	30	43	35	26
Average	37	37	37	37	37	37	37	37	37	37	37	37

2.2 Complaint themes

Formal complaints can be received for a variety of reasons. The following table shows the primary subjects of complaints opened during this reporting period:

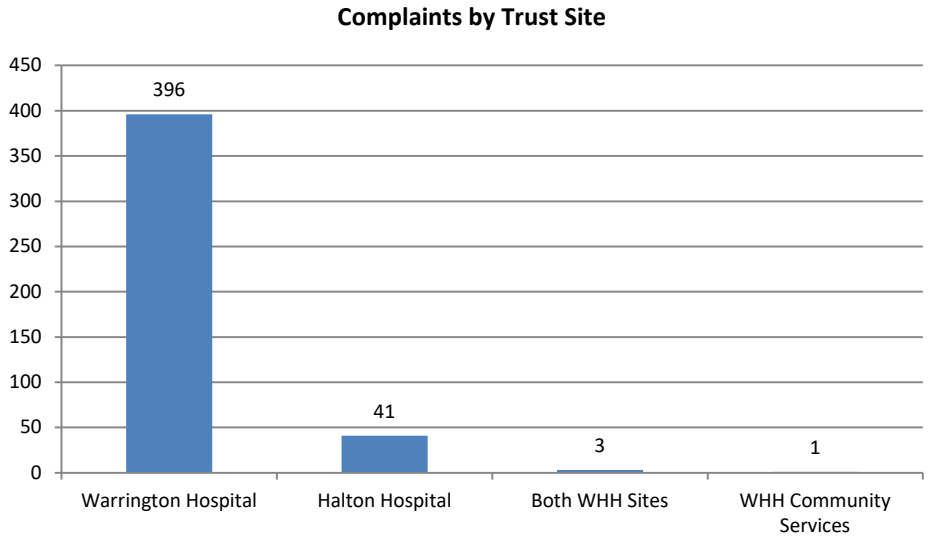
Theme	No.
Clinical treatment	220
Attitude and behaviour	77
Communication (oral)	26
Admissions / transfers / discharge procedure	22
Communication (written)	16
Personal records	16
Premises	13
Date for appointment	11
Patient property / expenses	6
Competence	5
Failure to follow agreed procedures	5
Date of admission / attendance	4
Aids / appliances / equipment	3
Cleanliness / laundry	3
Patient privacy / dignity	3
Patient status	3
Shortage / availability	2
Outpatient and other clinics	2
Test results	1
Catering	1

Policy & commercial decisions of NHS board	1
Transport	1
Total	441

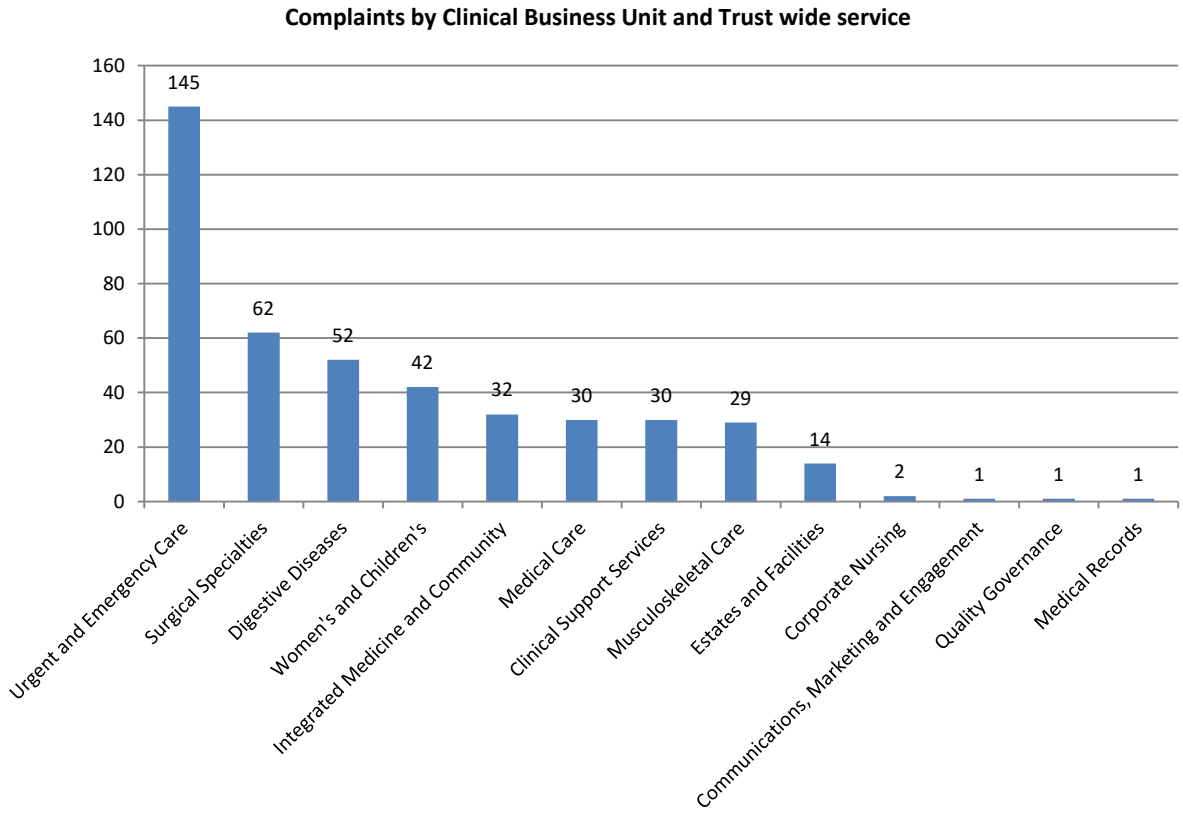
The most common cause for people to complain was that elements of their clinical treatment did not meet their expectations. Attitude and behaviour was also noted in a significant number of complaints. Prior to the covid-19 pandemic plans were in progress for work involving customer service training. This will be relaunched with specific areas of high reporting identified.

2.3 Complaints received by Locations/Service

The graph below details that the Warrington hospital site reported more complaints (396). This is to be expected as it is the larger site with significantly more activity.



The following graph details the 441 complaints received by the Trust in the reporting period by Clinical Business Unit and Trust wide service:



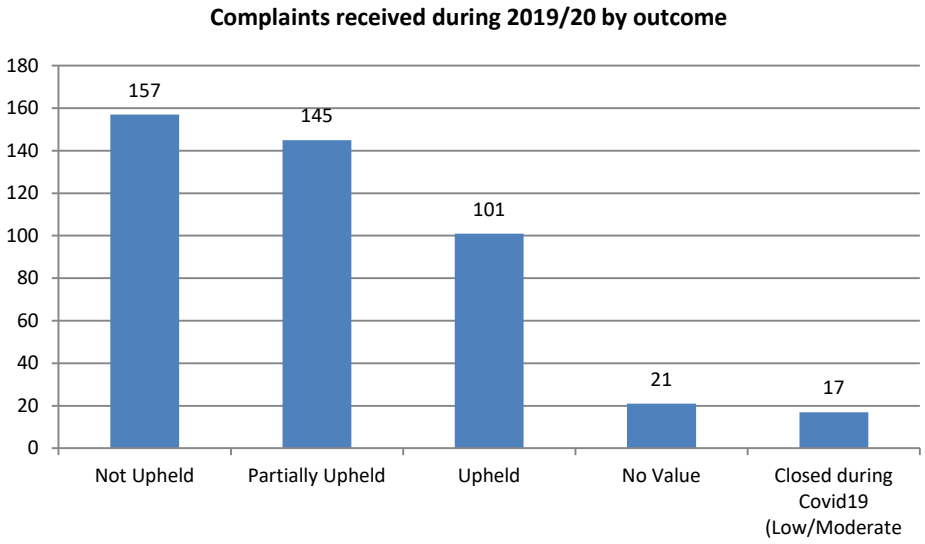
Urgent and Emergency Care received the most complaints followed by Specialist Surgery. This is in line with the pressures seen nationally in the Urgent and Emergency Care Sector.

2.4 Complaints upheld

Once a complaint has concluded (either following a local resolution meeting or once a formal written response has been sent) the outcome will be recorded in line with the findings of the investigation. A complaint will be "upheld", "upheld in part" or "not upheld".

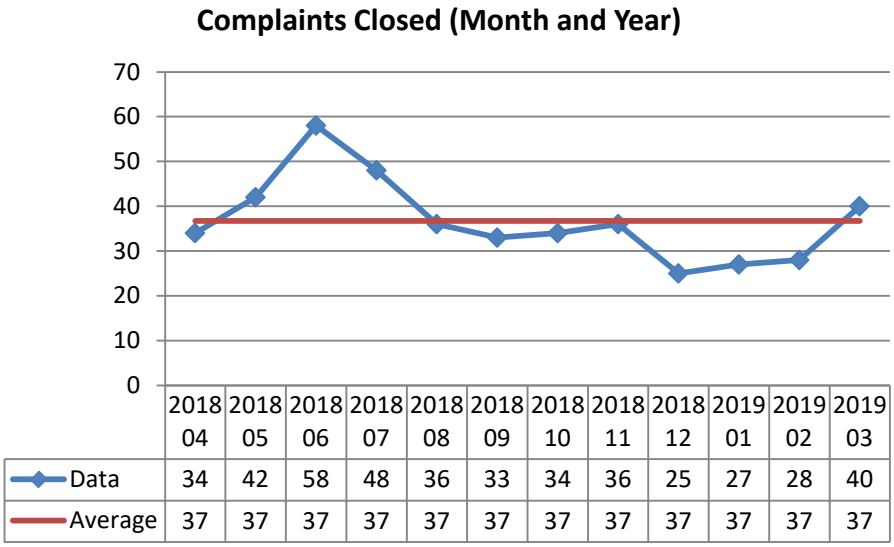
In March 2020 the NHS responded to the Coronavirus (Covid19) pandemic. National guidance was issued advising how to respond to complainants during this period. This resulted in 17 low and moderate complaints being closed.

Those not yet concluded at the time of writing this report, are categorised as "No value". The graph below show the outcome of closed complaint during the reporting period:



2.5 Complaints Resolved

In the reporting period the Trust closed 468 complaints. The graph below shows the closed complaints over time:



	2018 04	2018 05	2018 06	2018 07	2018 08	2018 09	2018 10	2018 11	2018 12	2019 01	2019 02	2019 03
Data	34	42	58	48	36	33	34	36	25	27	28	40
Average	37	37	37	37	37	37	37	37	37	37	37	37

In order to improve the experience of complainants, one of the major initiatives within the Complaints and PALS team has been to improve the timeliness of responses. The following table shows the timeliness of responding to complaints by each CBU in each quarter over the reporting period. This details 29% performance in Quarter 1 which improved to 100% in Quarter 4.

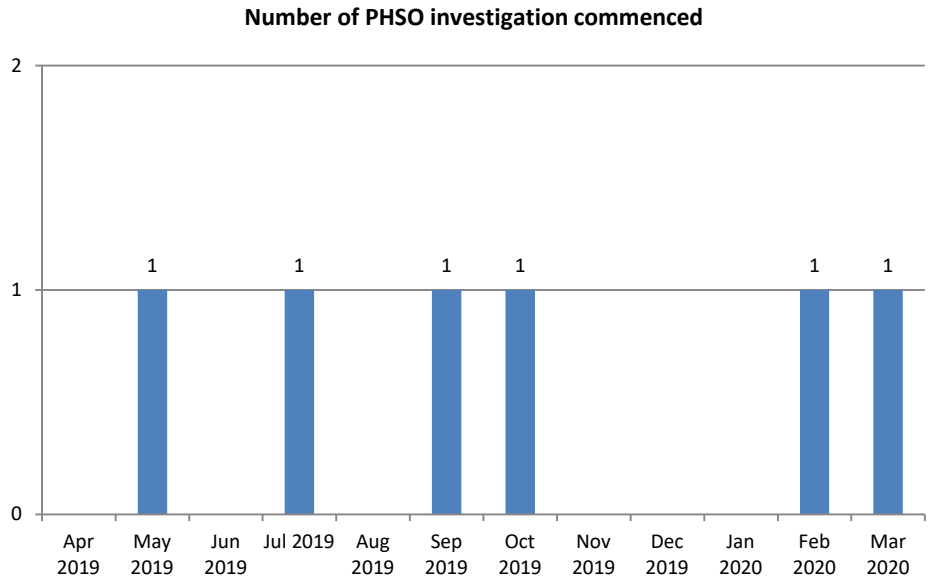
CBU	Number closed in Q1 2019/20	Responded to in time in Q1 2019/20	Performance in Q1 2019/20	Number closed in Q2 2019/20	Responded to in time in Q2 2019/20	Performance in Q2 2019/20	Number closed in Q3 2019/20	Responded to in time in Q3 2019/20	Performance in Q3 2019/20	Number closed in Q4 2019/20	Responded to in time in Q4 2019/20	Performance in Q4 20119/20
Medical Care	14	5	36%	11	6	55%	3	3	100%	5	5	100%
Digestive Diseases	20	2	10%	22	15	68%	13	7	54%	15	15	100%
Urgent & Emergency Care	28	4	14%	38	28	74%	44	28	64%	34	34	100%
Estates & Facilities	4	0	0%	6	6	100%	1	1	100%	4	4	100%
Integrated Governance & Quality	1	1	100%	0	0	0%	0	0	0%	0	0	100%
Clinical Support Services	6	3	50%	15	13	87%	6	6	100%	4	4	100%
IM&T	0	0	0%	0	0	0%	0	0	0%	0	0	100%
Pharmacy	1	0	0%	0	0	0%	0	0	0%	0	0	100%
Corporate Nursing	1	0	0%	2	1	50%	0	0	0%	0	0	100%
Integrated Medicine & Community	9	5	56%	11	7	64%	7	6	86%	9	9	100%
Surgical Specialties	28	11	39%	33	23	70%	26	25	96%	18	18	100%
Women's & Children's	6	3	50%	14	8	57%	16	12	75%	7	7	100%
Medical Records	0	0	0%	0	0	0%	1	1	100%	0	0	100%
Communications, Engagement, Fundraising and Corporate Affairs	0	0	0%	1	1	100%	0	0	0%	0	0	100%
TOTALS AND OVERALL TRUST PERFORMANCE	118	34	29%	153	108	71%	117	89	76%	96	96	100%

2.6 Referrals to Parliamentary Health Service Ombudsman

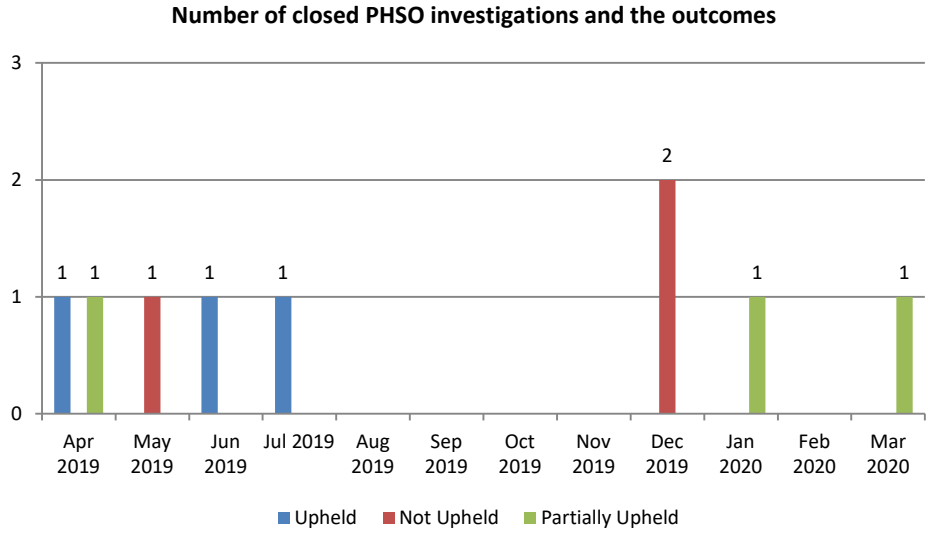
Complainants dissatisfied with the Trust's response have the right to ask the Parliamentary Health Service Ombudsman (PHSO) to consider their complaint. However, the complainant must be able to provide reasons for their continued dissatisfaction (in writing) to the PHSO. The Trust may also refer the 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 following graph shows the amount of investigations the PHSO has commenced at the Trust over the period:



The graph below shows the PHSO grading and outcome following their final report over the period:

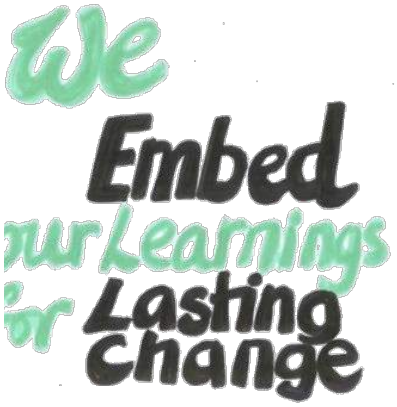


The PHSO has upheld three of the cases closed during this reporting period. Where cases were upheld or partially upheld the Trust acknowledged any failings identified and put in place actions to ensure improvements were completed as a result of the findings.

2.7 Learning from Complaints

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

- Equality awareness – We have worked with the Deafness Resource Centre (DRC) to improve the patient experience for our patients with hearing difficulties. The DRC have provided copies their user guide and these are prominently displayed this within the reception area of the Emergency Department to ensure that staff can easily access this information. Staff have also received additional training in relation to booking interpreters through the DRC.



- Improved communication – A collaborative was created to review our inpatients nutrition and hydration collaborative. As a result a patient safety 'at a glance board' was introduced to provide staff with a visual alert to identify those patients who have additional needs including support at meal times. Meal safety huddles have also been introduced, these take place prior to the meal service and staff on the ward discuss and review the management plan regarding meals for each patient.

- End of life awareness – We have implemented an enhanced Palliative/End of Life Essential Training programme. All staff that work in patient facing roles are required to attend the training sessions. This has improved the standard of care and respect that we provide to our patients and their families at this difficult time.

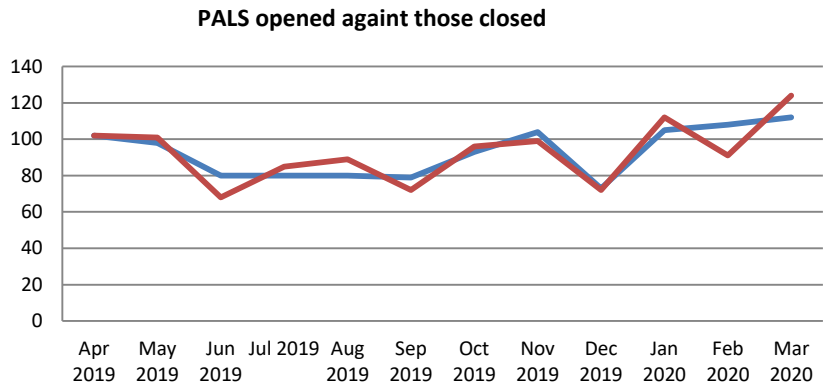
- Listening to concerns – The Women's and Children's Department implemented a teaching forum where staff share the experiences of our patients. This forum has provided an opportunity for staff to learn and improve the standard of care and support we provide in particular to women that have experienced pregnancy loss. Staff have used feedback to enhance their communication skills to listen to concerns raised and ensure information is delivered in a compassionate, clear and consistent manner.

- Reduce waiting times – The Emergency Department have implemented a new process flow chart which set out clear guidance for staff to follow to manage demand within the department. This has helped to ensure patients are seen promptly with clear processes in place for escalation.

2.8 Patient Advice & Liaison Service (PALS)

In the reporting period, PALS received 1114 enquires, which is a decrease from 2018/19 (PALS received a total of 1195 enquiries). The decrease in PALS activity can be due to staff proactively responding to concerns at source on the wards and in clinical areas and resolving concerns without the need for any additional support or advice.

The graph below shows the PALS cases that have been opened against those that have been closed over the year:



	Apr 2019	May 2019	Jun 2019	Jul 2019	Aug 2019	Sep 2019	Oct 2019	Nov 2019	Dec 2019	Jan 2020	Feb 2020	Mar 2020
Opened	102	98	80	80	80	79	93	104	73	105	108	112
Closed	102	101	68	85	89	72	96	99	72	112	91	124

The top 5 themes during this period were:

Clinical treatment	263
Date for appointment	165
Communication (written)	133
Communication (oral)	121
Premises	83

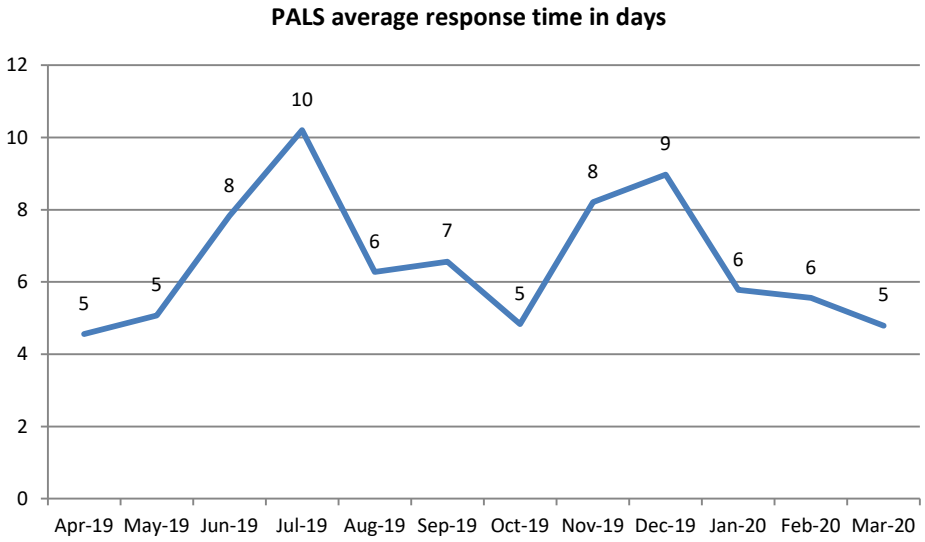
The top 5 reporting Clinical Business Units were:

Surgical Specialties	182
Urgent and Emergency Care	133
Digestive Diseases	128
Women's and Children's	123
Medical Care	117

The most common area for PALS concerns is Surgical Specialties followed by Emergency Care and Digestive Diseases. These 3 areas were all within the top 3 areas for the reporting

of complaints as previously detailed. This has helped the teams to focus on providing additional support and training for these areas.

During the reporting period a total of 1114 PALS were opened and closed. The graph below shows the average response time in days per month.



The Trust will continue to ensure that the PALS team aim to resolve as many concerns as possible in a timely manner, ensuring that patients their families and carers feel listened to.

3. Summary and Next Steps

The Trust set a target, as part of the Trust's Quality Account priorities in 2019/20 to significantly improve the timeliness of complaints responses and meet the Trust's target of 90% by April 2020. As a result of a quality improvement project led by the Head of Complaints, Claims and PALS the responsiveness of complaints has seen an improvement from 29% in Q1 2019/20 to 100% in Q4 2019/20.

During the next financial year, the complaints team will monitor both the timeliness and quality of the complaints responses provided. This will be reported via the Quality Assurance Group. There will be greater focus upon lessons learned not only within specialities but also across the wider organisation. This will be supported by the Head of Complaints, Claims and PALS who will lead a programme of engagement and learning. There will also be significant focus on the PALS service to improve early resolution in order to optimise patient experience.

It is important to note that challenges with attitude and behaviour were identified prior to the onset of COVID19 and work was in progress regarding customer service training. This will be resumed as part of the Trust recovery plans with a focus on specific areas identified through thematic complaints reviews. Appropriate behaviours and communication must be considered an 'always' event to truly offer high quality patient centred care.

4. Recommendations

The Board of Directors are asked to note the report.

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/20/07/76**	
SUBJECT:	**Safeguarding Adult and Children's Annual report**	
DATE OF MEETING:	29 July 2020	
AUTHOR(S):	John Goodenough, Deputy Chief Nurse	
EXECUTIVE DIRECTOR SPONSOR:	Kimberley Salmon-Jamieson, Chief Nurse & Deputy Chief Executive	
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	SO1 We will.. Always put our patients first through high quality, safe care and an excellent patient experience. SO2 We will.. Be the best place to work with a diverse, engaged workforce that is fit for the future. SO3 We will ..Work in partnership to design and provide high quality, financially sustainable services.	
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): **(*Please DELETE as appropriate)***	#1135 Failure to deliver an emergency and elective healthcare service caused by the global pandemic of COVID-19 resulting in major disruption to service provision. #1124 Failure to provide adequate PPE caused by failures within the national supply chain and distribution routes resulting in lack of PPE for staff. #115 Failure to provide adequate staffing levels in some specialities and wards. #134 Financial Sustainability a) Failure to sustain financial viability, #1134 Failure to provide adequate staffing caused by absence relating to COVID-19 resulting in resource challenges and an increase within the temporary staffing domain. #1114 Failure to provide essential, optimised digital services in a timely manner in line with best practice governance and security policies, caused by increasing and competing demands upon finite staffing resources whom lack emerging skillsets, sub-optimal solutions or a successful indefensible cyber-attack, resulting in poor data quality and its effects upon clinical and operational decisions / returns and financial & performance targets, reduced operational efficiencies, denial of patient access to services, inferior quality of care including harm, failure to meet statutory obligations (e.g. Civil Contingency measures) and subsequent reputational damage. #224 Failure to meet the emergency access standard. #125 Failure to maintain an old estate caused by restriction, reduction or unavailability of resources resulting in staff and patient safety issues, increased estates costs and unsuitable accommodation. #145 a. Failure to deliver our strategic vision. #145 b. Failure to fund two new hospitals. #1126 Failure to potentially provide required levels of oxygen for ventilators caused by system constraints resulting in lack of adequate oxygen flow at outlets. #241 Failure to retain medical trainee doctors in some specialties by requiring enhanced GMC monitoring resulting in a risk service disruption and reputation.	
EXECUTIVE SUMMARY *(KEY ISSUES):*	The Annual Safeguarding adult and children's Report contains a review of the information from the year's activity 2019/20. It describes progress of the actions and priorities laid out in the Annual Report 2018/19 along with an overview of the work associated to the Safeguarding Strategy, the strategy priorities are linked to this report. All associated actions and work streams continue to be monitored monthly via the Safeguarding	

	Committee. Assurance is provided to the Quality Committee via a monthly high level briefing paper (HLBP). The Annual Report offers assurance that the Trust is upholding its statutory duties and details that work streams are on track for completion within set timescales.			
PURPOSE: ***(please select as appropriate)***	Information	Approval	To note x	Decision
RECOMMENDATION:				
PREVIOUSLY CONSIDERED BY:	**Committee**	Quality Assurance Committee		
	Agenda Ref.	QAC/20/07/95		
	Date of meeting	7 July 2020		
	Summary of Outcome	Approved		
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	Choose an item.			

We are WHH

NHS Warrington and Halton Hospitals NHS Foundation Trust

Safeguarding Children and Safeguarding Adults Annual Report 2019-2020

Report written by:
John Goodenough, Deputy Chief Nurse and Head of Safeguarding
Contributions from:
Wendy Turner, Lead Named Nurse Safeguarding Adults
Katie Clarke, Lead Named Nurse Safeguarding Children
Jane Lang, Named Dr Adult Safeguarding
Dr Rachel Sutton, Named Dr Children's safeguarding

1. Introduction

This is the second joint Annual Report regarding Adult and Children's Safeguarding within Warrington and Halton Hospitals NHS Foundation Trust (WHHFT). Safeguarding is a Care Quality Commission standard (CQC) and a duty at the centre of our daily business. The scope of Safeguarding is wide reaching and incorporates all categories of abuse.

This report gives assurance to WHHFT Trust Board, the Local Safeguarding Adults Board (LSAB) the Safeguarding Children Partnerships and Warrington Clinical Commissioning Group (CCG) that the Trust is meeting its obligations to safeguard adults, children and is meeting our statutory and legal obligations to keep our patients, service users and staff safe from harm and abuse.

The safeguarding of vulnerable adults' young people and children in the NHS, Accountability and Assurance Framework (updated 2019) sets out the safeguarding roles, duties and responsibilities of all NHS organisations and is integral to the safeguarding work carried out within the Trust. This report provides assurance that the responsibilities of staff in this regard are promoted; making clear that safeguarding is everyone's business and responsibility.
The role of protecting adults at risk is supported nationally by the Care Act 2014. This piece of central government legislation introduced the first statutory and legal framework for protecting adults from abuse, harm and neglect. It formed a single, modern statute that was reviewed in 2016 when the definition explained that the duties to safeguard apply regardless of whether the adult lacks mental capacity.

Local Authorities were charged with forming Local Safeguarding Adults Boards (LSAB) that were responsible for producing policy and guidance that detailed how to keep adults at risk safe. The Trust policies and guidance reflect those of the LSAB and assurance is provided via our contribution to LSAB Annual Report.

In June 2018, Local Safeguarding Children Boards (LSCB's) were abolished by the Children and Social Work Act 2017, which has significantly amended the Children Act 2004; one of the main pieces of legislation on safeguarding children. The changes to legislation have resulted in the replacement of LSCB's with "local safeguarding partners". The new statutory framework requires the three safeguarding partners (local authorities, police and Clinical Commissioning Groups (CCG)) to join forces with relevant agencies, as they consider appropriate, to co-ordinate their safeguarding services; act as a strategic leadership group; and implement local and national learning, including from serious safeguarding incidents. Warrington and Halton partnerships were developed and introduced in 2019; those being the Warrington Safeguarding Partnership (WSP) and Halton Children and Young People Partnership (HCYPP). WHHFT support both partnerships and feed in via various meetings. At this time the arrangements for the Safeguarding Adult Board remain unchanged, however joint Warrington and Halton Adult and Children's Executive and Operational Groups have been formed following the abolishment of the LSCB's.

It is not known how many children in the UK are victims of child abuse. Child abuse is usually hidden from view and children may be too young, too scared or too ashamed to tell anyone about what is happening to them, (NSPCC 2017). The most recent statistic from 2016 suggests there are over 58,000 children identified as needing protection from abuse in the UK and it is estimated that for every child identified as needing protection from abuse, another 8 are suffering abuse. The Department for Education is responsible for child protection in England. It sets out policy, legislation and statutory guidance on how the child protection system should work.

At the local level, LSAB and Safeguarding Partnerships co-ordinate and ensure the effectiveness of work to protect and promote the welfare of adults young people and children. Each local board of partnership includes: local authorities, health bodies, the police and others, including the voluntary and independent sectors. The LSAB's and LSCBs are responsible for local adult and child protection policy, procedure and training. All Warrington and Halton Hospitals NHS Foundation Trust employees must be aware of their shared responsibility to safeguard adults, young people and children. This may be when the adult, child or young person is a patient themselves, an unborn, a visitor, a patient's child or presenting to an adult service.

The Trust aims to be proactive in fulfilling its safeguarding function. Effective safeguarding requires robust recruitment and vetting processes for staff and, enough well trained competent staff to identify potential safeguarding situations to enable services to be provided while the adult (under the care act), child or young person is 'in need' (under Section 17 of the Children act, 1989) or at 'Family support' level (known as early help) ideally before the child becomes a 'Child at Risk' (under section 47 of the Children Act). The Care Act instructs partner agencies to engage closely with adult victims to establish their needs and what they want to happen. There is an expectation that provider agencies should produce for their staff a set of internal guidelines which relate clearly to the Safeguarding Boards Multiagency Policy, which sets out the responsibilities of all staff to operate within it.

WHHFT has a responsibility to ensure it is able to discharge its statutory safeguarding duties and that its employees understand their joint responsibility in ensuring adults, young people and children are supported. Our organisation is obliged to adopt and support the practice described above. We achieve this by ensuring our own policies and procedures reflect those of our LSAB's and Safeguarding Partnerships and by adhering to our statutory and regulatory responsibilities. Assurance of adult and Children's safeguarding activity and practice is reported via the joint Safeguarding Committee to the Trust Quality Assurance Committee (QAC), a subcommittee of the Trust Board.

Mental Health (MH) was added to the safeguarding portfolio in June 2019, the safeguarding team have embraced this new element of their role, adopting national and local recommendations and working with North West Boroughs (NWB) via a service level agreement (SLA) to implement improved pathways for MH sections and patient care. Hill Dickinson and NWB have supported MH training for Trust teams and further work is underway to develop a MH Strategy and improve MH policies and training programs.

It should be noted that this report is written as we find ourselves in the midst of the Corona Virus Pandemic, the full impact of the pandemic is not known at this time however we are aware that a significant spike in safeguarding cases is expected following victims having been confined to their homes with perpetrators of abuse across the spectrum of known abuse categories and due to people not having access to their usual support network. We envisage that Mental Health, Domestic Abuse and Self Neglect are going to become areas of focus for safeguarding as we emerge from this lock down. The Safeguarding Team supported by their Executive Lead have a recovery plan to support the Trust in maintaining its statutory safeguarding duties and to ensure we are able to meet the demand of this approaching challenge. The plan includes increasing the establishment of the team, a dedicated training post and a review of job descriptions. The progress of this work will be monitored via Safeguarding and Quality Committees and will be detailed in the bi-annual report November 2020.

2. Summary

- Activity continues to increase across all areas of safeguarding as does the national picture; this is expected to significantly increase post COVID-19 lock down. An increase in highly complex cases involving vulnerable children, young people, adults, elderly patients and unborn children, is expected
- WHHFT have been the lead for the ICON programme across pan-Cheshire. Successfully launch held 17th July 2019 this will be explored further within this report
- Safeguarding training remains a priority face to face sessions in socially distanced rooms continued toward the end of the reporting period
- The safeguarding teams have undertaken a significant number of in house and multi-agency case reviews in the last year. Any actions arising from the case reviews have been monitored and tracked through the Safeguarding Committee
- Safeguarding of children and adults continues to be a priority for the Trust at both a national and local level, the detail of this activity will be described later in this report
- WHHFT have supported with an increased number of fabricated Induced Illness cases
- Allegations against staff referrals to the Local Authority Designated Officer (LADO) and Adult Social Care continue to increase resulting in increased internal investigations, monthly updates of these are shared with the Trust Triangulation meeting
- The safeguarding teams have undertaken a significant number of in house and multi-agency case reviews in the last year. Any actions arising from the case reviews have been monitored and tracked through the Safeguarding Committee
- Safeguarding of children and adults continues to be a priority for the Trust at both a national and local level, the detail of this activity will be described later in this report
- The teams have supported national awareness events throughout the year including;

  - Domestic Abuse
  - Elder Abuse Day
- Audit has led to improved safeguarding processes to support staff in their practice
- Amended policies and documents have improved staff safeguarding practice
- Assurance is provided via monthly and quarterly reporting to Safeguarding Committee, Quality Assurance Committee, Safeguarding Partnerships and Safeguarding Adult Board, Clinical Commissioning Group (CCG) and NHS England
- Internal safeguarding pathways and processes have been reviewed and updated to strengthen existing work
- Improved compliance against national guidance across the whole safeguarding portfolio
- Safeguarding strategy work plan continues to develop
- Safeguarding training plan continues to be reviewed and updated
- Work underway to develop Learning Disability (LD)
- Work underway to develop Mental Health (MH) strategies
- The Trust continues to support the National LD improvements Standards bench marking audit, an action plan has been written to support this work and will be driven with the support of the members of the newly formed LD steering group

Focus for the coming year

At the time of writing the report there is a national pandemic COVID-19 and the UK are currently in lockdown. It is unknown that safeguarding issues will surge as the national lockdown ends, however, national and local data along with safeguarding theory from the toxic-trio (mental health, substance misuse and domestic abuse), troubled families, think family, contextual safeguarding, trauma informed practice and strength based approaches informs that in exiting the COVID-19 acute phase, the safeguarding surge & recovery will only just be beginning and is predicted to last a number of years. The surge in patients living alone with mental health conditions, who are practicing substance misuse and self-harm, is also unknown. When considering the detrimental factors of a period of isolation on the mental health of the population nationally as well as locally, it is evident that people will begin to access services at an increased rate following a change in the lock-down conditions, therefore placing further demand on the current resource. The focus for the coming year will involve developing a safeguarding recovery plan and preparing for what is about to be a difficult few years. An update on the recovery plan will be provided in the 2020/2021 biannual report.

In addition to the recovery plan WHHFT will also focus on:

- MH strategy and to review existing mental health pathway and explore ways in which these can be strengthened

- Further development and review of the Safeguarding Strategy in line with post COVID-19 activity and priorities
- Embed ICON across WHHFT
- Review and strengthen mental health pathways within child health and Adults
- To move towards implementation of Liberty Protection Safeguards (LPS)
- Continued implementation of National Learning Disability (LD) improvement guidance via the LD Steering Group and Strategy
- To support the LSAB, WSP and HSCYPP priorities for Warrington and Halton
- Continue to raise awareness of Child Criminal Exploitation (CCE)

3. Update on objectives set for 2019 – 2020

The Trust's objectives for 2019-2020 were to discharge its safeguarding duties effectively based on the delivery of seven key priority outcomes that were aligned to the shared priorities detailed below (Figure 1). The 2019-2021 Safeguarding Strategy demonstrates how each of these priorities is to be addressed. The associated safeguarding strategy work plan is reviewed and updated on a monthly basis and progress is reported via the Safeguarding Committee. Each objective is explored further within the report with supporting evidence embedded throughout. All priorities are on target for completion in 2021.

Figure1

No.	Priorities	Target Date	Current position
1	**Domestic Abuse** 1. To raise awareness to enable staff to identify domestic abuse and what their responsibilities are 2. To ensure the learning from the 2018 DHR is shared with regards to coercive and controlling behaviour 3. To support our Occupational Health and HR departments where domestic abuse victims/perpetrator involved staff	Feb 2021 DHR completed September 2019	**On target for completion.**

		Feb 2021	
2	**MCA DoLS (LiPS)** 1. To continue to train staff with regards to their responsibilities of their MCA practice 2. To plan and monitor training with regard to the new LiPS process 3. To work towards roll out of LiPS	October 2020	**On target for completion.**
3	**Child Sexual Exploitation** 1. To raise awareness through masterclass training 2. To help staff to understand all elements of CSE including the criminal aspects of this abuse 3. To support staff in recognising and reporting this abuse HSAB priorities and actions to be added then circulate for comment before final sign off.	Feb 2021	**On target for completion.**
4	**Neglect** 1. This element of Safeguarding includes neglect of adults at risk and children it also includes self-neglect 2. To raise awareness of above issues amongst Trust staff and to provide education to enable them to recognise and report neglect of all types 3. To raise awareness of the self-neglect assessment tool 4. To raise awareness of processes that support child neglect	Feb 2021	**On target for completion.**
5	**Learning Disabilities** 1. To promote flagging of inpatients and outpatients by staff creating alerts in Lorenzo where	Feb 2021	**On target for completion.**

	required 2. To continue to support the learning disability improvements programme 3. Upon the appointment of the new Safeguarding Adults team member, to further support the learning disability agenda across the agenda		
6	**Early Help** 1. To raise awareness across the organisation of staff responsibility to offer early help to families in need in paediatric and adult settings 2. To ensure that staff in inpatient and outpatient areas are aware of this important support for families	Feb 2021	**On target for completion.**
7	**Modern Slavery/Trafficking** 1. To provide training to raise awareness of modern slavery and human trafficking issues in relation to children and adults at risk 2. To raise awareness of county lines via training 3. To support staff in recognising and reporting modern slavery and trafficking 4. To work with our procurement teams to gain assurance that our business is conducted with businesses that observe the modern slavery act 2015	Feb 2021	**On target for completion.**

In addition to the Safeguarding Strategy priorities, the below table (figure 2) provides an update on the objectives set in the 2018-2019 annual report that were further reported on in the 2018-2019 bi-annual report. Information to support the outcome of the objectives is demonstrated throughout the 2019-2020 Annual Report. In addition the objectives for the coming 2020-2021 reporting period are laid out here

Key

	Objective achieved
	Objective on target for completion with actions in place to address any exceptions

Figure 2

Safeguarding Children and Adults Objectives set for 2019 - 2020	Outcome
• Launch the Trusts Safeguarding Strategy in September 2019	The strategy was launched and is reviewed regularly at the Safeguarding Committee
• Continue to maintain compliance with safeguarding training across all levels	Training continues to be delivered to trust staff by a variety of ways: - In-house face to face training - External training available - E-learning training available.
• Further develop and strengthen the mental health pathways within the Trust	Initial meeting with North West Borough has been held to review current pathways. Work continues to further develop the existing pathways.
• Raise awareness of criminal exploitation, understanding the activity across the area and how agencies can raise awareness and support our young people	Monthly masterclasses delivered across the trust. The number of pre-screening tools completed has increased by 100% (27 to 54 tools). Not all of these cases required referral to the local Missing Children, Sexual Exploitation Operation (MCSETO) meeting however this increase demonstrates that front line professionals are considering child exploitation when young people attend and display specific triggers.

• Raise awareness of self-neglect	The face to face safeguarding training contains information letting staff know how to identify and support patients who self-neglect. The self-neglect risk assessment tool is used to support patients in planning their discharge.
• To increase knowledge in readiness for Liberty Protection Safeguards	Weekly master classes have been delivered between November 2019 and February 2020. The government were to publish guidance in the form of a code of practice and regulations that were to support the implementation of LPS by Spring 2020. The guidance is expected to advise regarding training, documentation processes, roles and establishments. The publications are currently awaited, without this information agencies are unable to proceed with implementation plans. The go live date is 1/10/20 the government have not issued guidance to inform agencies if this will change.
• National Learning Disability improvement standards	The National Improvement standards bench marking exercise second year review has been completed. The Trust has an action plan to follow that is monitored via the Safeguarding Committee. There are now plans for an LD steering group that will progress this action plan, the group will provide assurance to Safeguarding Committee.
• To increase knowledge in relation to county lines and trafficking	Specialised training brought in to the trust was well attended. Single point lessons have been shared.

4. Activity for the year

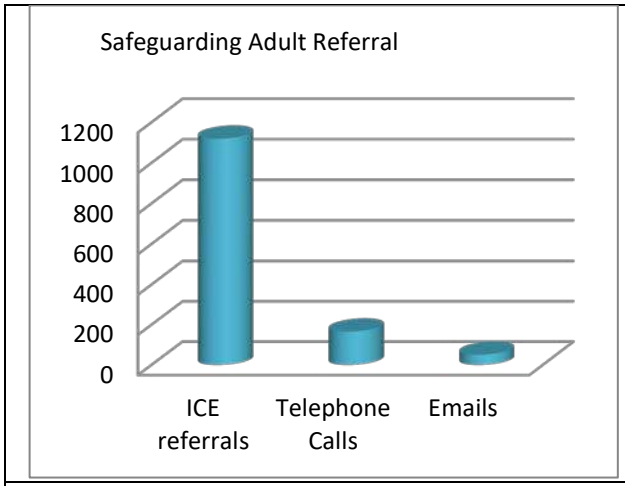
4.1 The Safeguarding teams receive information and requests via a number of routes. Electronic notifications are received to request advice and support and also to share vital information. In 2019/2020 the number of ICE requests has gradually increased. Each ICE notification is reviewed and actioned by a safeguarding practitioner. Notifications are also received by telephone the below table (Figure 3) demonstrates the activity year upon year and the overall increase over a two year period. Additional activity is demonstrated within the remainder of the report.

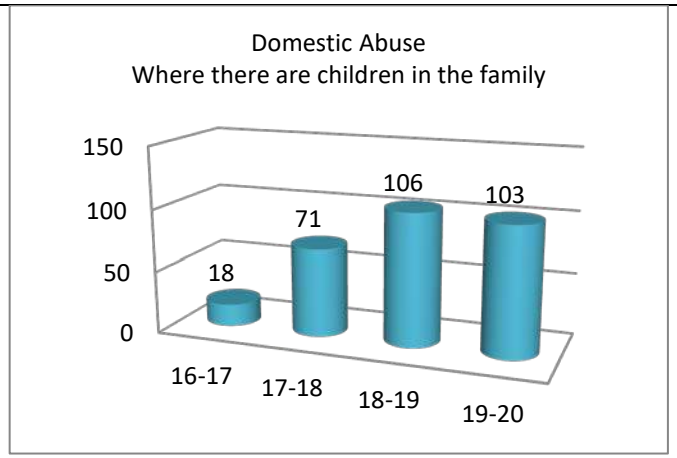
Figure 3

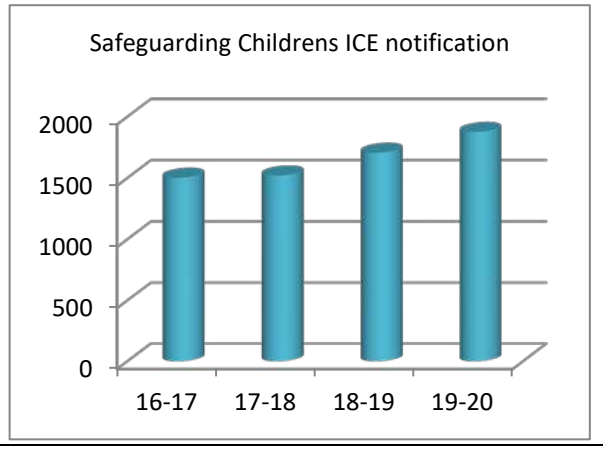
ICE notifications	Adult	Children's	Maternity	Domestic abuse (children in the family)	Domestic abuse adult only cases	Learning Disability in-patients	In-patient and outpatient Flagged Learning Disability Patients	Prevent
2016/2017	343	1502	795	126	18	6	0	0
2017/2018	696	1520	765	108	71	20	178	0
2018/2019	922	1706	955	135	106	79	175	4 cases
2019/2020	1336	1876	846	103	116	242	1433	0
% change 18/19 to 19/20	↑50%	↑10%	↓11%	↓23%	↑10%	↑206%	↑718%	↓100%

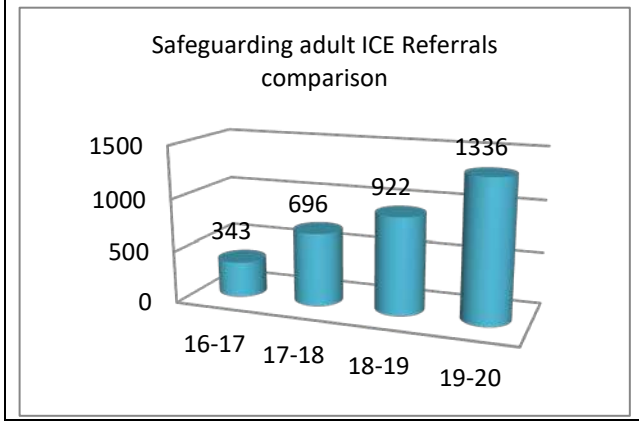
The above table has not previously included the number of telephone, email or face to face contacts and requests for safeguarding support that the adult team receive, from this year this information is now included . The above information is demonstrated in the graphs below (Figure 4)

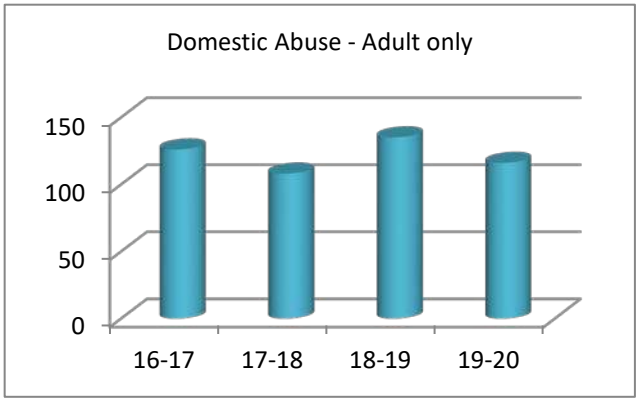
Figure 4

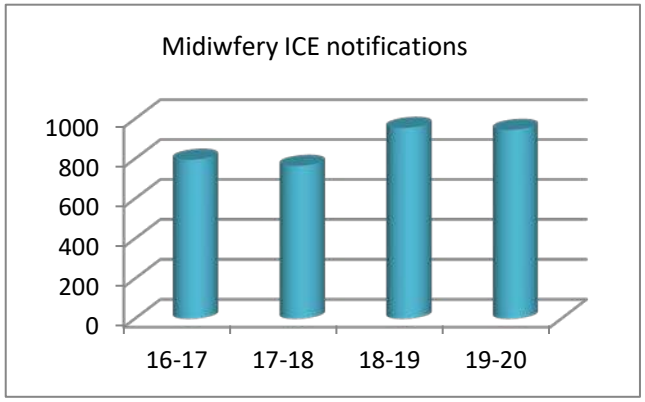












The numbers of patients, who have been flagged to us as in-patients, often have lengths of stay of more than one day, the in-patient data below demonstrates how many encounter via A/E or outpatients as well as becoming in-patients; the data below explains this activity

Outpatient Appointments for Patients with Learning Disabilities between 01/04/2019 to 31/03/2020

Month	Appointments
April	107
May	121
June	109
July	129
August	99
September	94
October	90
November	86
December	82
February	83
January	89
March	102
Grand Total	**1191**

Inpatient Admissions for Patients with Learning Disabilities between 01/04/2019 to 31/03/2020

Month	Admissions
April	21
May	15
June	16
July	26
August	18
September	22
October	13
November	17
December	22
January	21
February	24
March	27
Grand Total	**242**

5. Safeguarding training

Training	Safeguarding Children	Safeguarding Children	Safeguarding Children	Safeguarding Adults Level	Safeguarding Adults Level	Safeguarding Adults Level	Mental Capacit	DoLS	PREVENT 1&2	PREVENT 3&4 WRAP

	Level 1	Level 2	Level 3	1	2	3	y Act			
End of year compliance	91% ↓5%	86% ↓6%	90% ↓2%	92% ↓4%	74% ↓16%	86% This training data was not available year end 17/18	82% ↓16%	83% ↓3%	94% ↓1%	92% ↓1%

Safeguarding training compliance is an important indicator of the ability of staff to act on safeguarding concerns. In order to fulfil these responsibilities all professionals and their teams should have access to and engage in training commensurate to their role and level of responsibility. This will enable the trust to fulfil their safeguarding, LD, MH and MCA obligations and duties. WHHFT is committed to delivering a high quality inter-agency training programme, which supports professionals and volunteers in their work to safeguard and promote the welfare of adults, children and young people.

In February 2019 a revised and updated intercollegiate document (ICD) was published. A training needs analysis was written to align the roles and competencies of Trust roles to the new guidance. The recent publication of this document has aligned safeguarding training requirements across 5 levels on a national level 50% eLearning and 50% face to face training should be renewed every three years. All providers of health care now have the same guidance to follow ensuring that all staff are aligned to a competency level for their role, receiving appropriate training to support their practice. This document will be reviewed in 2021 by which time it is expected that all providers will have implemented the guidance. However extended national discussion and challenge from Designated Nurses regarding a level 3 eLearning package and concise guidance regarding exactly what face to face training consisted of, has delayed this element of the ICD, therefore WHH has been unable to record complete compliance in the absence of an eLearning package. An eLearning package has recently been circulated and WHH is now working with the CCG and local partners to develop a face to face program, the CCG have explained that they are not expecting providers to reach full compliance at this level by August 2021.

The Children's Intercollegiate Document was updated in 2019; no changes were made in relation to the levels however the content of the training required was updated.

The safeguarding training programmes are reviewed in real time following learning from case reviews and hospital incidents along with national guidance updates on an annual basis training is developed in line with both Intercollegiate Documents alongside local and national learning.

In addition to the level 1, 2 & 3 Children's Intercollegiate Document training, the safeguarding team updated and delivered specific training sessions in 2019/2020 which covered the following topics:

Children's training

- Child Sexual Exploitation
- Domestic Abuse
- The impact of domestic abuse on children
- Impact of neglect on children
- Learning from serious case reviews
- Physical harm
- Child criminal exploitation

During this reporting year the Trust has maintained the required mandatory eLearning and face to face training of level one and two adult safeguarding with the adult team delivering weekly level 1 and 2 training sessions. In addition the safeguarding adult team have delivered training that covered the following topics:

Adults Training

- Bi-weekly Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS)
- Monthly Prevent and Workshop to Raise Awareness of Prevent (WRAP)
- Bi-weekly Learning Disabilities
- In addition to the day time training program, Safeguarding Level 2 has been delivered outside of core business hours
- Additional out of hours Safeguarding Level one to specific groups who could not access eLearning
- Modern slavery and trafficking
- Safeguarding master classes for senior nurses
- Weekly LPS master classes
- Ward based focused training has been delivered in response to incidents as and when required
- Safeguarding remains part of the junior doctors induction training and essential Drs training
- Grand round MCA/DoLS and LD training has taken place

External partners training sessions delivered at WHH:

- Urban pure solutions; Knife crime, criminal exploitation, county lines and safeguarding
- LA MCA/DoLS lead and Advocacy lead; advocacy service, care and mental capacity act advocates and the MCA/DoLS
- NWB Learning Disability Specialist nurse; learning disability and autism training

- Hill Dickinson MCA, DoLS and MH

Following a change announced in 2019 Prevent training is no longer reported via the home office and prevent trainers are no longer required to register with the home office. Instead, prevent activity and compliance is reported quarterly via NHS digital. The Trust is still required to have a Prevent lead and to deliver both face to face Wrap and Prevent training updates time it was expected that all providers will have implemented and become compliant with the

6. Learning and improving

6.1 Safeguarding Reviews

6.1.1 Safeguarding Children Serious Case Review (SCR)

When a child dies, or is seriously harmed, as a result of abuse or neglect, a case review is conducted to identify ways that local professionals and organisations can improve the way they work together to safeguard children. WHHFT have been involved with two multi-agency case reviews. The published findings of both reviews are still awaited however it is noted that there were no actions requiring an immediate response from WHHFT. Both reports are expected to be published by August 2020 and therefore further information will be provided in the bi-annual report.

6.1.2 Safeguarding Adult Reviews (SARS) Domestic Homicide Reviews (DHR)

Figure 5 provides an update of the Safeguarding Adult Reviews

Figure 5

SAR	Brief description	Responsible body	Action required	Progress of action
SAR G detailed in 2018/29 report	An elderly man who was caring for his wife attempted to kill her. Following intense review it was discovered his wife was	LA	Learning from a carer crisis, (the domestic abuse element was found a year after the review was completed)	The actions assigned to WHH regarding supporting staff to recognise carer crisis has been completed, the safeguarding team promote awareness of carer crisis in training and during ward discussions

	a perpetrator of domestic abuse			
SAR F Warrington detailed in 2018/19 report	This SAR was regarding a young lady who took her own life whilst in the care of a local private Mental Health provider, she had been placed out of area and had attended our A/E on a number of occasions	This case is currently still under review and remains with the Safeguarding Adult Board whilst work is completed. Local partner agencies are supporting this work	The likely actions for the Trust are going to be about communication between partner agencies and out of area partners	Once the review is completed actions will aligned to agencies, there has been a delay due to leads leaving post and replacements being difficult to find, this was followed by a re-organisation of depts. at the LA
DHR Warrington detailed in 2018/19 report	This case was regarding a young lady who was violently killed by her partner, during a domestically abusive relationship. The victim had attended our A/E on a number of occasions, the perpetrator had attended once. There was a wide ranging partner agency involvement	Community Safety Partnership	All agencies involved were responsible for their own actions via a master action plan this was monitored via Safeguarding Committee. Actions for the Trust centred on record keeping and communication of information about care and treatment. It was also identified that staff required training with regard to recognising coercive and controlling behaviour.	The Trust Safeguarding Adult team were sighted in the report for their good practice with regard to domestic abuse management; all actions from this DHR are now completed and closed.
DHR in progress	This review is regarding a lady with a diagnosis of autism who had a daughter.	Community Safety Partnership	This case is still under review and actions are	It is recognised that there were no domestic abuse clues for agencies to foresee, and it is

	The husband was seen as supportive and caring for his family and was seen in a positive light by our Trust in his attendance to support clinic appointments for his wife and daughter, there were no suspicions of domestic abuse. The Trust had a number of contacts with the victim the last being an extremely difficult cancer fast track situation in which the victim attempted to self-harm and threatened her husband it transpired that the victim was self-harming at home when her daughter was present. Her husband admitted killing her some time later.		awaited once the report has been accepted by the home office. It is likely that agencies will be challenged regarding recognition of a child in need of protection in light of the awareness of the victims autism, self-harm and MH needs and the arrangements that were required to support the child not always being in place	recognised that the adult safeguarding team offered excellent MH support.

6.2 Positive Feedback

It is important to reflect and share the learning from recognised good practice. Some examples of good practice recognised this year:

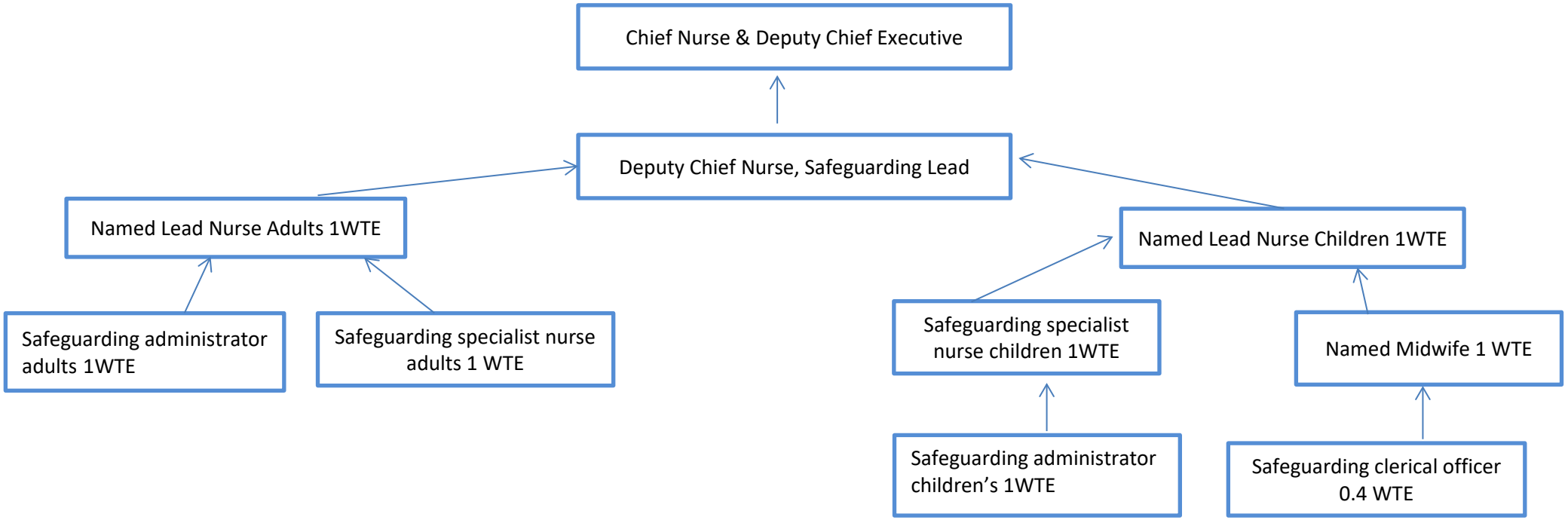
- CQC 2019 inspection was positive with regard to all aspects of safeguarding. There were no concerns regarding MCA following the regulatory breaches that were raised in the 2016 inspection
- County lines and safeguarding training morning delivered by Urban Solutions was well received with enthusiastic and positive feed back

- ICON – The Chief Nurse Kimberley Salmon-Jamieson, with the support of the Lead Nurse Safeguarding Children successfully launched the Icon programme across the pan-Cheshire footprint
- Domestic abuse case – adult safeguarding team
- Staff domestic abuse case was heavily supported by the adult safeguarding team, security and department managers
- Named Midwife highly commended for delivery of external training by head of service for Early Help, Warrington Local Authority
- Adult safeguarding specialist nurse highly commended for her delivery of mandatory safeguarding training
- The CCG and advocacy have recognised the efforts of the safeguarding adult team in their support of the LD agenda
- The Deputy Chief Nurse CCG has written the Chief and Deputy Chief Nurse WHH to express thanks for the work of the safeguarding Adult Team as the Pandemic began in February/March 2020
- The CCG have thanked the Named Dr and Lead Named Nurse for their work in supporting the LeDeR agenda
- A number of behaviour badges have been awarded to adult team members in recognition of their safeguarding work
- Trust Solicitors Hill Dickinson have recognised the work of Lead Named Nurse Adult Safeguarding in supporting Court of Protection cases on behalf of the Trust

6.3 Internal and Multi-Agency note audits

The safeguarding teams continue to support the Safeguarding Partnerships and LSABs (Warrington and Halton) as contributors to the audit and/or auditors for multi-agency case file audits. WHHFT supported 1 audit for the HCYSP based on child exploitation (4 cases) and one for WSP focusing on early help (12 cases). There were no immediate actions for WHHFT to complete. Findings from the audits were share with partner agencies which are shared internally via the Safeguarding Committee.

7. Safeguarding Team



It has been recognised by the Trust that safeguarding cases are increasing and becoming increasingly complex. The portfolio continues to expand with MCA/DoLS, Prevent, LD and MH having been added to this portfolio from 2016 to the present day. Following the successful completion of a business case the Trust has appointed an additional Specialist Nurse Safeguarding Adults taking the adult staff to 2 specialist nurses. A further business case is in progress to further review the adult and children's safeguarding specialist nurse establishment.

8. Inspections

The Safeguarding Bi-annual report 2019/2020 detailed inspections that the trust has been part of. Since the bi-annual report there have been no further inspections. There are no outstanding actions to report on.

9. Safeguarding Agenda

In addition to the robust reporting arrangements and governance structures, WHHFT actively support the Safeguarding Boards (Warrington and Halton) priorities and work plans. These priorities were due to be shared however due to COVID-19 this has been delayed and will be reported on within the Bi-Annual Report.

10. Safeguarding Strategy

The Trusts Safeguarding Strategy was completed in 2018/2019 and is due for review 2021. The Strategy sets out the safeguarding priorities for Warrington and Halton Hospitals NHS Foundation Trust (WHHFT). The Strategy demonstrates the significant role that WHHFT has to play in educating and supporting Trust staff to recognise and report suspected harm and abuse. We are committed to continually evaluating and improving our standards of safeguarding expertise and knowledge across the organisation and our ambition is that this Safeguarding Strategy will be embraced by all WHHFT Trust staff. The Strategy aims to empower our Safeguarding Team and all WHHFT Trust staff to ensure their voice is heard in relation to our Trust's vision, objectives, and values. Our strategy reflects the planned work of the safeguarding board's work that we support.

11. Internal Safeguarding Audits

In addition to the multi-agency notes, section 11 audits and Mersey Internal Audit the Trust safeguarding teams have undertaken a number of internal audits. The audits completed covered the topics:

- Domestic abuse within maternity
- Child Protection Information Sharing System
- Child protection medicals

Page 39 of 203

- Trust wide Learning Disability
- Trust Wide MCA / DoLS Bi-annual audits
- National Learning Disability Improvement Standards Audit
- Contribution to the DNACPR audit
- Quarterly report on progress of training action related to MIAA safeguarding audit continues, the report is required due to the level 3 element of the ICD recommendations awaiting national guidance the report will be needed until completion of the action can be confirmed

The findings, learning and recommendations from each audit have been shared via Safeguarding Committee and monitored until completion.

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

12.1 Mental Capacity Act (MCA)

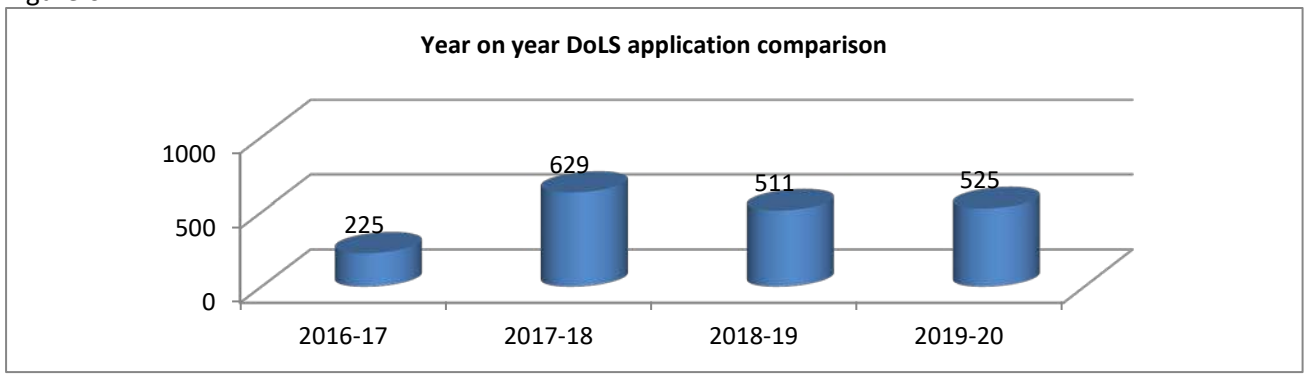
There has been much activity across the organisation in ensuring that we are improving our MCA compliance and knowledge. As described above increased access to training and practice support is in place and regular audit happens to provide assurance with regard the Trust's compliance and improvement in MCA practice. This has been supported by the Trust solicitors in their provision of MCA training. All staff are required to conduct capacity assessments in cases where a patients' capacity for a specific decision is in doubt; in line with Trust policy and national guidance and law staff must make an assessment of their patients' capacity. Following the completion of the assessment a copy of the document is received by the Adult Safeguarding Team for audit for compliance. It is evident via robust audit and monitoring that compliance with this element of MCA practice is improving. Staff have developed a greater awareness of their responsibilities with regard to ensuring patients best interests are protected.

During this reporting year the Adult Safeguarding Team, of which the Named Lead Nurse leads on MCA/DoLS, have supported the Trust with 525 DoLS applications this is a slight increase on the previous year which recorded 511 applications. The activity associated with this support is significant as each application is recorded and monitored via the DoLS Safeguarding data base. This entails liaison with the Local Authority responsible for the authorisation of the DoLS application to ensure that they and we have the same information and that all applications are captured. Each application is notified to the CQC in line with MCA statutory guidance. The notification includes visiting wards to obtain information regarding the care plan associated with the DoLS, the adult team call wards frequently to ensure staff are supported in caring for patients under DoLS.

The Lead Named Nurse has supported the Trust with two Court of Protection Cases since the least Annual Report; these are significant pieces of work that require many hours of concentrated work and preparation of court statements and papers.

The following graph demonstrates the above detail relating to the number of DoLS applied for at WHH along with comparison to previous years.

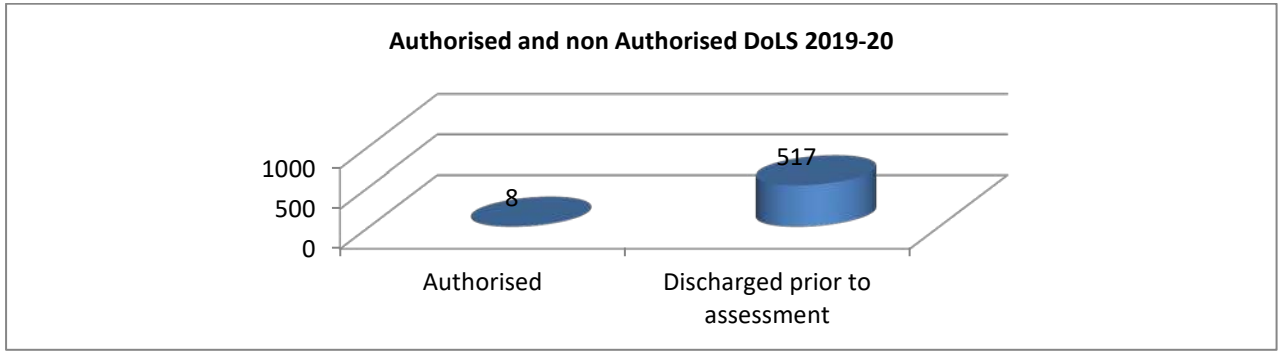
Figure 6



The data associated with 2017-18 was post CQC inspection, this sharp increase in applications included DoLS that were put in place in situations where the management of the patient under the MCA was more appropriate, the patients did not necessarily require DoLS as they were detoxifying, suffering confusion secondary to infection that responded quickly to treatment or where end of life. As the training program reached more and more staff, we observed that staff were taking a more balanced view of decisions relating to MCA / DoLS choices and care management.

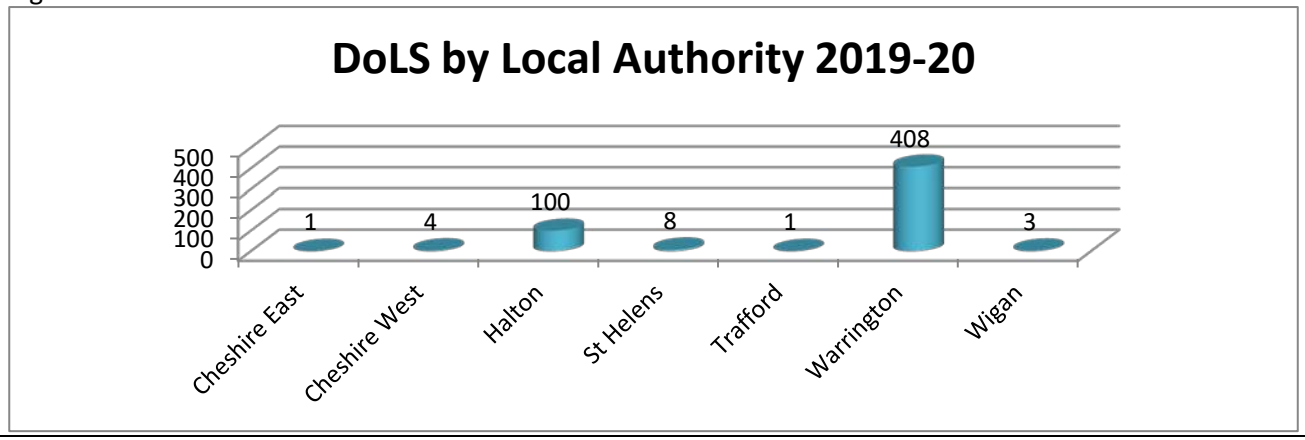
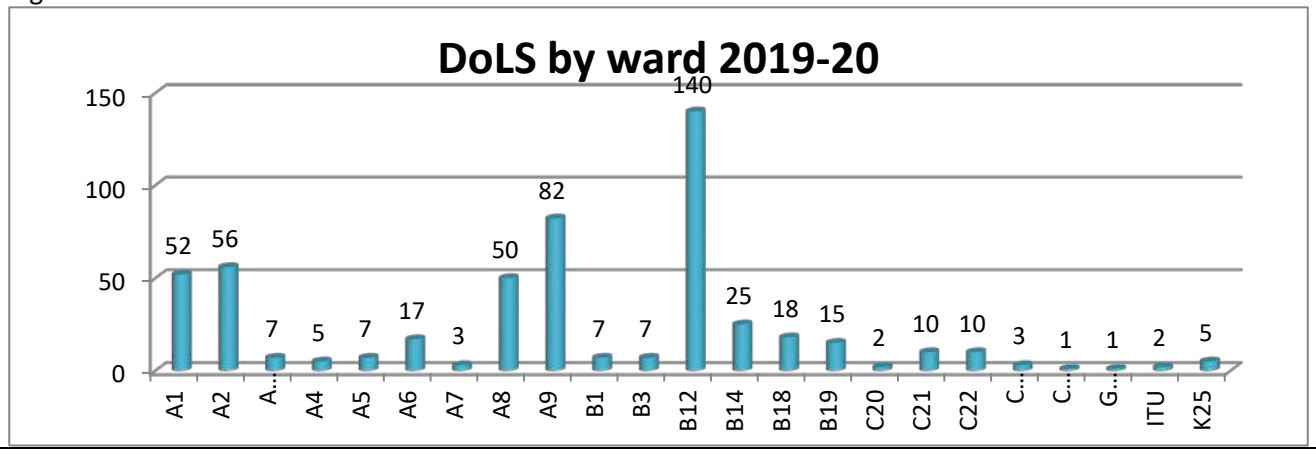
The local authority (LA) is the responsible body for authorisation of DoLS applications. Due to resource issues our Warrington and Halton Local authorities operate with a significant back log of applications. This is a national issue and one of the driving factors in the review of the DoLS act which has resulted in the new Liberty Protection Safeguards (LPS). Of the 525 applications described above, 8 were authorised.

Figure 7



Following the last Annual Report arrangements have been put into place to allow DoLS applications to be electronically completed and emailed to the relevant LA. The Safeguarding Team are copied in to the emails ensuring we are aware of the detail and conditions relating to the application. All standard DoLS documents are emailed back from the LA via the Adult Safeguarding Team where they are reviewed and then discussed with the receiving ward to ensure that the restrictions become a part of the patients' care plan. Due to their resources not allowing them to apply a standard to all applications, the Local Authority continue to risk assess those they receive using a national tool, only applying a standard in the most urgent of cases. However, this is not without challenge as there are patients who are assessed as being amber or green who are not reviewed for a standard DoLS prior to their discharge. Although the responsibility for this is carried by the Local Authority, Trust teams are encouraged to be in contact with the Local Authority to monitor their patients' needs and requirements, communicating changes that may raise the patients risk rating. The number of patients awaiting the review of the Local Authority has increased significantly, this matter has been discussed at the now disbanded Halton Health Safeguarding Sub Group and with the Trust Solicitors ensuring the best possible outcome for our patients.

Figure 8

Patients who require DoLS are referred to the LA where they are registered with their GP, the graph below demonstrates the range of LA the Adult Safeguarding team liaises with in their daily business.	Figure 8 
The chart demonstrates WHH activity by ward.	Figure 9 

12.2 Liberty Protection Safeguards (LPS)

Following a period of review, the law underpinning MCA practice is to change. The final parliamentary stage of Liberty Protection Safeguards (LPS) was completed on 24th April 2019, following this completion Liberty Protection Safeguards received royal assent on 16th May 2019 and became Law. This new legislation repeals the Deprivation of Liberty Safeguards contained within the Mental Capacity Act (2005) (MCA).

The review of the current system of Deprivation of Liberty Safeguards (DoLS) happened because it was felt that the system needed to change and move away from DoLS. This change makes health care providers responsible bodies as well as the CCG; the LA will also remain a responsible body. This will mean WHH will be responsible for authorising, monitoring and renewing their own DoLS, the law makers felt that by introducing a simpler process that also involves families would create faster access to assessments.

LPS establishes a process for authorising arrangements and enabling care and treatment which result in a Deprivation of Liberty, within the meaning of article 5(1) of the European Convention on Human Rights (ECHR), where a person lacks capacity to consent to the arrangements. The Government is currently working on a Code of Practice and regulations to support the use of this legislation. This was expected by the end of 2019 and was pushed back to early 2020 and then spring 2020. This guidance is still awaited; it will lay out how the process should occur and what roles should be in place to facilitate this new act of law. The 'go live' date remains 1/1/20 at this time.

13. Female Genital Mutilation

Female Genital Mutilation (FGM) is illegal in England and Wales under the FGM Act 2003 ("the 2003 Act"). It is a form of child abuse and violence against women. FGM comprises all procedures involving partial or total removal of the external female genitalia for non-medical reasons. The duty to mandatory report all FGM cases in under 18 years old came in to effect in October 2015.
WHHFT continue to support identified survivors of FGM and consider the safeguarding for family members. WHHFT contributes to The Female Genital Mutilation (FGM) Enhanced Dataset (SCCI 2026) which supports the Department of Health's FGM Prevention Programme by presenting a national picture of the prevalence of FGM in England. Female Genital Mutilation - April 2017 to March 2018, Annual Report, Experimental Statistics Report there were 6,195 individual women and girls who had an attendance where FGM was identified or a procedure related to FGM was undertaken in the period April 2017 to March 2018. These accounted for 9,490 attendances reported at NHS trusts and GP practices where FGM was identified or a procedure related to FGM was undertaken.

Within this annual report period, one survivor of FGM have been identified through midwifery services. The appropriate pathways were followed and relevant agencies notified to ensure the safety of the unborn and any siblings were assessed.

14. Domestic Abuse

In comparison to 2018/2019 data, there has been a significant increase of domestic abuse referrals 20% (182 referrals to 219 referrals). 90% of the referrals were on female victims. 13% of the referrals involved pregnant women (30 referrals), this figure remains static in comparison to the previous year. The ratio of domestic abuse referrals where children are in the family remains has reduced to 47% (103 of the 219 referrals). The domestic abuse pathway that was developed in 2018 continues to be used widely across the Trust. The hospital Independent Domestic Violence Advocate (IDVA) continues to deliver monthly domestic abuse training and has increase bespoke training sessions for wards and departments across the trust.

Figure 10

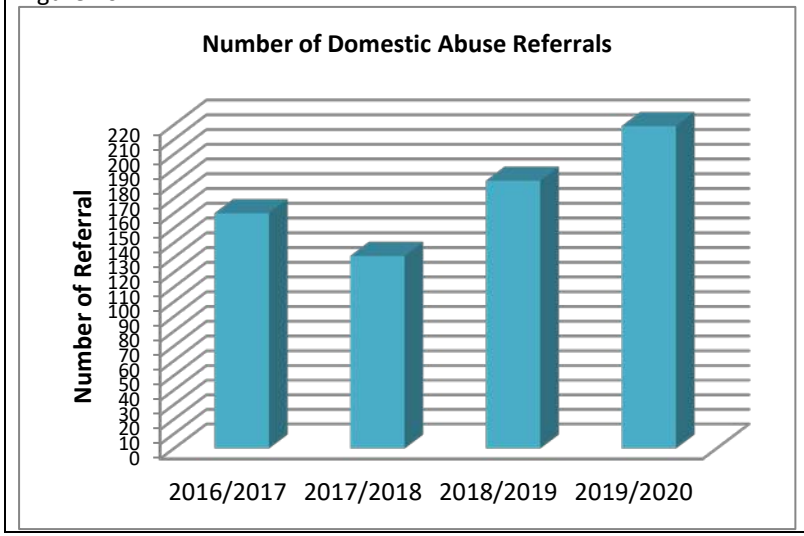
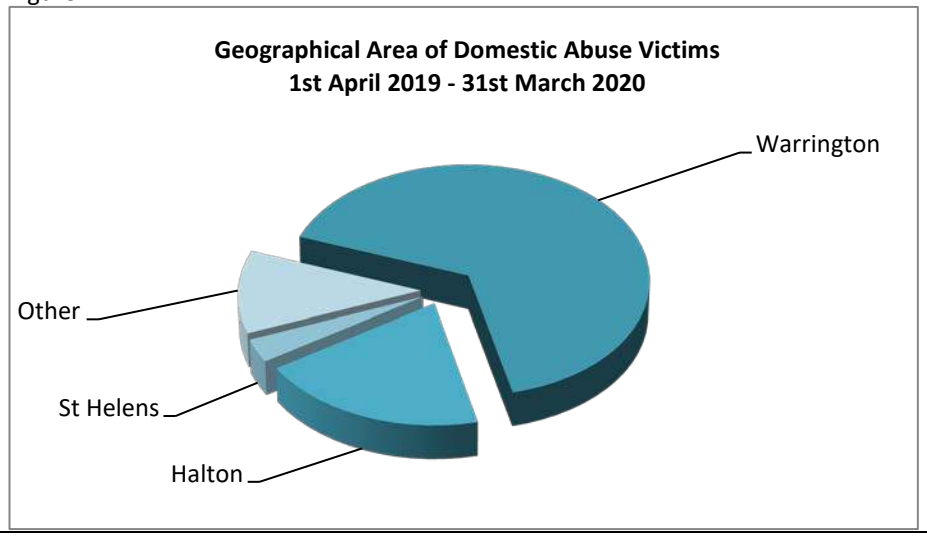


Figure 11



15. Mental Health

Mental Health (MH) has moved to the safeguarding portfolio in June 2019. A service level agreement (SLA) has been agreed with Northwest Boroughs that enables the Trust to carry out its statutory duties with regard to the Mental Health Act (MHA). The MH activity in the reporting year is noted to have increased with patients presenting to the Trust with increasing complex care needs and behavioural management challenges. Work is underway to scope how best to strengthen current policies and training provision. Policies are under review so that they offer clearer guidance to staff on mental health care and detention management. Trust Solicitors, the Named Dr Adult Safeguarding who also leads on mental health for the Trust and the Trust Mental Health liaison team Psychiatrist have delivered a training program to support staff knowledge gaps. Going forward this program delivery will be reviewed with regard to how and in what format this will continue.

Child health has been proactive and working closely with the Safeguarding Team, Security and North West Boroughs have further developed care pathways and inpatient risk assessments that have supported both adult and children's patient needs. Work is ongoing to continue to strengthen these processes and build on existing multi agency working relationships. Policies have been reviewed and strengthened to offer clearer guidance to staff on mental health care and detention management. A service level agreement (SLA) is in place to support the administration of sections and a training program has been put into place to address staff knowledge gaps. This has been delivered by the Mental Health Liaison team Psychiatrist, the Trust Named Doctor for Adult Safeguarding who also leads on mental health for the Trust and the Trust Solicitors. Going forward this program delivery will be reviewed with regard to how and in what format this will continue.

The importance of training staff to enable them to support this element of patient care has been recognised as the support required cannot centre on knowledge alone; adult and children's teams are to be trained in how to support patients where physical intervention may be required. National guidance will be observed in reviewing this training.

Collaboration with partner agencies is important we have good links with our NHS and private neighbours. Work to support this agenda within the Trust is progressing with such initiatives as the High Intensity User Group which looks to support patients avoid inappropriate A/E attendances by supporting with alternative routes for their needs, this is a multi-agency meeting attended by the adult safeguarding team. A multi-agency Mental Health Subgroup meets monthly and a HLBP is submitted to Safeguarding Committee to update the Trust on Mental Health activities

16. Mortality Review

The Named Lead Nurse Safeguarding Adults attends the monthly Trust Mortality review group (MRG). As a member of the group the Lead Named Nurse offers safeguarding oversight of the cases reviewed and is asked to complete further in depth reviews where problems relating to MCA have been found. All patients who have passed away in the Trust who have a Learning Disability are also reviewed here using the Standard Judgement Review (SJR) process.

In order to link the Learning Disability Mortality Review (LeDeR) and SJR process, the SJR is shared with the monthly LeDeR review panel so that the patients care and treatment, in line with the national LeDeR process, can be reviewed. The panel is multi-agency and chaired by the CCG, the Lead Named Nurse Safeguarding Adults and the Named Dr Safeguarding Adults are members of the panel, any learning from the reviews are shared with MRG to be disseminated throughout WHH. To date the panel has not asked for any of the patients cases to be further reviewed by MRG.

Child death cases are presented quarterly by the Named Dr for Safeguarding Children with the children's Lead Named Nurse deputising when required.

17. Learning Disability (LD)

Following the March 2017 CQC inspection the Trust examined its LD provision; the Trust has progressed with improvements following its own Trust wide audit and in taking part in the yearly National Improvement Standards LD audits since it was launched two years ago, a gap analysis and action plan have been written by the Named Lead Nurse Adult Safeguarding and presented to the Safeguarding Committee, Quality Assurance Committee and the CCG quality committee for review and noting of the analysis. In order to progress the extensive action plan and the LD agenda an LD Steering Group is planned. Work is underway to address the priority areas; to monthly Safeguarding Committee. The Lead Named Nurse Adult Safeguarding is a member of a newly formed LD Board and represents the Trust at this meeting.

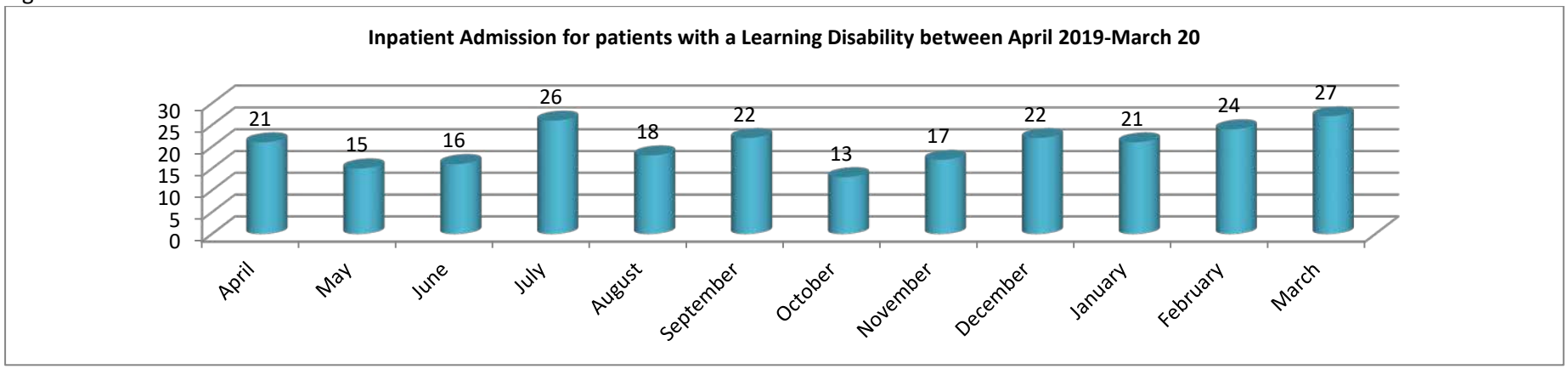
The introduction of the inpatient and outpatient LD flagging system has supported the care of patients with LD and enabled reasonable adjustments to be considered ahead of appointments. The increased awareness of the needs of patients with an LD has created more enquiries and requests for assistance by staff from the Adult Safeguarding Team. Clinicians are better at proactively enlisting the support of the safeguarding adult staff in ensuring that planned admissions and appointments support the needs of our LD patients. Best interest processes are better understood and have become more frequent in the outpatient setting. The Safeguarding Adults Team have supported a number of planned admissions and have been involved in supporting Ward and department teams with complex patient care needs. The safeguarding adult staff upload passports and care management plans into the Lorenzo record

enabling staff to have information at hand as soon as their patient arrives on wards and in Depts. The LD Community Teams contact the safeguarding adult staff when they know one of their patients are enroute as an emergency enabling the adult safeguarding staff to contact A/E so that preparations can be made for the patients' arrival.

Improvement in care planning and accommodation of reasonable adjustments is evident. Ward teams and leads have welcomed the guidance and a tool written to support them with accommodating patients with an LD and in completing a welfare check on their behalf, prompted by twice daily emails alerting them of the location of patients in their areas. An LD training program began post March 2017 it should be noted that staff have responded well to the training and attendance has been notable. This has been further supported by the North West Boroughs Learning Disability Team who have attended the trust to deliver training to medical and nursing teams. The Trust and the Adult Safeguarding Team have worked closely with community partners in improving the care of patients with an LD and in supporting their reasonable adjustments. The Safeguarding Adults Team have supported a number of planned admissions and have been involved in supporting Ward and department teams with complex care needs.

The graph below (Figure 12) describes the number of in-patients with LD who have been admitted to the Trust and received support from the safeguarding adult's team.

Figure 12



18. Prevent

Responsibilities under the Home Office Prevent strategy have now been placed on a statutory footing from July 2015 with the introduction of the Counter Terrorism and Security Act 2015. The Named Lead Nurse is the Prevent lead for the Trust and attends regional prevent meetings ensuring that important information and learning is brought back to be shared via Safeguarding Committee.

Contest is the government anti-terrorist/anti-radicalisation program, the Prevent /Work shop to Raise Awareness of Prevent (prevent/WRAP) program is part of this. Of the four elements of contest Prevent is the area of responsibility for health. The trust now delivers WRAP at induction for all newly appointed clinically facing staff. WRAP is delivered monthly during face to face sessions for staff to access as and when they require, eLearning is also in place.

Following the increase in terror activity in 2017 the Home Office instructed all Trusts to ensure that 85% of their staff where compliant with this training by 31st March 2018. WHH continues to exceed this target. CBU teams are monitored on their Prevent compliance through the joint Safeguarding Committee. Staff receive three yearly updates to maintain their competency.

All staff are aware of how to raise a prevent concern, once a person is reviewed by the relevant agency some are referred to the Pan Cheshire Channel Panel. Channel panels, established under the Counter-Terrorism and Security Act 2015, assess the extent to which identified individuals are vulnerable to being drawn into terrorism, and, where appropriate, arrange for de-radicalisation support to be provided. The panel is multi-agency; the Trust is represented by the Lead Named Nurse Adult Safeguarding.

19. Allegations against staff

All allegations of abuse of children by those who work with children must be taken seriously. Allegations against any person, who works with children, whether in a paid or unpaid capacity, cover a wide range of circumstances.
This procedure should be applied when there is such an allegation or concern that a person who works with children, has:

- Behaved in a way that has harmed a child, or may have harmed a child;
- Possibly committed a criminal offence against or related to a child;

Page 49 of 203

- Behaved towards a child or children in a way that indicates he or she may pose a risk of harm to children.

The safeguarding team provide monthly updates to the trusts triangulation meeting in relation to allegations against staff, at the point of writing the report updates are provided on 11 cases. The trust currently has 1 ongoing case requiring Local Area Designated Officer (LADO) input.

20. Child Death

Working Together to Safeguard Children 2018 Chapter 5 sets the functions and processes of the Child Death Overview Panel (CDOP), which includes the collection and collation of data following the death of a child and subsequent recommendations following data analysis. This is an essential process for the CDOP, as the information gathered is used to safeguard and promote the welfare of children and for strategic planning purposes to support effective service delivery.

The Sudden Unexpected Death in Childhood (SUDIC) proforma & Guidelines have been updated in 2019 and has been circulated trust wised. This guidance provides a framework for the investigation and care of families after an unexpected death of an infant or child. 2018/2019 has seen a significant decrease in the number of child deaths requiring reviews coordinated by the trust Safeguarding Children Team. 2018/2019 saw a sudden increase in deaths however this has reduced to a similar number of deaths seen pre 2018. There are no specific reasons for this and no concerns have been identified by CDOP. Figure 13 demonstrates the number cases dealt with.

Figure 13

	2017/2018	2018/2019	2019/2020
Number of deaths pronounced at WHHFT	5	15	3
Total number of child deaths requiring further information sharing / input from WHHFT	12	22	19

Due to confidentially and ongoing investigations / meetings the causes of deaths cannot be documented within this Annual Report. It can be noted however that there were no suspicious deaths. Bereavement support is offered to the family and also the staff involved in any child death incident. Following relevant multi-agency meetings, feedback and learning is presented internally to the WHHFT Mortality Review Group.

CDOP produce their own annual report which will provide more details regarding the deaths and any lessons to be learnt. At the point of writing this annual report the CDOP annual report is not available to share.

21. Child Protection – In patient

The Hospital Safeguarding Children Concerns Form was introduced in 2002/3 to ensure compliance with the national standards and to give a measure of performance against the Laming recommendations. The 'Concerns form' is used in the trust to highlight safeguarding children concerns. The form ensure staff are alerted to issues identified for a child and what action plans are in place or completed, It contains a minimum data set for children that have been identified as 'potentially' requiring some level of 'Safeguarding'. 2018/2019 saw a drop in concerns forms commenced however 2019/2020 there were 399 forms commenced. This is an increase of 38%. As the previous reduction was recognised, the Safeguarding Team worked in collaboration with senior nurses from child health, the safeguarding link nurse on paediatrics and the Registered Nurse with a Specialist Interest in safeguarding children to continue to monitor the activity on the ward ensuring that where appropriate, concerns forms are commenced and action accordingly. As shown in the graph below (Figure 14) the under 1s continue to be the most vulnerable group of patients. 25% of concerns forms commenced are for patients under 1 year old. Figure 15 provides an overview of the categories of concern.

Figure 14

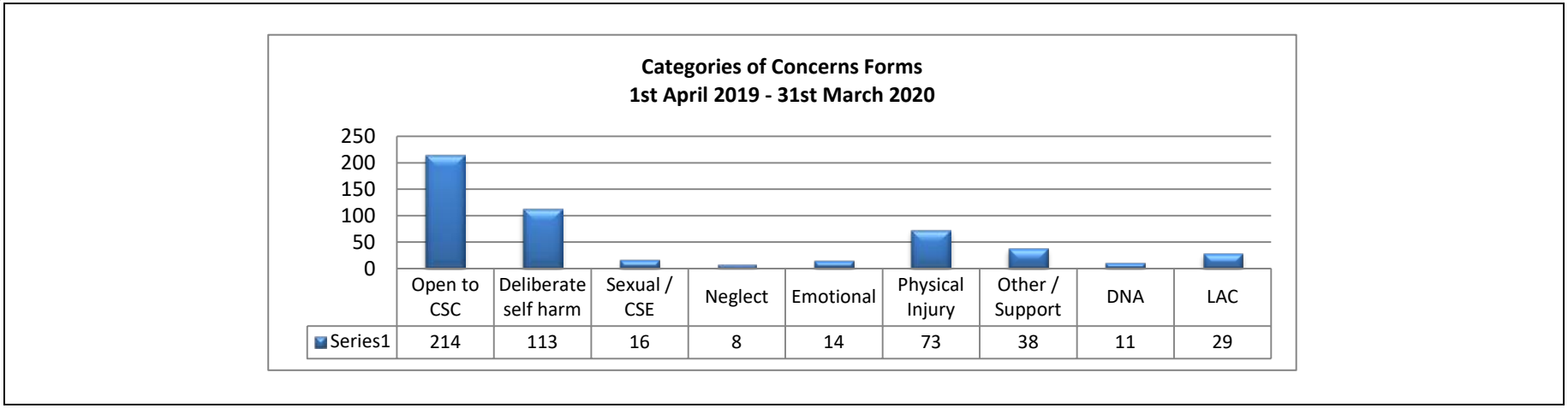
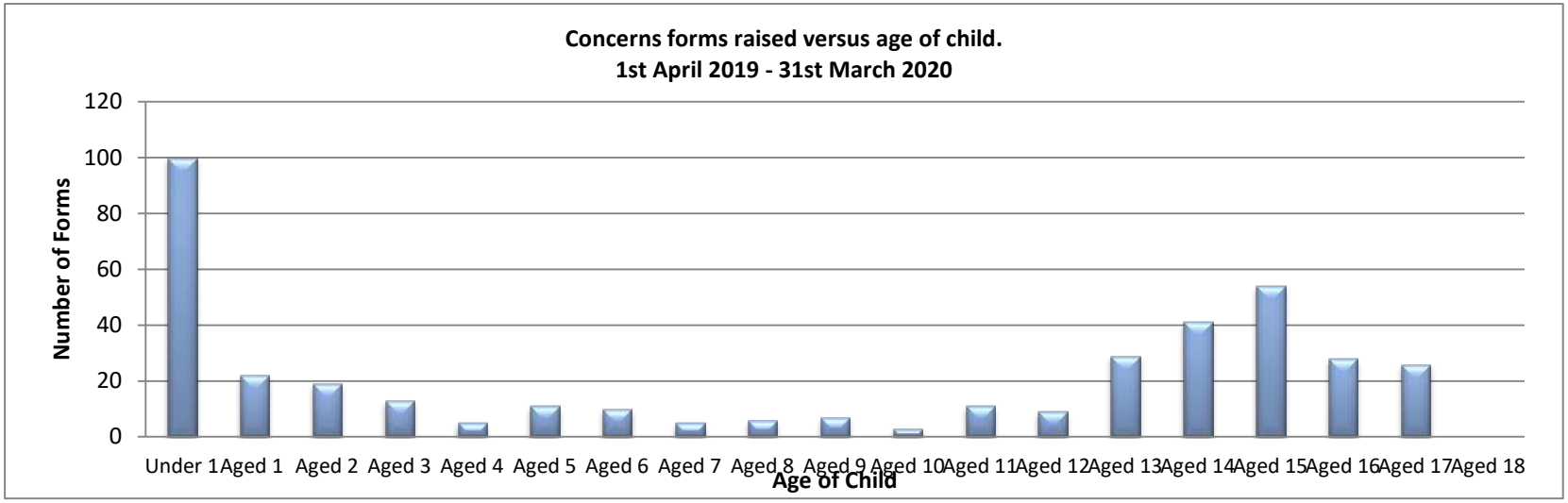


Figure 15



21.1 Child Protection Medicals

A child protection medical (CPM) assessment should always be considered when there is a suspicion of, or a disclosure of, child abuse and/or neglect involving injury, suspected sexual abuse or serious neglect. The need to consider a medical assessment in these cases arises from section 47 of the Children Act 1989 (and 2004) which places a statutory duty on the Local Authority to make enquiries to enable it to decide whether it should take action to safeguard and promote the welfare of a child. In 2018/2019 83 child protection medicals were completed by WHFFT. Compared to the previous year, there has been a significant increase (151%). In 2018 WHHFT accepted a contract which resulted in all of Halton community medicals being completed at WHHFT. 51 of the 83 medicals were Halton children. The significant increase in the child medical process impacted on the administration of the medicals and therefore child health invested in a dedicated administrator to provide support for the child protection

medical reports. The standards of the reports are reviewed on a monthly basis at peer review. It has been recognised by partner agencies that the standard and speediness of the child protection medical report has improved.

21.2 Peer Review

Peer review is the evaluation of work or performance by colleagues in the same field in order to maintain or enhance the quality of the work or performance in that field. The word peer is often defined as a person of equal standing. However, in the context of peer review, it is generally used in a broader sense to refer to people in the same profession who are of the same or higher ranking.

It is a core competency for all clinical staff working with children to undertake regularly documented reviews of practice, including peer review. It is a component of the Clinical Governance Framework and is expected by the judiciary, GMC and professional bodies. 89 cases were discussed as part of the peer review process with attendance from medical staff has been consistent; this is an increase of 49 on last year's figures.

In 2017/2018 the Police, Children's social care and community health were invited to join peer review and has continue to further develop and strengthen working relationships.

Page 53 of 203

22. Safeguarding in Midwifery

Safeguarding within midwifery is constantly changing and becoming more complex. Research and experience indicate that very young babies are extremely vulnerable to abuse and that work carried out in the ante-natal period to assess risk and to plan intervention will help to minimise harm. The below table demonstrates a slight decrease in the number of women with identified vulnerabilities who WHHFT are supporting through their pregnancy. Figure 16 provides information regarding women who book to deliver at WHHFT however live out of area. 28% of women commenced on special circumstance forms live out of the area. The Safeguarding Children Team provide a robust channel of communication with external partners and ensure that patient records and care plans are up to date in readiness for delivery of the baby. The data below in figure 17 provide detailed information in regards to number of special circumstance forms comments and from which geographical area the patients are from.

Figure 16

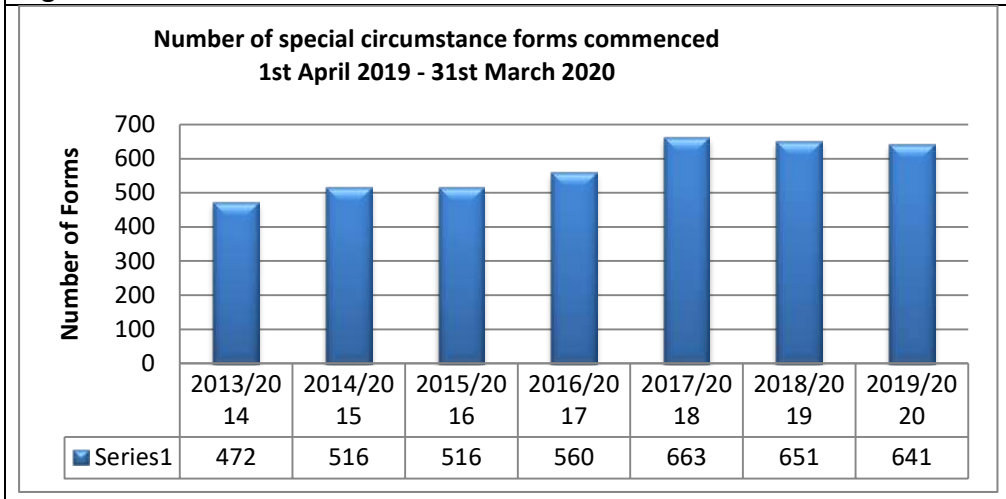


Figure 17

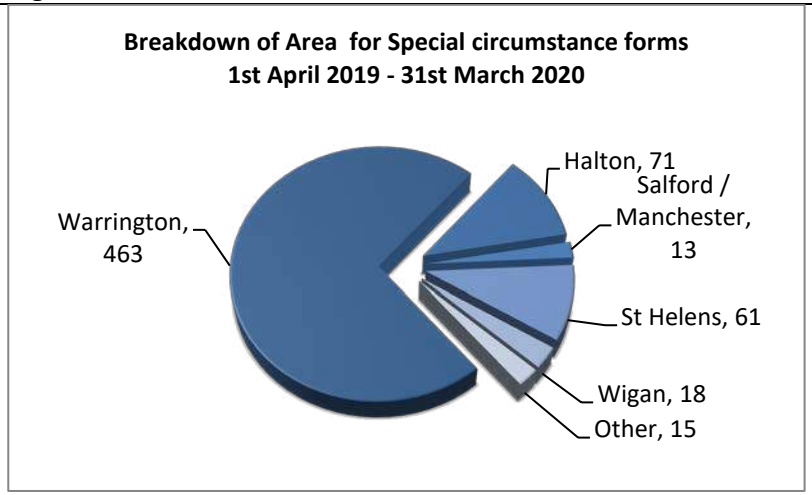
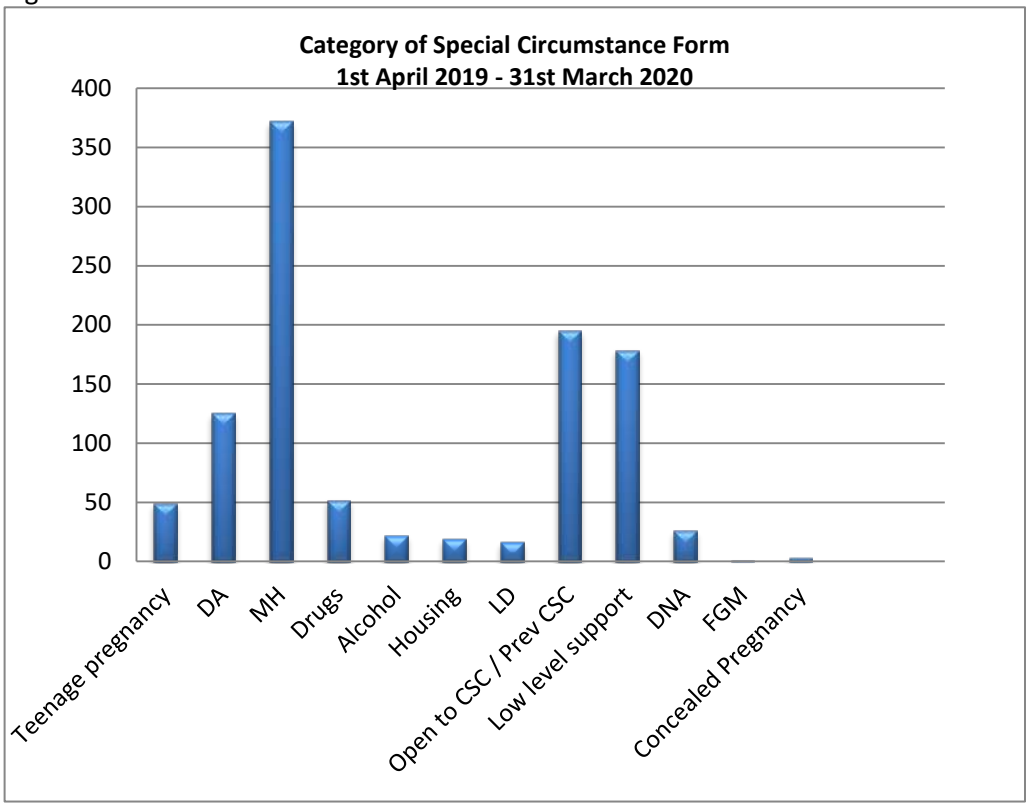


Figure 18 breakdowns the category of concerns raised. Consistent with the previous year's data mental health continues to be the most selected reason for concern (58 %). The perinatal period, as defined in relation to mental illness, spans the time of conception to when the infant reaches the age of one. Perinatal mental illness is relatively common and affects at least 10% of women. The severity of the condition will vary from individual to individual and may have some serious consequences if not identified and managed early and effectively. It is positive that so many women have been identified during the antenatal / postnatal period and commenced on the special circumstance forms. Following a review and update of the Guidance for Special Circumstance Forms (SCF), electronic SCF were introduced. The electronic form was developed to enable midwives to input up to date information and reduce the risks of information being missing when case notes were not located timely.

Similar to last year's figures, 195 women were identified as needing low level support; this may be in addition to other issues identified. Not all cases where low level support was identified required an early help assessment however it is positive that midwives recognised this and was able to support the women and her unborn.

Warrington Safeguarding Partnership introduced the graded care profile 2 in 2019. The Named Nurse Safeguarding completed the training to deliver this course and is currently rolling out the training to all community midwives.

Figure 18



23. Incident reporting

23.1 Safeguarding Children reported incidents

DATIX incidents are reviewed as the team are alerted of them. The Safeguarding Children Team will often be asked to review DATIX that fall under a separate category however have an element of safeguarding to it, for example young people absconding from the departments. 49 incidents were reported under the category of safeguarding abuse, this is a 104% increase on the previous year. Figure 19 provides an overview of the trends recognised and what actions have been taken to address the issues identified. The Safeguarding Children Team have supported one comprehensive Incident Investigation. The final report from this review has been shared with the appropriate teams and learning identified. Safeguarding Committee will have oversight of the review summary and learning will be discussed.

Figure 19

Trend identified	Actions to address
Domestic Abuse – Incidents of domestic abuse have been recognised however the pathway is not being fully completed.	- Feedback has been provided to individuals involved - Hospital IDVA will make contact with those involved and provide training
Midwifery – Safeguarding pathway not followed. Vital information not shared.	- Both cases reviewed and one individual midwife has been identified for both cases. Community midwife team leader aware and will work in conjunction with the safeguarding midwife to provide feedback / supervision with the midwife involved on their return to work.
Midwifery - Safeguarding concerns not recognised at booking which resulted in delayed referral to social care - Advice not acted upon. Referral to social care delayed.	- Individual feedback provided an opportunity to reflect. - Weekly contact with community midwives manager to discuss any high risk cases

Midwifery not following domestic abuse process resulting in delay in supporting victims of domestic abuse. - Not recognising it - Midwives on shift have no access to trust intranet to access referral forms (no passwords set up)	Immediate action was taken at the time to address the concerns raised within maternity. A meeting between midwifery and safeguarding took place to address the concerns and put actions in place. - Where possible the safeguarding team have supported and attended conferences to reduce the impact on the unborn and mother. - Increased support offered to the newly appointed midwives involved to go through the processes. - Named Midwife attended the wards / clinic on a daily basis to support staff - Named Midwife to attend 10 at 10 where possible to support - Domestic abuse pathway re-circulated - 7 Minute briefing to be circulated focussing on domestic abuse - Midwives to complete domestic abuse training
Child protection Information Sharing (CPIS) not being actioned.	- ED Lead Nurse has re-circulated the CPIS briefing.
Significant information not obtain or acted upon in ED - CPIS not accessed - NOK not recorded - Childrens social care not contacted when required - Patients children in the care of person unknown to ED. Name not obtained and social care not contacted	- Lead Nurse from ED has provided CPIS information again via daily huddles. - Staff involved updated
Lack of information being obtained when children attend hospital. - 2 address - No named parent / carer - Voice of the child not evident	- Feedback to practitioner and manager. - Will reiterate importance within training programme - Raised at safeguarding committee
Transfer from ED to paediatric ward: - Lack of information provided in hand over - Concerns care pathway not being commenced in ED at the point concerns are identified	- Feedback to practitioner and manager. - Advised ED and PAEDS to meet and discuss.

23.2 Adult Safeguarding reported incidents

The Adult Safeguarding Team receives notifications for all incidents that have a safeguarding element to them. They require review in order to evaluate any possible safeguarding concerns. Once reviewed the incident is either closed or escalated for further investigation.
The team have reviewed 90 incidents in the reporting year, this in an increase of 80%.

The graph below describes reports by area whilst the following graph describes themes and trends (Figure 20 & 21). We provide advice and support for all reviewed incidents. The main themes from these are demonstrated in figure 22

Figure20

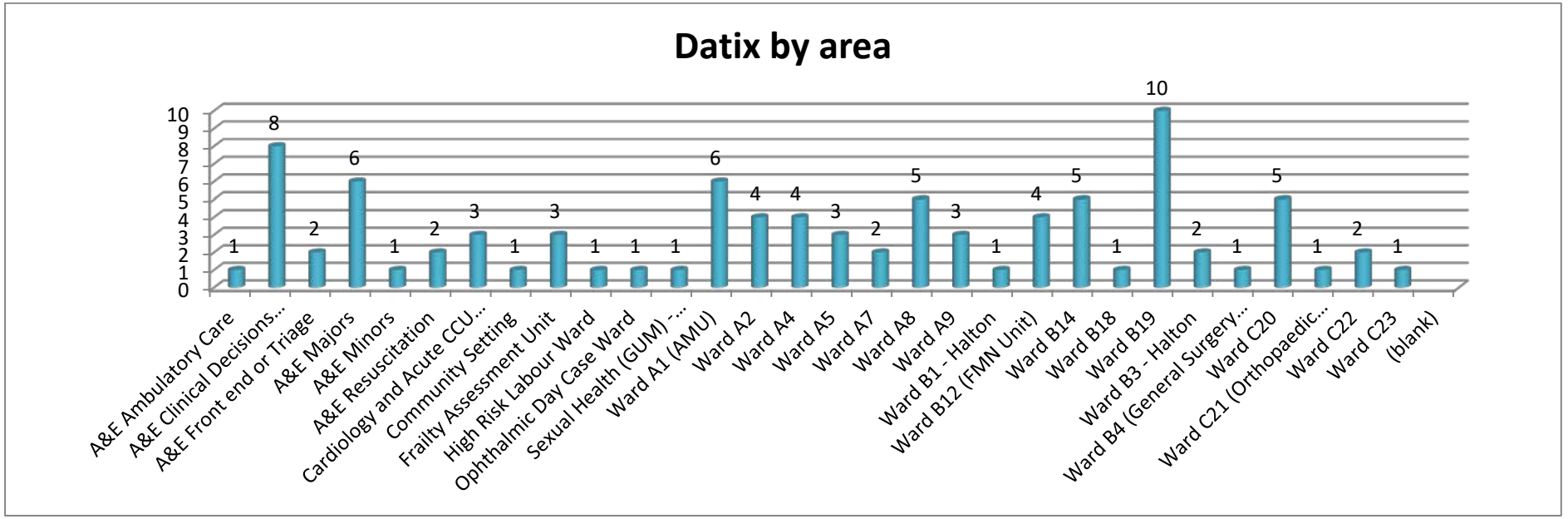


Figure 21

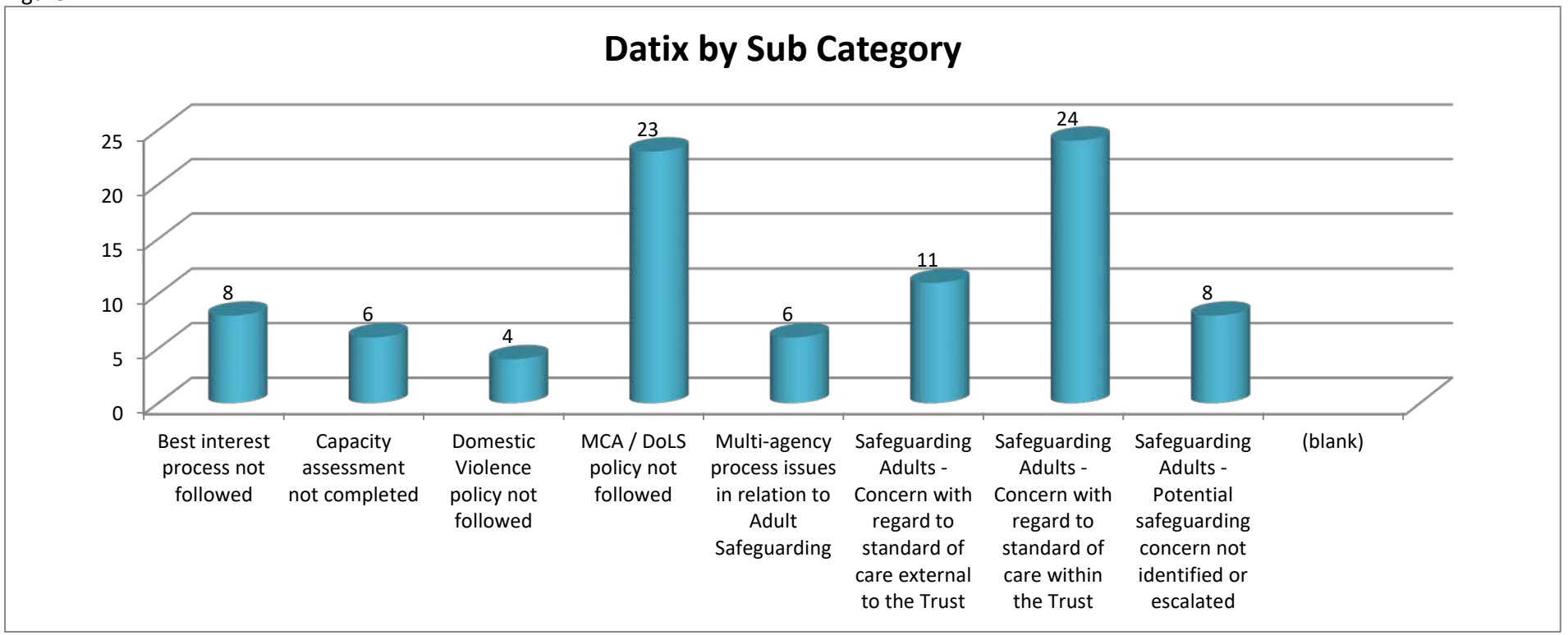

Datix by Sub Category
25
20
15
10
5
0
8
6
4
23
6
11
24
8
Best interest process not followed
Capacity assessment not completed
Domestic Violence policy not followed
MCA / DoLS policy not followed
Multi-agency process issues in relation to Adult Safeguarding
Safeguarding Adults - Concern with regard to standard of care external to the Trust
Safeguarding Adults - Concern with regard to standard of care within the Trust
Safeguarding Adults - Potential safeguarding concern not identified or escalated
(blank)

Figure 22

Main Issues / trends	Action taken from Safeguarding Adult Team
Domestic Abuse policy/hospital pathway not followed	• 4 of the 90 DATIX reported were in this category, in all cases the patients were appropriately safeguarded and the correct agencies were informed. Targeted training has been offered to support the staff involved
MCA/DoLS policy, capacity assessment not completed, best interest process not followed	• In all 37 of the 90 DATIX reported were in these three categories, in all cases the patients were appropriately safeguarded and the correct process instigated with regard to DoLS and MCA the relevant agencies were informed. Targeted training has been offered to support the staff involved and continued audit monitors this practice across the Trust. All MCA/DoLS activity is reported via Safeguarding Committee
Potential safeguarding concern regarding the standard of care from another health provider	• 11 of the 90 reported Datix fall into this category. This category describes concerns raised about other health provider. If patients are admitted to us with skin damage or with concerns about any aspect of their care. In such cases the safeguarding adult team and local authority work together to review the concern
Potential safeguarding concern regarding the standard of care from an areas at the Trust	• 24 of the 90 DATIX reported where in this category. This will include incidents regarding skin damage and complaints about care. Where required a 72 hr review is held, all concerns are reviewed by the safeguarding team and the CBU leads.
Multi-agency process issues in relation to adult safeguarding	• 6 of the 90 DATIX reported where in this category. Where situations such as this arise, agencies will review the case and address any shortfall, lessons learnt are shared between all partners, WHH discusses at Safeguarding Committee. There has been one learning event January 2020 following such a case, however there were no actions for WHH
Safeguarding adults potential safeguarding concern not identified or escalated	• 8 of the 90 DATIX reported where in this category. Incidents have been raised following audit and incidental findings, these have been retrospectively reviewed. None of the incidents resulted in patient harm and awareness of near misses has been discussed at Safeguarding Committee

24. Policy Development

24.1 A number of policies written by the safeguarding teams have been reviewed and updated

These include:

- Safeguarding Children and Young People
- Safeguarding Adults
- MCA/DoLS
- Clinical Holding and Restraint
- Care of Prisoners
- Prevent
- Chaperone

25. Achievements

Throughout the annual report there are areas of good work and positive achievements. In addition to those areas it is important to recognise additional work that has taken place.

25.1 ICON Lead

Warrington and Halton Hospitals NHS Foundation Trust successfully launched the ICON on Wednesday 17th July 2019 in a bid to help to reduce harm and provide help and support for families. WHHFT are leading the ICON programme with support from Pan-Cheshire partners.

Abusive Head Trauma (AHT), also known as Shaken Baby Syndrome, is a devastating form of child abuse. Catastrophic injuries which result often present in a constellation including intracranial injuries, retinal haemorrhage and certain long bone fractures and spinal fractures. The causal mechanism in cases of AHT is rarely confirmed and may well include elements of both impact and acceleration/deceleration injury. 1 in 14 cases is fatal before hospital discharge and half of severely injured survivors will die before 21 years of age (Smith 2016). AHT affects one in 4000–5000 infants every year and is one of the most serious forms of physical child abuse that has a high associated mortality and morbidity (Kemp 2011). In practice, an average sized District General Hospital can expect to see a case every 1 or 2 years.

Page 61 of 203

"Babies Cry, You Can Cope – never, ever shake or hurt a baby" is the message from 'ICON' – a national programme of interventions and awareness that aims to help parents and carers to cope with a crying baby. ICON is an evidence based programme, consisting of a series of brief 'touchpoint' interventions that reinforce the simple message making up the ICON acronym. The programme, which was founded by Dr Suzanne Smith PhD, was conceived following years of study and research into prevention of Abusive Head Trauma (AHT). Each 'touch point' is brief but reinforces the simple evidence based four point message which makes up the ICON acronym:

I - Infant crying is normal and it will stop.

C - Comfort methods can sometimes soothe the baby and the crying will stop.

O - It's **O**k to walk away if you have checked the baby is safe and the crying is getting to you.

N - Never, ever shake or hurt a baby.

The ICON message is delivered through primary prevention interventions, population based awareness, raising public health interventions and secondary prevention interventions. The materials to support the programme have been co-designed and agreed by a multi-agency steering group, a group of parents and families affected by AHT and include a wrap-around brief e-learning education package designed for professionals of all agencies who have contact with families who have babies.

The core programme of 'touch point' interventions includes:

- Community midwifery intervention at 36 weeks gestation
- Hospital based intervention at birth
- Community midwifery intervention < 10 days
- Health Visitor (HV) intervention at primary birth visit
- HV team intervention < 3 weeks
- GP intervention at 6/8 week check

25.2 Learning Disability easy reads

The Safeguarding Adult Team continue to work with advocacy and user groups to review and improve how information is presented to our patients with an LD, further work will be progressed via the newly formed LD Steering Group.

25.3 Implementation of the Adult Safeguarding Roles and competencies Intercollegiate Document

25.4 Reaching and exceeding WRAP and levels one to three across all safeguarding training targets

As already discussed, the commitment to training from across the Trust to achieve the targets can be seen within the consistent increasing compliance figures. The Safeguarding teams have regularly reviewed training programme and increased sessions available.

25.5 Safeguarding Team Development

- The Lead Named Nurse and Safeguarding Specialist Nurse Safeguarding Adults have completed a Bond Salon Safeguarding Supervisors course.
- Safeguarding Named Midwife has successful being trained to delve the Graded Care Profile 2 programme.
- Safeguarding Adult Administrator successfully completed the Edwards Jenner management course.
- Safeguarding Lead Nurses completed a 1 day Bond Solon Safeguarding Executive course.
- Safeguarding Lead Nurses attended the North West Safeguarding Conference

Page 63 of 203

27 Assurance Statement

Whilst this Annual Report provides many examples of the positive and inspiring progress we have made in 2019/2020, we are constantly exploring ways in which we can improve how we work together to ensure the best outcomes for all those who use or come into contact with our service. We are looking forward to the year ahead in ensuring safeguarding is maintained as a high priority for the Trust and is everyone's business. The Trust will continue to monitor and receive assurance via the existing robust governance arrangements.

28 Key Objectives for 2019/2020

The Trust's objective to discharge its safeguarding duties effectively to continue to focus on the delivery of seven key priority outcomes and is aligned to the shared priorities that are described in section 3.

At the time of writing this Annual Report the country is currently experiencing COVID-19 pandemic and therefore in addition to the seven priorities the Safeguarding Team have been developing a recovery plan in relation the safeguarding surge that is expected. In summary, it is unknown what safeguarding issues will surge as the national lockdown ends, however, national and local data along with safeguarding theory from the toxic-trio (mental health, substance misuse and domestic abuse), troubled families, think family, contextual safeguarding, trauma informed practice and strength based approaches informs that in exiting the COVID-19 acute phase, the safeguarding surge & recovery will only just be beginning and is predicted to last a number of years. The surge in patients living alone with mental health conditions, who are practicing substance misuse, is also unknown. When considering the detrimental factors of a period of isolation on the mental health of the population nationally as well as locally, it is evident that people will begin to access services at an increased rate following a change in the lock-down conditions, therefore placing further demand on the current resource. Mental health problems are highly prevalent in acute inpatient wards, outpatient clinics and emergency departments, and can profoundly affect outcomes of care for acute physical illnesses.

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/20/07/77**			
SUBJECT:	**Risk Management Strategy Annual Report**			
DATE OF MEETING:	29 July 2020			
AUTHOR(S):	Layla Alani, Deputy Director Governance			
EXECUTIVE DIRECTOR SPONSOR:	Kimberley Salmon-Jamieson, Chief Nurse + Deputy Chief Executive			
LINK TO STRATEGIC OBJECTIVE:	SO1 We will.. Always put our patients first through high quality, safe care and an excellent patient experience.	X		
	SO2 We will.. Be the best place to work with a diverse, engaged workforce that is fit for the future.			
	SO3 We will ..Work in partnership to design and provide high quality, financially sustainable services.	X		
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF):				
EXECUTIVE SUMMARY ***(KEY ISSUES):***	The Risk Management Strategy Annual report describes the management of risk throughout the Trust over the last 12 months. Risk management is a critical component of the overall Governance agenda, with the safety of patients and staff being a core value.			
PURPOSE: ***(please select as appropriate)***	Information	Approval	To note x	Decision
RECOMMENDATION:	The Board of Directors is asked to note the report.			
PREVIOUSLY CONSIDERED BY:	**Committee**	Quality Assurance Committee		
	Agenda Ref.	QAC20/07/100		
	Date of meeting	7 July 2020		
	Summary of Outcome	The Quality Assurance Committee were asked to note the report.		
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	Choose an item.			

REPORT TO BOARD OF DIRECTORS

SUBJECT	Risk Management Annual Report

1. BACKGROUND/CONTEXT

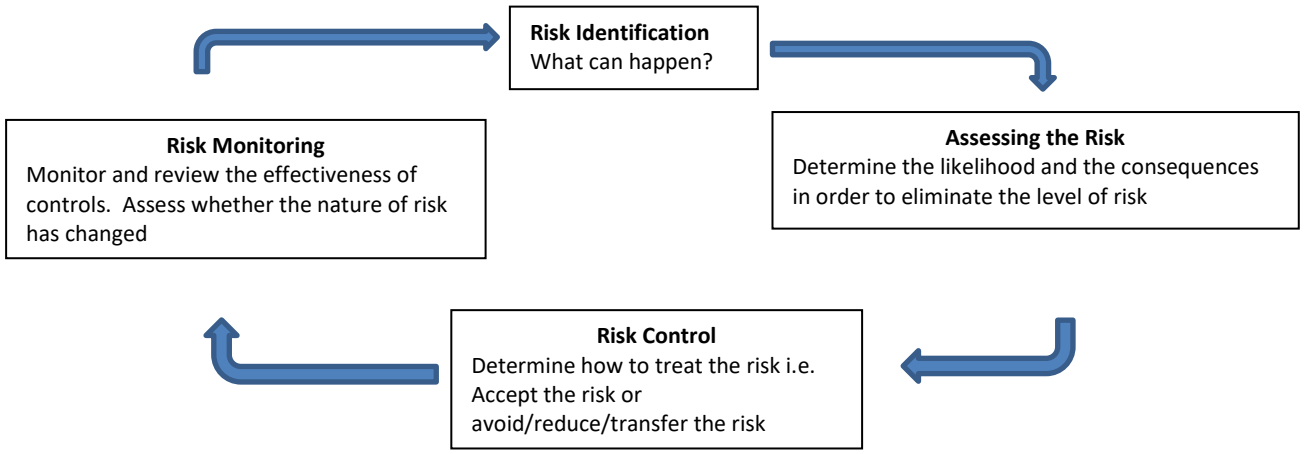
The annual report describes the management of risk throughout the Trust over the last 12 months. Risk management is a critical component of the overall Governance agenda with the safety of patients and staff being the core value.

Over the past three years a complete review of risk management has been undertaken and a new fully embedded process can now be evidenced across all areas of the organisation.

2. KEY ELEMENTS

2.1 Risk Management Process

There is a clear risk management process embedded across the Trust. The process describes a proactive approach whereby possible risks or challenges are identified before they occur. This allows for the development of procedures and processes to mitigate against risk and / or minimise its impact.



2.1.1 Assurance

The risk management process has been successfully embedded across the Trust and was identified in the 2019 CQC inspection report as “Good”. Various levels of risk registers have been developed and are actively managed and reviewed by identified Leads and Clinical Business Units. There is a training programme in place to continually support with the risk management process.

2.2 Review of the Risk Management Strategy

A full review of the Risk Management Strategy was undertaken in May 2019. The aim of this strategy is to ensure the Trust has an effective process to support better decision making through good understanding of risks and their likely impact.

The revised strategy sets out clear, understandable objectives to enable the Trust to further strengthen the risk management process over the next two years.

Risk Management Objectives 2019/2021:

- Defining and setting out the benefits of risk management.
- Help the Trust to understand risk appetite and tolerances.
- Continuously improve risk management arrangements within WHH.
- Assess the current status of risk management within the Trust.
- Outline the approach to managing, maintaining and reviewing of risk registers.

2.2.1 Assurance of meeting the Objectives

Through the risk management process, the Trust can identify significant risks to enable the achievement of the organisation's strategic and operational objectives. The potential consequences and impacts are evaluated to ensure the most effective way of controlling them.

2.3 Risk Management Training

A review of Risk Management Training was undertaken in 2019 to ensure that all training programmes where appropriate to meet the needs of both the staff and the organisation.

Training in place includes:

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

2.3.1 Assurance

The training is mandatory to ensure that all staff have an understanding of various aspects of risk management relating to their role. Although the training is a one off session, there is a rolling programme of dates available each year.

2.4 Risk Registers

Board Assurance Framework
The Board Assurance Framework (BAF) has developed over the past two years and is now fully embedded within the Trust. This assurance framework records the principal risks that could impact on the Trust achieving its strategic objectives.

The key information reported to the Board includes:

- Identifying controls in place to manage strategic objectives.
- Provide assurance about the effectiveness of the controls in place.
- Identify those objectives at risk because there are gaps in the assurance.

The BAF now links in effectively with the Corporate Risk Register with risks being de-escalated from the BAF to the Corporate Risk Register where appropriate.

Corporate Risk Register

The Corporate has been developed over the past 18 months and is now fully embedded within the Trust. The risk register comprises of all risks which may potentially prevent the Trust from carrying out daily operations.

The Corporate Risk Register now effectively links with the BAF. Risks from the Corporate Risk Register are escalated to the BAF where appropriate.

Clinical Business Unit (CBU) and Corporate Services Risk Registers

All CBU''s and Corporate Services have fully developed risk registers in place. There is a consistent and standardised approach to the reporting and managing of risk registers.

Local Risk Registers

Local risk registers are in place and are managed at Ward level. There is an escalation process in place should the risks need to be added to the CBU risk register for more stringent review.

2.4.1 Assurance

The Trust is now able to track Trust Wide risks to assure both operational and strategic objectives are being met. The Trust can be assured that risks are being mitigated and/or escalated when required. The Trust has full sight of all levels of risk which are monitored and reviewed from CBU level up to Board. There is a clear escalation process in place to ensure risks are detailed on the most appropriate risk register. Any risks escalated or de-escalated from the BAF or Corporate Risk Register is done so via the recommendation of the appropriate Committee meeting.

2.5 Risk Register Annual Position Statement

	No. of Risks	No. of Risks 15 +	No. of Risks 12	No. of Risks of 9 and 10	No. of Local Level Risks
Surgical Specialities	25	6	5	10	4
Urgent and Emergency Care	13	1	6	3	3
Digestive Diseases	32	0	3	13	16
Medical Care	26	0	7	10	9
Women's and Children's	20	2	4	6	8
Clinical Support Services	34	2	6	6	20
Integrated Medicine and Community	5	0	0	4	1

3 ACTIONS REQUIRED/RESPONSIBLE OFFICER

Further actions required to ensure the Trust meets the objectives set out in the Risk Management Strategy 2019/2021.

Action	Responsible Officer
The monthly Risk Review Group to continue to scrutinise risk registers and propose any recommendations to the Quality Assurance Committee for escalating or de-escalating risks from the BAF or Corporate Risk Register.	Group Members
Development of a Risk Appetite Framework by the Trust Secretary. (Risk appetite is the level of a risk that an organisation is prepared to seek, accept or tolerate).	Trust Secretary
Development of refresher training for risk management by the Head of Safety and Risk	Head of Safety and Risk
To ensure more consistent grading across the Trust. Ensuring the scores reflect the risk, not just being scored high for visibility.	Head of Safety and Risk
Development of specialist risk registers i.e. Medical Devices	Service Lead

4 TRAJECTORIES/OBJECTIVES AGREED

Risk Management Objectives (as outlined in section 2.2 of this report):

- Defining and outlining the benefits of risk management.
- Help the Trust to understand risk appetite and tolerances.
- Continuously improve risk management arrangements within WHH.
- Assess the current status of risk management within the Trust.
- Outline the approach to managing, maintaining and reviewing of risk registers.

5 RECOMMENDATIONS

The Board of Directors is asked to note the report.

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/20/07/78**	
SUBJECT:	**Health & Safety Annual Report 2019/2020**	
DATE OF MEETING:	29 July 2020	
AUTHOR(S):	Layla Alani, Deputy Director Governance	
EXECUTIVE DIRECTOR SPONSOR:	Kimberley Salmon-Jamieson, Chief Nurse & Deputy Chief Executive	
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	SO1 We will.. Always put our patients first through high quality, safe care and an excellent patient experience. SO2 We will.. Be the best place to work with a diverse, engaged workforce that is fit for the future. SO3 We will ..Work in partnership to design and provide high quality, financially sustainable services.	x x
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF):		
EXECUTIVE SUMMARY *(KEY ISSUES):*	The report outlines the statutory requirement to report on the Health & Safety work undertaken throughout the year. There has been focus throughout the year on: • Ensuing policies and procedures have been updated appropriately. • Ensuring staff have an adequate level of training. • Ensuring that the Trust meets its legal obligations on having statutory risk assessments in place with regard to Health & Safety. • Ensuring there are appropriate audits and inspections in place. • Ensuring incidents are reported and investigated appropriately. • Ensuring action is taken appropriately to safeguard patients, public and staff safety. • Ensuring risks are escalated appropriately. All of the above provides assurance that the Trust has fully discharged its Health & Safety duties. Assurance statement - There is an established pro-active safety management system within the Trust in particularly with audits and inspections. Documentation is now standardised and Departments are compliant with Health and Safety legislation.	

PURPOSE: *(please select as appropriate)*	Information	Approval	To note x	Decision
RECOMMENDATION:	The Trust Board are asked to note the report.			
PREVIOUSLY CONSIDERED BY:	**Committee**	Quality Assurance Committee		
	Agenda Ref.	QAC/20/07/98		

	Date of meeting	7 July 2020
	Summary of Outcome	Quality Assurance Committee asked to note the report.
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	Choose an item.	

REPORT TO BOARD OF DIRECTORS

SUBJECT	Health & Safety Annual Report 2019/2020

1. BACKGROUND/CONTEXT

The report describes Health and Safety (H&S) activity over the past 12 months at Warrington and Halton Hospitals NHS Foundation Trust. The management of H&S is a critical component of the overall Governance agenda, with the safety of patients and staff being the core value.

This year has seen improvement in the systems and processes for H&S which has included simplified documentation for audits and inspections, better recording of lost time incidents and continued improvement in both communication and engagement.

2. KEY ELEMENTS

2.1 Health and Safety Training

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

Topic	Training Requirements
Health and Safety Training for Senior Managers	Booklet to be read and signed 3 yearly
Health and Safety Training	E-learning to be completed 3 yearly
Non Clinical Manual Handling	Class room or e-learning to be completed 3 yearly
Clinical Manual Handling	Class room training to be repeated every 2 years
Working at Height	Departmental based annually
Risk Management Training for Senior Managers	All the training to the left is one off training with a rolling programme of dates if required
Risk Management Training	
Risk Assessment Training	
COSHH Training	
Hazard Awareness Training	

The programme consists of:

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

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

- Risk Management Training for Senior Managers – this is a one off training session for senior managers to ensure there is good, clear understanding of risk management within the Trust.

- Risk Management Training for Managers – this is a one of training session for managers to understand and gain knowledge and training around the principles of risk management and the overall risk process.

Additional Training

There have been specific courses run throughout the year which include:

- Working at Height (Step ladders and kick-stool training).
- Non Clinical investigation form training.
- Manual Handling training.
- Control Of Substances Hazardous to Health training (COSHH0.
- Display Screen Equipment Training (DSE).
- Hazard Awareness Training.
- A short video has been produced on assembling a sharps bin. This has been circulated through the Communications media to prompt staff on the correct assembly techniques to prevent incidents whereby the lids have not been secure.

2.1.1 Assurance:

All health and safety training packages have been reviewed throughout 2019/20 to ensure all instruction, guidance and information is fully up to date with current health and safety legislation.

2.2 Health and Safety Policies

There are a wide range of policies and guidance documents developed and now embedded across the organisation.

During the past 12 months the following policies and guidance documents have been reviewed and approved at the Health and Safety Sub Committee meeting:

- Display Screen Equipment Policy.
- First Aid at Work Policy.
- Control of Substances Hazardous to Health (COSHH) Policy.
- Latex Policy.
- New and Expectant Mothers Policy.

- Slips, Trips and Falls Policy.
- Smoke Free Policy.

2.2.1 Management of Ligatures Policy

The Management of Ligatures Policy was developed in July 2020. This was to ensure the Trust has processes in place to keep all patients and visitors safe and well. An example risk assessment was also produced to support managers in completing ligature assessments within their areas of work. The Management of Ligatures has been added to the Health and Safety Annual Audit Tool to further support the work undertaken and to monitor compliance with the Trust Policy.

2.2.2 Assurance:

All Health and Safety Policies and Guidance documents are fully up to date and are complaint with all relevant legislation.

2.3 Guidance, Information and Advice

The H&S team, over the past two years have developed a number of pages on the Trust HUB (now the Extranet) to provide support and advice to Wards and Departments on a wide range of H&S topics.

Information includes:

- A Health and Safety Library Page – which provides an A-Z list of all H&S guidance documents, templates and checklists.
- Example risk assessments – this provides an example of risk assessment for each standard within the risk management framework.
- Advice pages on specific topics which include, Slips, Trips and Falls, Stress, COSHH, DSE, Housekeeping, Good Practice, Working at Height.
- A programme of practical training dates for various topics.
- Copy of safety alerts developed for any particular issue that may need immediate attention.

2.3.1 Health and Safety Newsletter

The Health and Safety Newsletter is produced on a bi-monthly basis and is disseminated to all wards and departments.

The newsletters keep staff informed of “hot topics” as well as raising awareness of safety issues across the Trust. The aim is to provide staff with up to date information on H&S topics throughout the Trust. Letting them know the work that goes on to help keep them healthy and safe.

Each issue holds photographs to demonstrate evidence of good practice and areas where improvements have been made. On occasions “before and after” shots have been taken of examples of work that has been carried out to make improvements.

We Found	We Acted
 In November 2019, outside the Cardiac Catheter Suite, there was a incident with a wheelchair user due to the incline of the drop down kerb	In February 2020, Estates installed a new disabled ramp at the side and reinstated a full kerb along the pavement to allow suitable access for wheelchair users 
The mobile Breast Screening Unit have re-located within the Halton Hospital Grounds. There wasn't sufficient segregation with the trailer and pedestrian walkway 	Additional barriers were purchased by Breast Screening and put into position. This is clearly an improvement and safety measure to prevent pedestrians walking into the head of the trailer 

2.3.2 Assurance:

All guidance, training and information are updated regularly throughout the year.

There is a suggestion section on the Health and Safety newsletter to encourage staff to actively get involved in their health and safety at work.

2.4 Health and Safety Audit Tool April 2019 to March 2020

The Risk Management Framework is the basis of the H&S Management System for the Trust. This provides a structure for managers to follow to ensure compliance with legislation in their areas of work.

The tool is the process by which, the Trust can provide assurance that there is an effective system of internal control to monitor H&S risk and continually improve to provide a safe and healthy environment.

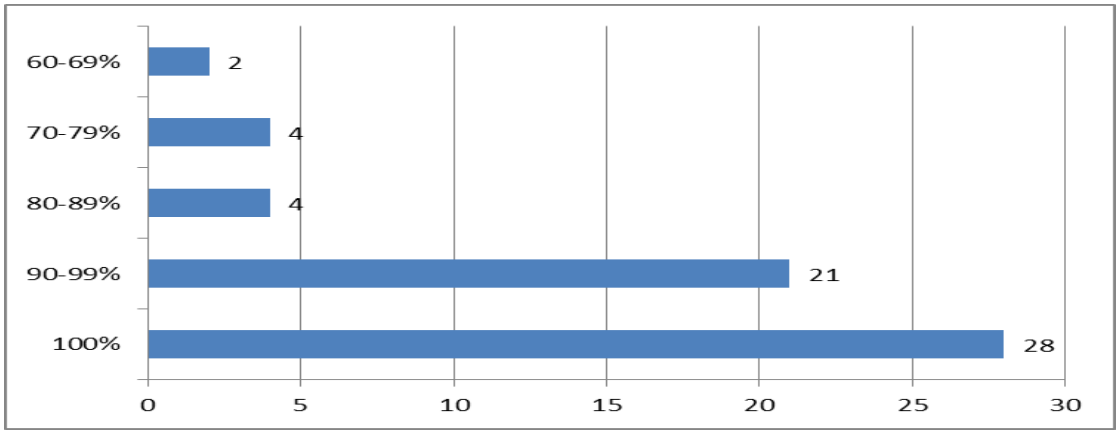
The Risk Management Framework consists of a number of standards each supported by a set of Performance Criteria and policies and guidance. The standards and criteria have been taken from key legal requirements relating to health and safety.

Risk Assessments	Night Work
Workplace Transport	Home Working
Control of Substances Hazardous to Health	Fire Safety
New and Expectant Mothers	Display Screen Equipment
First Aid	Incident Reporting

Work at Height	Legionella
Work Equipment	Radiation
Welfare Provisions	Stress at Work
Health and Safety Local Induction	Young Persons
Management of Sharps	Slips, Trips and Falls
Personal Protective Equipment	Management of Ligatures
Risk Assessment Tool	Manual Handling

For the financial year of 2019/20, the Health and Safety Team carried out 59 audits of Wards and Departments.

The graph below shows overall compliance of Health and Safety Management throughout the Trust.



Managers were supported with information to meet full compliance, though at the time of the audit, it was noted that changes in both staff and ward areas impacted on completion of action plans e.g. other Managers trying to work through unfamiliar handed over action plans.

Audits throughout March 2020 where suspended due to the global pandemic.

2.4.1 Assurance:

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

Managers have the benefit of splitting risk assessments from the risk register. This has made it much easier to manage.

Due to the global pandemic, audits towards the year end where suspended. However, Health and Safety have ensured Wards are up to date with statutory risk assessments by providing a pack of risk assessments until such time, audits can recommence.

2.5 Control of Substances Hazardous to Health (COSHH)

To manage COSHH, the Trust uses a system called SYPOL. All COSHH risk assessments, COSHH control forms and Safety Data Sheets are managed, maintained and reviewed on the system.

To-date, there are 1,169 completed COSHH assessments available with new assessments being added on a regular basis and there are 1,038 different materials used within the Trust. The majority of products and their activities fall within the category of low risk.

2.5.1 Assurance

During January 2020, a full review on the current COSHH inventories was carried out.

The vast majority of substances used within the Trust grade low to medium.

A programme of training dates continues throughout the year as well as ad hoc training sessions on a 1-1 basis. Any substances that would rate high would be managed with a robust safe operating procedure, following advice from the safety data sheet and/or manufacturer.

2.6 Inspections

A 12 month inspection programme is developed each year. Observations include:

- The Building and Estate
- The Environment
- Procedures and Assurance Checks

These inspections will be unannounced to provide a true reflection of the working environment. If any issues/concerns are highlighted an action plan is provided to the relevant manager. The action plan will be reviewed on the next inspection date to ensure actions are complete or in progress to be complete.

Common themes were:

- Management of sharps bins – finding the incorrect assembly of sharps bins, incomplete labelling, temporary locking in operation and safety devices being used.
- Storage - review cleanliness and appropriate usage of the area and storage of articles.
- Hazardous substances - no unauthorised chemicals brought into the Trust and chemicals being used were identified and stored securely, issues of missing labels, open lids or poor storage were highlighted.

2.6.1 Inspections of Internal Corridors

Corridor inspections for both Warrington and Halton hospitals are carried out by the Health and Safety Team. Findings are recorded and significant issues e.g. damage or waste – are raised

immediately to the relevant departments. Reports are generated from the inspections with good practice also highlighted via Communications, Health and Safety Newsletter or safety alerts.

2.6.2 Assurance

Each has a formal inspection at least every quarter. Areas which show actions are required or if there is a particular problem inspections are carried out more frequently until the issues are resolved.

Evidence of inspections is collated and reported to the Health and Safety Sub Committee each quarter.

2.7 Display Screen Equipment (DSE) Assessments

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

During the period April 2019 to March 2020, the department carried out 47 workstation assessments for referred staff. 40 of these related to existing medical conditions whereby the member of staff was able to stay in work due to reasonable adjustments being made. A number of staff where referred to physiotherapy which again, enabled staff to remain in the workplace.

2.7.1 Assurance

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

2.8 Management of Sharps

The Trust has in place a clear process for the prevention of exposure to blood borne viruses. Safer sharps have been implemented throughout the Trust and areas that could not find a suitable alternative sharp are required to have an equipment specific risk assessment in place.

Health and Safety carry out an annual sharps audit for the Trust in the month of August.

This includes:

- Check areas of compliance, identifying the type of device used in each area.
- To identify any non-safe devices and ascertain why they are still in use.
- To calculate the amount of non-safety devices (old stock) still in circulation.
- To ensure all sharps training is up to date.

Due to the results in August 2019 not being satisfactory, a further audit took place in November 2019 which showed significant improvement with double the number of areas reporting full compliance.

The table below compares the audit findings:

	August 2019	November 2019
No. of areas with temporary bins open	27	28
No. of areas with no labels completed on assembly	19	12
No. of areas with loose lids	8	5
No. of areas with items protruding from the lids	3	4
No. of areas fully compliant	14	28

2.8.1 Assurance

The Trust has in place arrangements to provide a safe working environment in relation to sharps management which includes the provision of safe equipment, training and guidance on safe systems of work. All relevant areas have sharps management packs in place which include information and instruction on the management of sharps. Each areas has been given an action plan following the audits to highlight areas of non-compliance and recommendations to be put in place to ensure that full compliance is achieved and sustained. Audits will be carried out on a bi-monthly basis to provide further assurance.

2.9 Incidents Reportable to the Health and Safety Executive under the RIDDOR Regulations

All non-clinical incidents are reviewed daily by the Health and Safety Team and allocated to the appropriate manager for action. All incidents reportable under RIDDOR are graded moderate and are fully investigated.

The Table below shows an overview of all RIDDOR Incidents reported within the period April 19 to March 2020. This also includes days lost due to sickness absence relating to the incident. Strains and sprains is the most common injury noted.

ID	Month	Department	Work Status	Injuries	Days Lost
131562	April	Domestics	Staff Member	Strains and sprains	48
131617	May	Ward C21	Staff Member	Bone Fracture	24
132111	May	Car Park	Public	Lacerations	0
132512	June	Ward A3	Staff Member	Exposure to BBV	0
132454	June	A&E	Staff Member	Bone Fracture	28
132719	June	Medical Records	Staff Member	Strains and sprains	12

ID	Month	Department	Work Status	Injuries	Days Lost
133008	June	Pharmacy	Staff Member	Bone Fracture	27
133855	July	Radiology	Staff Member	Burns	18
133949	July	Ward B3	Staff Member	Strains and sprains	63
134215	July	Ward A8	Staff Member	Bone Fracture	95
134507	August	Ophthalmology	Staff Member	Concussion	8
135922	September	Ward A9	Staff Member	Bone Fracture	32
136219	September	Ward A8	Staff Member	Strains and sprains	12
136646	October	Hospital Grounds	Public	Fracture	0
136733	October	Ward B3	Staff Member	Strains and sprains	37
137489	November	Ward B14	Staff Member	Bone Fracture	132
137815	November	Community Midwives	Staff Member	Contusions and bruising	32
137895	December	Domestics	Staff Member	Strains and sprains	118
138285	December	Outpatients	Staff Member	Strains and sprains	61
138553	December	Ward A2	Staff Member	Strains and sprains	19
138813	January	Labour Ward	Staff Member	Strains and sprains	45
138975	January	Domestics	Staff Member	Strains and sprains	67
139574	January	Ward B10/B11	Staff Member	Contusions and bruising	8
140021	January	Ward B14	Staff Member	Strains and sprains	30
139668	February	Medical Records	Staff Member	Strains and sprains	11
139800	February	A&E	Staff Member	Contusions and bruising	10
140176	February	Off site	Staff Member	Bone Fracture	16
139972	February	Ward A9	Staff Member	Strains and sprains	15
140205	February	Theatres	Staff Member	Exposure to BBV	0
140480	March	Theatre 2	Staff Member	Strains and sprains	26
140820	March	Radiology	Staff Member	Lacerations	14

ID	Month	Department	Work Status	Injuries	Days Lost
Total					1008

2.9.1 Assurance

All non-clinical incidents are reviewed each morning by Health and Safety. Each incident is allocated to the relevant manager for action. There is a tracking spreadsheet in place to ensure that all information is monitored and relevant actions are detailed before the incident is closed. Health and Safety investigate any incident that has resulted in loss or harm. Data is collected in relation to any lost time incidents due to injury or ill-health. A report of incident data is produced bi-monthly and reviewed by the Health and Safety Sub Committee. A quarterly report is presented at the Quality Assurance Committee, which includes lessons learnt from non-clinical incidents. A lessons learnt section is covered in the Health and Safety bi-monthly newsletter.

2.10 Health and Safety Award

The Royal Society for the Prevention of Accidents (RoSPA) has an international award scheme. Health and Safety entered for this award in July 2019.

The RoSPA Health and Safety Awards are open to organisations of all sizes across a wide spectrum of industries all over the world. These awards are non-competitive and are based on the organisation's individual occupational health and safety performance. Judges include the Health and Safety Executive and the Chairman of the Institution of Occupational Safety and Health.

The Trust has to provide evidence of a robust and effective health and safety management system by providing answers and evidence to a set of key performance questions. The awards are rated as a credit, bronze, silver and gold. The Trust was successfully awarded with the prestigious gold award in recognition of a robust health and safety management system.

3 DISCUSSION

3.1 Learning and Improvements

- A Review of the Trust's Health and Safety Strategy, policies and reporting has been undertaken.
- A review of the Trust's Health and Safety Sub Committee has been undertaken including frequency, terms of reference and assurance reporting.
- A review of all mandatory training has been undertaken to ensure staff have the knowledge and skills to carry out their roles safely and healthy.
- A full audit of compliance has been undertaken within the past year of all Departments.

There has been a number of Health and Safety improvements put in place including:

- Flooring has been replaced with non-slip flooring in many areas or new flooring to reduce hazard tape and slips, trips and falls.
- Weekly inspections of corridors to identify damage that could cause injury – raise issues to Estates before incidents occur.
- Gates have been installed on some linen cupboards to hold in bags of dirty linen to stop overflowing onto corridors.
- Heavier matting at entrance doors to prevent tripping and ruffling of carpets.
- Metal barriers installed at car park near bus stop to stop short cuts and stop people crossing road in busy areas.
- Resurfacing works to external carpark areas to reduce the potential of a tripping hazard.
- Slips, Trips and Falls – wet floor signage has been placed at front entrances so they can be put in situ immediately to warn of wet floor until mopped up.
- Moved clinical waste bins around the Trust, most have been relocated to external locations from the corridors so not to be visible to patients and visitors.
- External walkabouts identify broken flags, obstacles etc to prevent slips and trips, more undertaken at Halton which have identified numerous broken flags.

3.2 Future Development

The priorities over the next 12 months are:

- Increase in the number of inspections for Wards and Departments by collaborative working with the Union Representatives.
- Increase safer sharps audits.
- Raise awareness and develop a campaign to be disseminated across the Trust to promote safer user of sharps, correct disposal etc.
- Sharing feedback and learning on non-clinical incidents.
- Provide good practice links in Communications to highlight areas of excellent housekeeping or other areas of outstanding performance in health and safety.
- Continue to analysis lost time incidents looking at trends and themes.
- Ensure investigations have appropriate detail and are completed within required timescales.
- Ensure all RIDDOR incidents are effectively tracked and reduce the incidents of claims due to ensuring robust risk assessment and training is available.
- Review of incident reports.
- Develop dashboard reports for all CBUs.
- Review generic risk assessments to ensure they are appropriate to the needs of the Organisation and effectively implemented.
- Review policies and guidance documents in line with current legislation.
- Produce comprehensive DSE reports for staff and managers to minimise the risk of work related upper limb disorders.
- Continue to develop the extranet pages.
- Develop risk assessment training for all levels of staff across the Trust.

3.3 Conclusion

There is an established pro-active safety management system within the Trust particularly with audits and inspections. Documentation is now fully standardised and Departments are meeting compliance with the health and safety legislation.

There are much better lines of reporting within the Health and Safety Sub Committee providing detailed assurance reports for all Health and Safety legislation the Trust must comply with.

The health and safety management system is fully embedded within the Trust and the Trust is meeting compliance with all relevant health and safety legislation and guidance.

4 RECOMMENDATIONS

The Board of Directors is asked to note the report.

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/20/07/79**		
SUBJECT:	**Quality Strategy Annual Update**		
DATE OF MEETING:	29 July 2020		
AUTHOR(S):	Layla Alani, Deputy Director Governance		
EXECUTIVE DIRECTOR SPONSOR:	Kimberley Salmon-Jamieson, Chief Nurse & Deputy Chief Executive		
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	SO1 We will.. Always put our patients first through high quality, safe care and an excellent patient experience. SO2 We will.. Be the best place to work with a diverse, engaged workforce that is fit for the future. SO3 We will ..Work in partnership to design and provide high quality, financially sustainable services.	x x x	
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF):			
EXECUTIVE SUMMARY *(KEY ISSUES):*	The purpose of this paper is to provide a summary of the following: • Progress made in relation to the Trust Quality Strategy and the Quality Pledges detailed within the strategy. • Proposals for reviewing the Quality Strategy to ensure that it is still aligned to the Trust's current priorities.		
PURPOSE: *(please select as appropriate)*	Information	Approval	To note x	Decision
RECOMMENDATION:	The Board of Directors is asked to note the report.		
PREVIOUSLY CONSIDERED BY:	**Committee**	Quality Assurance Committee	
	Agenda Ref.	QAC/20/07/99	
	Date of meeting	7 July 2020	
	Summary of Outcome	The Quality Assurance Committee were asked to note the report	
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full		
FOIA EXEMPTIONS APPLIED: *(if relevant)*	Choose an item.		

REPORT TO BOARD OF DIRECTORS

SUBJECT	Quality Strategy Annual Update

1. BACKGROUND/CONTEXT

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

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

For each priority domain we have a series of Quality Pledges and Quality Priorities; the progress of each priority is reported on a quarterly basis to the Trust's Quality Assurance Committee. Where possible we include performance indicators to measure and benchmark progress and they are reported on a monthly basis, via the Quality Dashboard to the Board of Directors.

2. KEY ELEMENTS

The Quality Strategy uses the following measures of success:

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

With the above measures of success in mind, the following infographic details some of our key achievements from the Quality Priorities for 2019/20:

1. Assurance and Quality Pledge progress

The Quality Strategy contains Quality Pledges and the table below contains updates have been on each of the pledges and an assurance levels has been assigned;

Patient Safety Pledges

Pledge: A 20% reduction in serious harm falls for our patients who stay in hospital

Lead: Alison Kennah, Associate Chief Nurse - Patient Safety

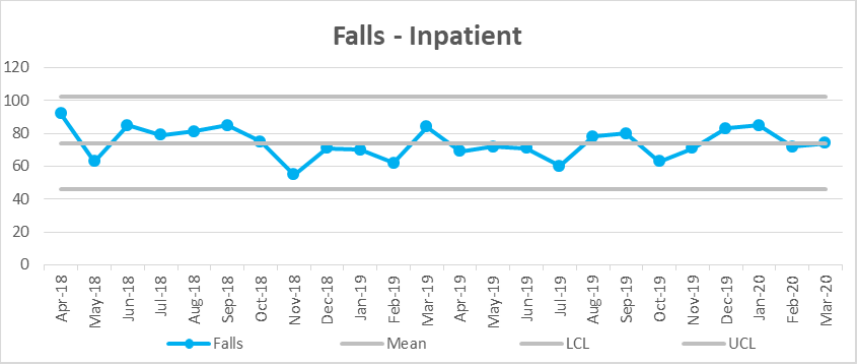
Implementation Plan and progress to date:

The human cost of falling in hospital can be devastating and may lead to pain, injury, loss of confidence, loss of independence and increased morbidity and mortality. Falling also has an impact on quality of life.This pledge linked in with our Quality priorities for 2019/20 and 2020/21 where we committed to achieve a 10% reduction in Serious Harm Falls by 2020 and a further 10% by the end of 2021.

The workstreams that deliver this pledge are monitored monthly at the Falls Steering group. An overall summary of falls in 2019/20 is as follows;

- In quarter 1, 2019/20 we re-launched the updated multifactorial documentation and commenced QI Breakthrough series collaborative launch.
- Multifactorial audit pro-forma was completed and an audit conducted in November 2019.
- Ward based Patient Safety Champions identified for all areas with role description completed. The first meeting was held in October 2019.
- Quality improvement programme continued with collaborative learning session held in September 2019.
- Updated patient safety leaflet developed in collaboration with external partners.

Table 1 below is an extract from the Trust Integrated Performance Report and shows inpatient falls for 2019/20. A reduction of 11.9% was noted for inpatient falls for 19/20 compared with the same reporting period for 18/19.



How progress will be monitored and reported

- Trust IPR, Falls monthly steering group, PSCEC, Quality Committee

Pledge: 100% medicines reconciliation when patients come into hospital and promotion of safe prescribing and administration of medicines

Lead: Diane Matthew, Chief Pharmacist

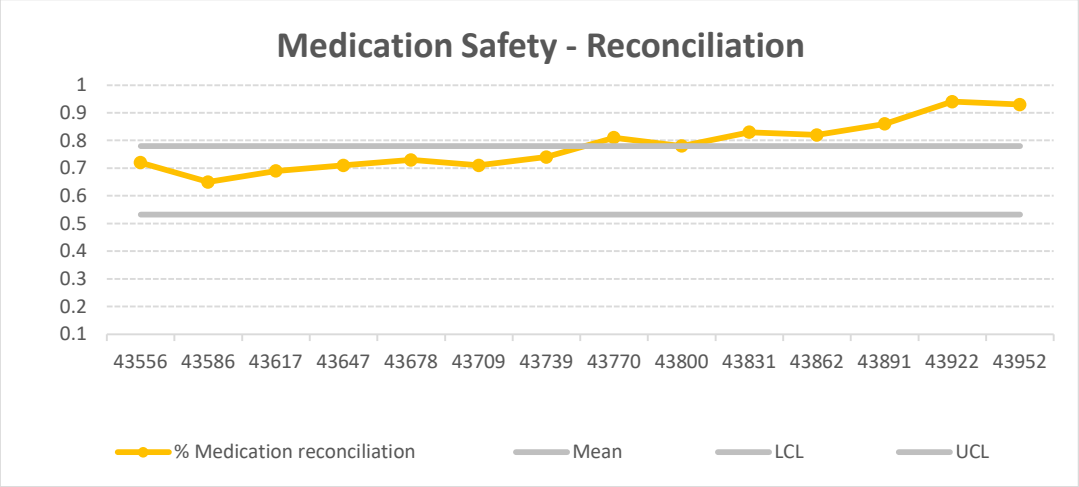
Implementation Plan and progress to date:

Medication reconciliation is monitored by the Medicines Improvement Group that reports to the Moving to Outstanding Steering Group.

The following changes have been made;

- Recruitment within Pharmacy
- Pharmacists are now available on wards
- Re-modelled weekend working as there are now a higher number of doctors working at weekends
- Pharmacy have created a dashboard populated nightly to enable staffing resource to be allocated according to apparent workload.

By making the above changes we have seen medication reconciliation rates increase throughout the year, as seen in the table below;



How progress will be monitored and reported

- Trust IPR, Medicines Governance group, PSCEC, Quality Committee

Pledge: A 10% reduction in Hospital Acquired Infections – particularly focusing on safe catheter care and implementation of the Trust's Urinary Tract Infection (UTI) pathway

Lead: Lesley McKay, Associate Director of Infection Control

Implementation Plan and progress to date:

Weekly email circulated with up-to-date information on cases by location & monthly dashboard.
Internal GNBSI reduction action group set up which meets monthly.
Gram Negative Collaborative driver diagram and action plan have been developed with the Quality Academy with agreed tests of change. Focus of activity includes:-

- Aim to reduce use of urinary catheters – daily challenge in place
- Improvements to care of urinary catheters – review of all urinary catheter policies

required and introduction of competency assessments incorporating ANTT
- Patient Hand Hygiene Strategy
- Hydration Strategy
- Report to Medical Cabinet
- Grand Round Presentation

With regards to health care acquired infections (HCAI) during 2018/19, the Trust threshold was 0 cases of Meticillin-resistant Staphylococcus aureus (MRSA) bacteraemia and despite the continued focus on managing HCAI; the Trust reported 2 cases of MRSA bacteraemia. In relation to Clostridium difficile The Trust reported 49 hospital onset cases against the annual threshold of 44 cases. 14 cases considered avoidable, 15 cases unavoidable and 20 cases yet to be reviewed. Delay in case reviews due to Coronavirus pandemic with meetings to be established as soon as reasonably practicable.

The Trust also carefully monitors Meticillin-sensitive Staphylococcus aureus (MSSA) bacteraemia and E. coli bacteraemia. The Trust reported 15 hospital onset cases of MSSA bacteraemia during the financial year. This is a decrease of 2 cases compared to the previous financial year. These cases are under review to identify any areas for care improvement. The Trust reported 46 hospital onset cases of E. coli bacteraemia. Partnership working is in place across the health economy and the Trust is working with community partners to progress the action plans. Work streams related to the reduction of healthcare acquired infections continue with oversight at Patient Safety Sub Committee and Quality Assurance Committee.

How progress will be monitored and reported

Trust IPR, Meeting minutes and action log – to monitor progress.

Actions not completed will are escalated to the Deputy Chief Nurse for discussion at 2:1 meetings with the Chief Nurse, urinary catheter data and quarterly prevalence surveys (scheduled for June: Sep; Dec & Mar), Male catheterization policy and competency assessment currently under review.

Pledge: 100% of patients having sepsis screening and being treated appropriately

Lead: Alison Kennah, Associate Chief Nurse - Patient Safety

Implementation Plan and progress to date:

- Obstetric, paediatric and adult sepsis policies unified into one sepsis policy. This has been reviewed and approved by the sepsis steering group and policy review group and shared across the trust via the Patient Safety and Clinical Effectiveness Sub-Committee.

- Developed a weekly audit of patients in receipt of treatment for Sepsis, to ensure they receive the full bundle of care aligned to Sepsis 6. This weekly audit to be launched via electronic sepsis bundle in July 2020. Retrospective data is collected monthly for sepsis screening and treatment.

- Ward based education has been developed and delivered by the Patient safety champions in relation to the Sepsis 6 in December 2019.

- “Hot Topic” at Trust wide safety brief was delivered between 20th-24th January 2020.

Blood culture training for wider nursing population has commenced via clinical education, and emergency department education programme.

- Antimicrobial ward rounds continue twice weekly across the trust.
- Plan to embed the Sepsis Care Bundle pathway into the Trust electronic record keeping system – the Patient Safety Team are currently exploring the use of electronic sepsis bundle which they aim to launch in July 2020.
- The Trust have signed up to participate in the Advancing Quality programme, run by AqUA, which supports Trusts to improve the reliability of their clinical practices and reduce variation in the care of patients with Sepsis. The Sepsis improvement network from AqUA supports delivery of the highest quality care to every Sepsis patient, every time across the region. The interim target with AqUA is 75%, this is a national target set for all Trust's within the programme. We have input Quarter 3 and 4 data and by year end 19/20 the Trust had achieved 68% of patients being screened against the 75% target. It is important to note that there is a 2 months delay in national reporting for this dataset.
- In 2020/21 the Patient Safety team have planned quality improvement work with AQUA to address identified areas of improvement on latest performance.
- Sepsis training has been delivered via trust induction, AIM and ILS.
- The Patient Safety Team standardised the approach to the access and storage of screening equipment across all wards and departments in 2019/20.

How progress will be monitored and reported

- Quality Dashboard, Quarterly Sepsis Steering group, PSCEC, Quality Committee

Pledge: 100% of patients to have a Venous Thromboembolism (VTE) assessment and to have appropriate treatment

Lead: Alison Kennah, Associate Chief Nurse - Patient Safety

Implementation Plan and progress to date:

- The Trust policy has been streamlined in relation to VTE and shared across the Trust via the Patient Safety and Clinical Effectiveness Sub- Committee.
- Targeted training utilizing simulation – this has been completing through the nurse preceptorship programme, Aims, ILS. Formal VTE training has been added to medical induction training which is due to commence August 2020. An E-learning module is also available.
- Updated Patient Information is now available and in use across the Trust.

- Risk assessment documentation modification complete to include 16yr old and above. This has been approved by the VTE steering group and shared across the Trust.

- Root Cause Analysis process in place. RCAs are completed where any harm is caused and Duty of Candour completed. Oversight of RCA by the Associate Medical Director for Patient Safety

- There are escalation processes in place and accountability for specialties to highlight any concerns in relation to VTE assessments in their areas; this was reviewed by pharmacy and shared at the VTE steering group. Oversight of any concerns by the Associate Medical Director for Patient Safety

- The VTE Steering Group have revised the PE/DVT protocol; this is currently being reviewed by the CCG.

- GIRFT - Data capture commenced October 2019 planned to continue until March 2020. However, data collection has now been extended until June 2020 due to COVID-19.

Venous Thromboembolism (VTE) – percentage of risk assessments undertaken

Year	Q1	Q2	Q3	Q4
2019/2020	90.45%	90.40%	90.49%	86.66%
2018/2019	95.76%	95.02%	95.03%	95.58%

How progress will be monitored and reported

- Trust IPR, Specialty dashboards, PSCEC, Quarterly Thrombosis Group meeting.

Clinical Effectiveness Priorities

Pledge: Reduce DTOCs to no greater than 3%

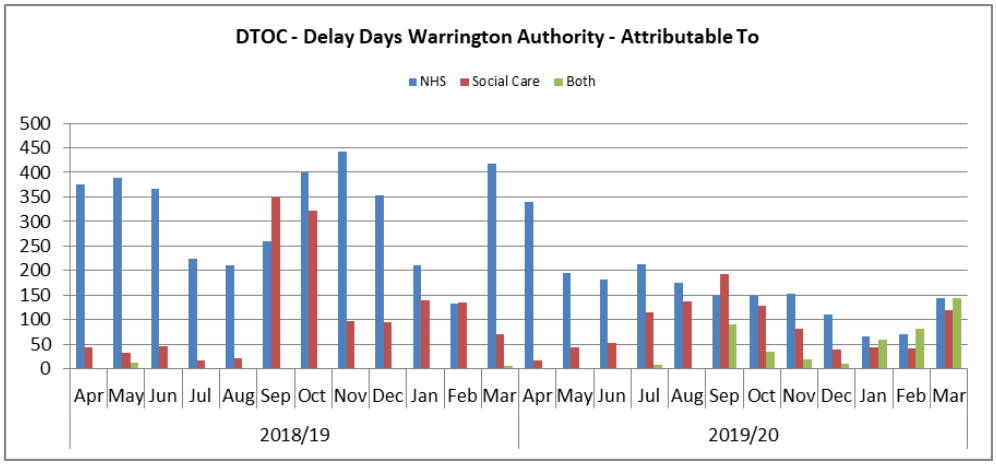
Lead: Dan Moore, Deputy Chief Operating Officer

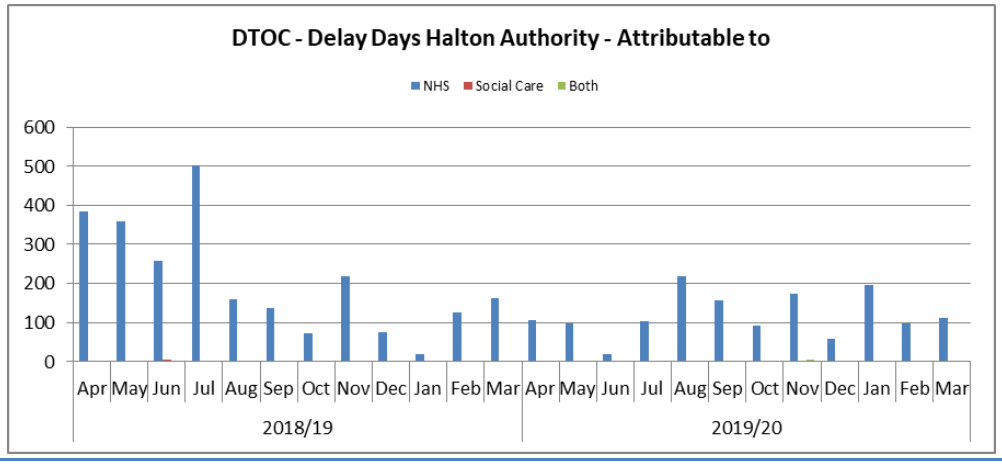
Implementation Plan and progress to date:

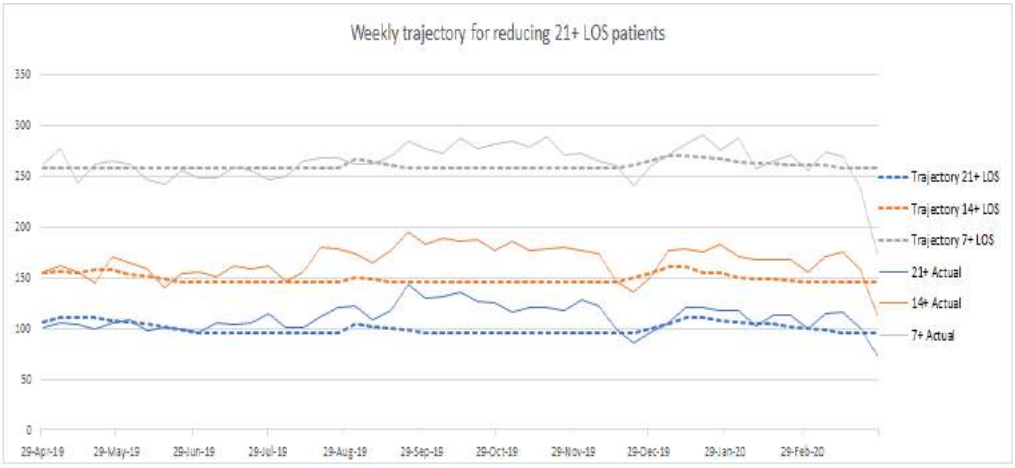
- Super Stranded Patients – we worked with our regulators to agree an improvement trajectory which will see no more than 95 patients with a LoS over 21 days. Over the course of 2019-20, we made incremental improvements and met our initial trajectory.
- Work is well established having embedded NHSE's Where Best Next philosophy in relation to long lengths of hospital stay.
- The health and social care elements of the Discharge Team that are now fully integrated and co-located under a single leadership structure accountable to both WHH and WBC and with strong working arrangements with HBC.
- Daily Where Best Next ward rounds take place providing a flow and education offer in supporting colleagues to understand the adverse impact of a long length of stay and overcoming barriers to a safe and timely onward transfer from hospital.
- Daily Where Best Next meetings take place within the Discharge Team to ensure patients

transfer to their next best destination without delay and to identify barriers that require a different intervention or escalation.

- The Trusted Assessor approach has been embedded across care homes and intermediate care adding value to the patient journey and also fostering stronger relations across our health and social care community.
- Operational management and co-ordination of transfers into the intermediate care beds is now led and overseen by the Discharge Team rather than remotely in the community; this provides real time information on bed availability and planned transfers and has almost eradicated delays in accessing intermediate care.
- Our intermediate care offer has also been complemented by the addition of residential intermediate care beds and additional resource has been recruited to in the intermediate care at home offer where people typically transfer home with 2-3 days of request.
- Towards the end of 2020, the new Community Rapid Response Service was launched; this service aims to provide a community within 2 hours of referral and is also open to all assessment functions in the trust to expedite a return home.
- Collaborative between NHSI and ESIS is complete across 5 wards who have adopted a QI collaborative approach to a raid improvement cycle of ward based initiatives to optimise length of stay including the Red to Green approach to assessing value and a Ward Round Accreditation programme focused on eliminating patient harms.
- ED Improvement Committee established







How progress will be monitored and reported

- Quality dashboard, Specialty dashboards, Quality Committee

Pledge: Reduce readmissions within 30 days for patients >65 to no greater than 12.5%

Lead: Dan Moore, Deputy Chief Operating Officer

Implementation Plan and progress to date:

- The baseline and review is yet to be established as it was to be reviewed in quarter 4, which was impacted by COVID preparedness. In line with recovery the Trust will look to establish this baseline metric and review performance against this standard within Qtr 2 2020/21. This data is currently monitored for all patients and relates to readmissions within 30 days. The new data capture which is currently being produced will capture >65 specifically.

How progress will be monitored and reported

- Quality dashboard, Specialty dashboards, Quality Committee

Pledge: Understanding variance in clinical outcome measures across all specialities, measure and agree improvements

Lead: Gary Sutton, Quality Academy Manager and Hayley McCaffrey, Head of Clinical Effectiveness

Implementation Plan and progress to date:

The GIRFT (Getting It Right First Time) national programme has 44 specialties, service and cross cutting work streams coordinated through regional implementation teams and supported by national specialty reports. The Quality Academy manager and AMD for clinical effectiveness ensure that all GIRFT programmes are directed through the quality academy and communication

coordinated with the specialty teams required. This process is monitored on a high-level tracker. Actions agreed with the regional (GIRFT) implementation manager and Trust specialties are inputted on the specialty action plan and GIRFT action tracker and progress monitored. Failure to progress is evaluated by the Quality Academy manager and AMD and escalated to the executive team or PSCE committee if required.

Deep Dive Visits:

Deep dives are the bedrock of the GIRFT process. They provide the opportunity to have clinician to clinician discussion and debate on the specialty's own data to identify areas of good practice that can be shared across the NHS via GIRFT and areas for improvement.

The Trust have had deep dive visits during 2019/20 for the following specialities:

Specialty	Date of Visit	Observation Notes received	GIRFT Implementation Team Visit	Improvement work initiated
Breast Surgery	December 2019			✓
Cardiology	August 2019	✓	✓	✓
Critical Care	November 2019			
Endocrinology[i]	September 2019	✓		
Gastroenterology	October 2019			
Respiratory	October 2019	✓		
Rheumatology	October 2019	✓	✓	

Due to Covid-19 outbreak visits from the GIRFT Implementation Team have been postponed. GIRFT are revaluating the best method to restart these, but it has been recognised that physical visits will be replaced with virtual meetings via video conferencing. Variance updates following the deepdives can be seen in **Appendix one.**

3. Recommendations

The Board of Directors is asked to note the report.

Appendix one

Variance following Deep Dives:

Specialty	Positive Variance	Negative Variance
Cardiology	• Daily Consultant input and 24/7 cover is a model of care. • Inpatients and Outpatients' waiting times are good and well within the 18-week target. • Cardiology Outreach – reconfiguration of bed base facilitated improved outreach capabilities to other specialty	• **Increase capacity of CTCA** – work with the network to make this the default investigation for stable chest patients. • **Catheter Lab Utilisation** – Review utilisation as Cath Lab is not being fully utilized. ACS patients should be catheterized in a PCI-capable lab by a PCI-capable operator. • **Access to CMR** – work with the network to ensure adequate, timely

	areas.	access to CMR as current waits are excessively long. • Operators' diagnostic coronary angiograms should perform a minimum of 100 per year. • Develop nurse-led chest pain and heart failure review clinics. • Develop physiologist or nurse-led valve follow up clinics. • Work with the network to improve access to 24/7 ECG. • Currently new to follows up is higher than the national average. • Repatriate complex device follow up from Liverpool Heart & Chest hospital.
Endocrinology	• The administrative support is good with the longest wait for patient letters at a 2-week delay. There is a system to flag any urgent letters which are usually completed 24-48 hours. • There is lots of training provided within the trust by the one consultant	**Coding** • An investigation is required into the coding of day cases as 32% of day cases being coded to 300/302. • Secondary coding requires review for both sites, particularly for the Halton site as the coding figure is below the national mean. • Ensure the level of secondary diagnosis codes for endocrinology day cases is reviewed when the day cases are all classified correctly, as the numbers will increase at that stage. **Clinics** • The current referral process requires review as referral letters are not being pre-screened consistently. There are also issues with the consultant receiving the referrals in a timely manner. The majority of the referrals are screen by the consultant but the currently process has led to referrals being received late. • Pretesting needs to be increased for completion before the clinical appointment, which would reduce capacity issues and increase efficiency. • It is recommended that the remote/virtual clinics are increased to further reduce capacity issue and the recruitment of specialist

		endocrine nurse could facilitate this. • An increase of the administration service/support is recommended to fully adopt the process of sending the patient results by letter. **Capacity** • More endocrine sessions are required as there is a significant capacity problem for follow ups appointments with a five month wait. **Specialist Endocrine Nurse** • Recruitment of an Endocrine Specialist Nurse(s) is highly recommended to reduce the backlog of follow up appointments and improve clinic capacity issues. . **Thyroidectomy and parathyroidectomy** The Endocrinologists are not involved in the MDT, which seems to work but this is unusual. On the whole the numbers of surgical thyroidectomies are low at 27 and thyroid cancer is referred to the regional cancer services. Parathyroid surgery is completed at the Trust with 23 completed between 2 surgeons. • There is no thyroid bleed protocol in the wards for thyroidectomy patients, which needs to be implemented. • The thyroid non-malignant figure is 27, which is low. • The incidence of hypocalcaemia following thyroidectomy for endocrine reasons is unknown and it is recommended to gain this data for review. • The length of stay and complication rate from the data provided for parathyroidectomies is longer than the national average, which requires review. **Adrenal**

		• Patients with known adrenal insufficiency should be given hospital prescribed injection kits consisting of hydrocortisone sodium phosphate, a needle and syringe. **Obesity Services** The obesity service is currently commissioned through the community and patients referred back to GP. This is provided in Warrington by a private company. **Quantity and cost of long acting somatostatin analogues** • It would be worth exploring the price differences between Octreotide and Lanreotide with Procurement/Pharmacy Department(s) to ensure that the lowest cost is achieved.
Respiratory	• The organisation has standardised the use of the NIV machines across the site which demonstrates good practice for consistent and efficient use. • The flu vaccination uptake rate is higher than the England average at around 85.5%. The high uptake rate is achieved by a comparative competition between the business units with an added incentive of a pen and the flu fighter shield. • Full Pulmonary Function Tests (FPFT) is captured well. • Within the outreach respiratory service there is an integrated respiratory team, where the staffing resource is externally funded delivering physio and rehabilitation. This is to be captured by the GIRFT Implementation Team as this is an efficient way of delivering respiratory care across boundaries. • There is a process of	**Audit & Data** The Trust have returned all the BTS Audits apart from emergency oxygen. • It is recommended to implement coding training for junior respiratory doctors, perhaps at a journal club to ensure the accuracy of coding is improved. • The Trust should consider a nominated respiratory consultant taking responsibility as a department coding lead. **Respiratory Department Level –** • Given that only around 40% of the acute respiratory activity is coded to Respiratory Medicine, there needs to be a greater input of respiratory services into the Trust. • The overall length of stay for respiratory patients within the respiratory department and more importantly, from the DZ chapter activity, is high at 8.5 days compared with an England mean of 6.6 days. • The new to follow up ratio is higher

	appropriate conversations and management around end of life with the ITU (not going into ITU). The Trust are to share this with the GIRFT Implementation Team. • There is an externally funded prescribing smoking cessation service delivered by the community by in reach at 2 sessions per week, which will be captured by the GIRFT Implementation Team. • There are robust practices around partial booking that prevent patients being "lost" or "cascaded" through the outpatient system	the England average at 1:3.3, which was attributable to the mechanism within the EPR system there is assurance that this is being reviewed. **Workforce** There is a low number of Respiratory Medicine Consultants giving a DDC per bed ratio of 1.0. There are 4 weekly sessions in the community. There is no daily ward and no dedicated asthma nurse. • It is recommended to run a hot clinic twice a week to support the community team and to prevent admissions. **Diagnostics** • The environment in which the physiology team we were informed fails to meet the national ARTP standards around space. • Fractional concentration of exhaled nitric oxide (FeNO) testing is not available, which for a significant activity in asthma is not acceptable practice and needs to be rectified. **Sleep Medicine** Sleep services are provided with 1,700 patients on CPAP and the time to initiation is 8 weeks. **Non-invasive ventilation service** It is strongly recommended to review the NIV services to ensure they meet the NCEPOD and subsequent BTS standards. A system re bed protection needs to be agreed to ensure the appropriate patients are selected for these specialist beds and that inappropriate patients are not placed on the NIV unit. **Pleural Disease** There is a high LoS at 19 days for pneumothorax vs 11 days that requires

		an audit to determine the reasons why. The infrastructure is inadequate to run a comprehensive pleural service with only 1 DCC and no supporting nurse infrastructure. **Asthma** • A 1.0 WTE Band 6/7 asthma nurse is required for the asthma service. The LoS is high at 6.8 days and the readmission rate is high in respiratory medicine compared with the England average. • Additionally, an asthma nurse would allow development of specific nurse led clinics for early review (NICE recommendation) and likely to reduce the high 30 day readmissions. This would reduce the pressure on consultants to see such patients and thus increase consultant clinic capacity. **Pneumonia** There are high admissions for pneumonia which is in the top quartile. **Chronic Obstructive Pulmonary Disease (COPD)** As there is a high readmission in patients discharged from under care of the elderly a more proactive approach may be worth trialling to see if nurse in-reach to these wards to access this patient population may improve care and lead to reduced readmissions.
Rheumatology	• The Referral to Treatment times for Rheumatology specialty has reduced; this is due to a very good urgent referral pathway and investment in consultant staffing • There is in-house succession planning and training for staff with progression of bands. • Out-patient joint injection procedures are well recorded; the unit have forms used to	• There is need for the trust to address the workforce and capacity challenge. Waiting times are currently high with backlogs in both new and follow-up patient booking. • The department would benefit from reviewing the skill-mix of the team to consider potential of other staff types e.g. administrative staff, physician associates, to complement the existing disciplines, particularly where there are recruitment difficulties.

	record these outpatient procedures. • Joint injections are being undertaken in outpatient clinics as opposed to the day-case unit which is more convenient for patients. • The day-case unit is a nurse-led service and patients are not routinely seen by medical staff, which is good and efficient practice. The nurses are also trained in non-cancer chemotherapy. A rheumatology consultant is on-call for emergencies and there are neighbouring wards should the team not be able to engage the on-call rheumatologist promptly. • The department has benefited from gain share for switching to biosimilars. The rate of switching to biosimilar drugs was rapid. • There is a fairly robust system in place for DMARD monitoring in the community with follow-up patients. • A dedicated clinic for early inflammatory arthritis has recently been established on each site with access to ultrasound. • Good amount of research getting through; will be able to do more with support.	• The early arthritis pathway does not currently meet NICE targets in the National Early Inflammatory Arthritis Audit. This should be a departmental and Trust priority. Patients meeting criteria will be eligible for the Best Practice Tariff. • The GCA Pathway, as in many Trusts, needs to be reviewed as there is currently delay in seeing these patients to avoid potential life-changing complications. • Length of stay for inpatient admissions with acute hot joints is high in the trust compared to average: if this is consistent the rheumatology department may be able to help improve inpatient pathways.

Update on action plans for 2019/20

Specialty	Total Actions	Not Yet Started	In Progress	Complete	Overdue
Cardiology	12		11	1	
Diabetes	18		16	2	
Emergency Medicine	8				8
ENT	1			1	

General Surgery	24		7	4	13
Hospital Dentistry[1]	TBC				
Obstetrics & Gynaecology	19			19	
Ophthalmology	9		1	8	
Orthopaedics	4			4	
Paediatric General Surgery	9	5		2	2
Radiology	10		6	4	
Urology	18			10	8

The Urology implementation plan has been incorporated into the action plan, from November 2019, that underpins the Urology Improvement work that is on-going within the Trust and being chaired by the Deputy Medical Director.

There are occasions where the number of actions recorded against a specialty will increase following the publication of a national report associated with the specialty. These national reports provide a national overview following deep dive visits and benchmarking of data sets and will then provide several recommended actions for Trusts to implement. Due to timing, there have been instances where the national report actions and actions identified have been available and agreed at the initial meeting with the GIRFT Implementation Manager and Trust staff. The process was for the GIRFT Implementation Manager to meet with the team on a regular basis to monitor completion of the actions, alongside the Trust GIRFT team, and offer support by acting as a broker between Trusts in terms of best practice.

However, following on from a reduction in the number of implementation managers, they will now attend the deep dive meeting and a follow on meeting to agree the actions. Afterwards it is up to the Trust GIRFT Team to monitor the actions as it was doing prior to the implementation managers' arrival. The implementation managers will visit the Trust on a more regular timetable if they consider the actions to be high risk and/or progress is limited.

Specialty level overview

Cardiology

Assurance Level: Green – all actions in date and progressing

The specialty had a deep dive visit in August 2019 and received the observation notes from GIRFT in October 2019. Since receiving them the CBU have been proactive and identified a series of actions that they would like to take forward (please see action plan for details). The specialty is to meet with the GIRFT Implementation Manager to agree any additional actions as required.

Diabetes

Assurance Level: Green – all actions in date and progressing

The specialty had a deep dive visit in March 2019 and received the observation notes from GIRFT in April 2019. Since receiving them the CBU have met twice with the GIRFT Implementation Manager and completed two actions. The CBU have requested that some of the remaining actions that are due during October are put back to January 2020 due to business planning and internal governance reorganisation. The actions have been risk-assessed and are all low risk; therefore, this has been agreed with the WHH GIRFT team.

[1] GIRFT Implementation Manager has changed several times for this specialty. Waiting to hear back who the new implementation manager is so we can arrange a meeting.

Emergency Medicine

Assurance Level: Red – There are actions overdue due to GIRFT nationally

The specialty had a deep dive visit in November 2018 and received the observation notes from GIRFT in January 2019. Since receiving them the CBU have met twice with the GIRFT Implementation Manager to agree a set of actions. It was identified and subsequently acknowledged by GIRFT that the data sets used to benchmark ED were outdated (2016/17) and that ED were aware of the historic issues and had implemented actions to rectify these. There are eight actions, sitting with GIRFT, that are currently overdue and a request for an update had been sent to GIRFT Implementation Manager to ascertain their current progress in October 2019. The Implementation Manager has left GIRFT and is waiting for a replacement to be identified. In November 2019, GIRFT replaced the Implementation Manager and a request was sent regarding an update on progress with the eight outstanding actions. The Trust GIRFT Team was informed in December that GIRFT's BI Team were currently working on Acute & General Medicine work streams and would contact the team with an update. The Trust GIRFT Team has contacted the Implementation Manager in January and May 2020 for an update and was advised that the BI team are not in a position to run data due to national projects on-going. There is no local BI team for the GIRFT regional hubs and so we are reliant on a gap for the BI team to run data report.

ENT

Assurance Level: Green – action completed with others to be added

The specialty had a deep dive visit in March 2018 and received the observation notes from GIRFT in May 2018. There was a positive report from GIRFT and one action was identified which has been completed. There has been a national report published for ENT GIRFT in November 2019 and a meeting has been set up in February 2020 to look at what recommendations require implementation locally.

General Surgery

Assurance Level: Red – 13 actions overdue and require a progress update

The specialty had a deep dive visit in June 2018 and received the observation notes from GIRFT in August 2018. Since receiving them the CBU have met with the WHH GIRFT team twice and have completed four of the actions. They met with the GIRFT Implementation Manager to agree the national and local actions in April 2019. The Trust GIRFT team have contacted the Specialty twice requesting an update. This has now been escalated to the Medical Director.

Hospital Dentistry

Assurance Level: Assurance Level: Green – all actions in date and progressing

The GIRFT Implementation Manager has changed twice since the deep dive meeting held in December 2018, therefore we have been unable to meet with the team and GIRFT. A meeting was arranged for October 2019, but this was cancelled due to the replacement manager leaving GIRFT. A meeting took place in February 2020 with the new GIRFT Implementation Manager and an implementation plan agreed.

Obstetrics & Gynaecology

Assurance Level: Green – all actions complete

The deep dive visit was held in December 2017 and the observations notes received in February 2018. The actions nineteen actions formed part of the Maternity improvement work undertaken by the Trust during 2018 and early 2019. All of the actions have been completed.

Ophthalmology

Assurance Level: Green – all actions in date and progressing

The specialty had their deep dive visit in March 2017 and the observation notes were received in May 2017. To date, the specialty has met three times with the WHH GIRFT team to monitor progress and have closed eight of the nine actions identified. The latter of the three meetings was held in May 2019 with the GIRFT Implementation Manager in attendance. The remaining action has been partially completed but meeting the suggested 7 cataract patients per session is difficult due to patient complexity.

Orthopaedics

Assurance Level: Green – all actions are complete

The specialty held their deep dive meeting in September 2017 and the observation notes were not received until March 2018. To date the specialty has met with the WHH GIRFT team once and the four recommendations identified have now been completed.

Paediatric General Surgery

Assurance Level: Red – 2 actions overdue requiring a progress update

The Trust lead for Paediatric Surgery attended a regional GIRFT deep dive meeting at Alder Hey where the benchmarked data was discussed. A meeting was held in April 2019 with identified Trust staff (Paediatrics and General Surgery), WHH GIRFT team and GIRFT Implementation Manager to agree the implementation plan. Two of the nine actions have been completed with the remaining seven progressing. This has now been escalated to the Medical Director.

Radiology

Assurance Level: Green – all actions in date and progressing

The deep dive visit was held in December 2018 and the observation notes received in March 2019. A meeting was held with the WHH GIRFT team, specialty and GIRFT Implementation Manager to agree the recommendations to be implemented.

Urology

Assurance Level: Amber – There are actions overdue, but a plan is in place to progress

The specialty had their deep dive visit in March 2017 and the observation notes were received in May 2019. The WHH GIRFT team have met with the specialty twice to monitor progress and close fourteen of the seventeen actions. The team have also met a further three times with the GIRFT Implementation Manager in attendance. At the last meeting held in July 2019, a refreshed data set from HES[2] was provided to highlight that several issues originally identified in March 2017 were still apparent. A new action plan was developed and agreed with GIRFT and this has been incorporated into the Urology Improvement work that is on-going within the Trust and being chaired by the Deputy Medical Director.

We are WHH & We are PROUD to make a difference

NHS Warrington and Halton Teaching Hospitals NHS Foundation Trust

QUALITY ASSURANCE COMMITTE

AGENDA REFERENCE:	**QAC/20/07/101**
SUBJECT:	**Medicines Management and Controlled Drugs Annual Report**
DATE OF MEETING:	7 July 2020
AUTHOR(S):	Diane Matthew, Chief Pharmacist
EXECUTIVE DIRECTOR SPONSOR:	Alex Crowe, Executive Medical Director
LINK TO STRATEGIC OBJECTIVE:	SO1: We will... Always put our patients first through high quality, safe care and an excellent patient experience.
EXECUTIVE SUMMARY	1. Aseptic Service overview highlights the approach taken to provide aseptic products and the gaps magnified by COVID-19 that the Trust may wish to consider. 2. Medicines Information Services continue to support the specialist medication information needs of clinical staff and provide an information service utilised by patients 3. Pharmacy procurement staff work tirelessly to ensure the continuous supply of routine and urgent medication needs of patients in the most cost-effective manner available. This has never been more evident than during COVID-19 when supplies of critical medicines were at times kept to a maximum stock of 4 days. Minimising waste continues to be an important approach to keeping medicines costs down 4. The Trust implemented EPMA across the majority of wards during November 2019. The Pharmacy and IT teams plus agency staff provided floor-walking staff 24/7 to support clinical teams during this critical change period. The Pharmacy admissions service to ED was successfully commenced in November 2019 and the first phase of the business was completed in January 2020. Significant improvements resulted in the timeliness of medicines reconciliation, supply of medication to patients, use of patient's own medication and the service received positive feedback from the ED team. Changes arising during COVID-19 required a re-think of service delivery and staff were re-deployed to wards to undertake admissions work and provide pharmaceutical support for the ward clinical

teams. Close monitoring of VTE risk assessment completion was undertaken by Pharmacy staff given the clotting issues detected in COVID-19 patients during the pandemic, allergy status, antibiotic selection, therapeutic drug monitoring were closely checked, timely medicines reconciliation (MR) was driven to assist in ensuring medicines governance/safety was maintained. Tight control of staff ward resource allocations together with lower admission and discharge levels and staff overtime at weekends enabled the Trust to achieve medicines reconciliation levels possibly second to none in the country and with this enhanced patient medication safety.

5. Medicines Governance Committee work continues to ensure that NICE Guidance, Policies and Guidelines are scrutinised carefully before introduction, some of this work continued with email sign off during COVID-19. The Medicines Governance Committee meetings are re-commencing in July 2020.
6. The Trust continues to perform well against Model Hospital Pharmacy indicators (see Appendix) and has contributed to top 10 medicines savings by achieving over £1m savings for 3 consecutive years. Areas for review improvement in the coming year are listed in the body of this report.
7. Medication incidents are reviewed by the Medicines Safety Officer and Pharmacy senior staff contribute to 72 hour reviews and serious incidents involving medicines. Quarterly Reports are submitted and reviewed at Medicines Governance Committee and learning is shared and actions implemented to improve safety. Close working between the MSO and Medical Education Pharmacist has improved the communication of safety information to junior medical staff with regular safety updates at educational sessions and handovers.
8. The Trust is currently performing well in terms of MHRA adverse drug reaction reporting levels

PURPOSE: (please select as appropriate)	Information √	Approval	To note √	Decision
RECOMMENDATIONS:	The Committee is asked to consider / approve the proposed areas of review / improvement.			
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***	**None**			
FREEDOM OF INFORMATION STATUS (FOIA):	**Release in Full**			
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	Choose an item.			

NAME OF COMMITTEE

SUBJECT	Medicines Management and Controlled Drugs Annual Report	AGENDA REF:	QAC/20/07/101

1. BACKGROUND/CONTEXT

2. KEY ELEMENTS

Aseptic Services

In June 2014, Lord Carter of Coles became Chair of a the NHS Procurement & Efficiency Board to direct the NHS Procurement & Efficiency Programme and its portfolio of projects which included a review of hospital pharmacy and medicines optimisation in the work of the Board. In September 2014, Dr Keith Ridge, Chief Pharmaceutical Officer joined the NHS Procurement & Efficiency Board and became chair of the Hospital Pharmacy and Medicines Optimisation Project (HoPMOp).

In the final report[1] in February, 2016, Lord Carter 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 was an area that required review and new ways of thinking to improve delivery and maximise efficiencies.

Within Cheshire and Merseyside and Nationally, aseptic services was considered to be an important area for review and a National survey of aseptic service provision was conducted. Since then, limited progress has been made in determining an overarching aseptic service strategy.

The Trust has a 20 year old Aseptic Unit and has operated with limited staffing resource since the Radiopharmacy closed. In keeping with the ethos of working collaboratively with St Helens and Knowsley NHS Trust (StHK) and the recommendations of Lord Carter of Cole, the Trust's parenteral chemotherapy, biologic and total parenteral nutrition needs are currently provided by a combination of StHK, homecare and approved private sector providers.

The Trust has a gap in relation to the provision of some pre-prepared products for which suppliers have not yet been identified. This has been highlighted within the Cheshire and Merseyside healthcare partnership Pharmacy forum. During COVID-19 we re-visited external options and were able to source additional pre-prepared products to support intensive care

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

in particular however this has highlighted differences in ways of working in relation to use of pumps and syringe drivers that warrants further discussion within the Trust.

Medicines Information Services

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

This service supports healthcare professionals with evidence-based answers to medication related problems and a medicines hotline for patients. Of the 637 enquiries in 2018/19, 44% were raised by patients and 56% were raised by healthcare professionals.

Procurement and Supply Services

Pharmacy procured £15,440,077 of medicines in 2018/19 and £14,996,264 of medicines in 2019/20.

The Trust has a focus on minimising waste and assessing and recycling Trust medicines that are suitable for use is one of the important ways that this is achieved by Pharmacy. In 2018/19 the amount of stock Pharmacy credited was £787,477, and in 2019/20 the amount credited was £855,299.

Ward Pharmacy Services

Two major changes have impacted on Ward Pharmacy this year, the roll out of electronic prescribing and medicines administration (EPMA) in November 2020 and the introduction of the extended service to patients being admitted to hospital that also commenced in November 2020.

The implementation of EPMA required the scheduling and provision of intensive support from senior Pharmacy staff members to aid the rapid acquisition of skills by ward based staff and minimise risks to patient safety during this major change programme.

The implementation of EPMA radically altered the way that Pharmacy staff worked at ward level requiring considerable thought as to how to optimally use the different parts of the EPR when reviewing patients who are newly admitted or being discharged. Refining the approach is ongoing. Time was dedicated to reviewing the use of the system by staff in the early part of the COVID-19 period to ensure that staff time was being used maximally.

The introduction of a Pharmacy admissions Service within the emergency department was undertaken as a result of a three phase business case approved by the Trust intended to support required patient medication safety improvements through timely medicines reconciliation, reduction in omitted and delayed medicines and also to reduce medicines waste.

Recruitment and training was undertaken prior to the launch of the ED admissions service in November and Phase One roll out was completed in January 2020. This provided two shifts at weekends and a late shift on Fridays and Mondays. The improvements in medicines reconciliation data can be seen in a later section of the report.

Medicines Governance Services

Medicines *Governance activities are reviewed by the Trust Medicines* Governance Committee. The Medicines Management Pharmacist ensures that NICE Guidance is reviewed and those relating to medicines are implemented in a timely manner. The Medicines Management Pharmacist recently retired, this work has been taken up by the senior pharmacist team whilst a new member of staff is recruited.

The work encompasses the following 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 & Local Intelligence Network (CD LIN) input and 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

Over 50 medicines related audits were completed during the year. This includes Audits relating to Safe and Secure Handling of Medicines, Controlled Drugs, Antibiotic Point Prevalence, Pharmacist Interventions, Wholesaler Dealer Authorisation.

1. Extrapolating from Pharmacist Intervention Audits, around 25,000 patient safety interventions are undertaken by clinical pharmacy teams mainly in relation to inpatient activities.
2. Service developments to improve medicines optimisation include extension of the role of the ward pharmacy technician to undertake drug histories and administer medicines and the implementation/ extension of the use of IT for electronic transfer of discharge information to Community Pharmacy and the roll out of electronic prescribing and medicines administration.

3. Of the £15.3m medicines procured and issued by Pharmacy 98% was issued to Trust cost centres. WHH Trust related pharmacy transaction activity accounted for 97% of the 380,480 transactions made.
4. Overall Trust medicines expenditure (PbR included and excluded) reduced by 2.9% in 2019/20 against an increase in transactions of 4.3%.
5. The Trust performed well against the majority of Model Hospital parameters (see Appendix 1). Areas for improvement and continued effort include:
    a. completion of the EPMA roll out to all wards,
    b. implementation of electronic outpatient prescribing,
    c. identification of how medicines can be supplied to patients who are seen using virtual media,
    d. re-submission of the pharmacy transformation business case for phases two and three,
    e. review of aseptic services,
    f. improve the use of antibiotics/antifungals through effective antimicrobial stewardship strategies,
    g. improve Trust performance against the medication questions in the National Inpatient Survey

MEDICINES/CONTROLLED DRUGS/SAFETY

Medicines Reconciliation

Medicines reconciliation (MR) figures include adult, children and maternity admissions and are generated from Lorenzo **discharge** data. National Guidance and therefore CQC scrutiny only relates to adult services however during the last inspection, the CQC were impressed that the Trust was also monitoring medicines reconciliation data for children and the potential for this to reduce the overall % when comparing data with other Trusts.

Only 68% of medicines reconciliations were achieved in 2018/19 with around 25% occurring within 24 hours of admission. A similar picture can be seen in the early months of 2019/20. This figure was unacceptably low, improving this formed part of the expectations of the Pharmacy Transformation Plan and a business case was prepared. Following the approval of Phase One of the business case, staff consultation and recruitment took place. The consultation was completed in September 2019 with the exception of reviewing individual cases of need. Recruitment and training were largely completed by November 2019 and the Pharmacy admissions service was introduced in the emergency department (ED) alongside the roll out of EPMA (electronic prescribing and medicines administration) at the beginning of November 2019.

Initially the service comprised of one shift on each weekend day, gradually this increased to one late ED shift on Fridays and Mondays and one early and one late shift on each weekend day by January 2020. From the table it can be seen that as the service extended there was a stepwise improvement in the percentage of medicines reconciliations completed within 24 hours (expected as the service was brought closer to the start of the inpatient episode by the introduction of the late Friday and weekend shifts) the % MR total increased in November and then plateaued (expected as this is more of a reflection service capacity).

In late March 2020, the COVID-19 Command and Control period commenced. Pharmacy ways of working were adapted to the changing ED and Ward environment. On 25 March 2020, Pharmacy Command and Control took over staffing rotas and an early morning daily ward by ward activity (workload) analysis commenced to inform allocation/re-distribution of staff to rotas. Rotational staff were retracted from Halton, staff cancelled annual leave, activities prioritised indirect and direct patient related work, all staff who could work on wards were re-directed towards ward activities and staff training was intensified. This allowed the service to increase staffing levels on wards. From Easter onwards, the staffing levels provided to wards at weekends (on ward admissions service) was increased using volunteers. This enabled the weekend Pharmacy service to complement and cope with the increase in prescribing activity anticipated from the increase in medical staffing that occurred from that point in time. Around this time, the staffing for the ED service was re-directed to wards. This reflected the changing activity and turnaround times within ED and the need to prioritise other service users/inpatients.

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 Reconciled within <24hr of admission		**Total completed medicines reconciliation activity**	**% Patients with reconciled medicines**	**Medicines not reconciled during admission**	**% Patients with medicines not reconciled during admission**	**Total No. of inpatients with a LOS>24hr**	Implementation of new service
Month	**Activity**	**%**			**Activity**	**%**		
Apr-19	530	29%	1282	**71%**	515	29%	1747	Recruiting
May-19	433	22%	1247	64%	691	36%	1797	Recruiting
Jun-19	462	25%	1280	68%	592	32%	1938	Recruiting
Jul-19	525	26%	1401	70%	589	30%	1872	Recruiting
Aug-19	513	29%	1280	73%	483	27%	1990	Training
Sep-19	517	29%	1277	71%	523	29%	1763	Training
Oct-19	557	30%	1345	72%	525	28%	1800	Training
Nov-19	741	39%	1513	81%	363	19%	1870	ED service launched
Dec-19	979	51%	1559	81%	375	19%	1876	Service extended
Jan-20	1075	56%	1611	**84%**	317	16%	1934	Service extended
Feb-20	1014	56%	1488	82%	328	18%	1928	
Mar-20	1045	60%	1511	80%	236	14%	1816	COVID-19-Pcy C&C
Apr-20	958	79%	1132	94%	74	6%	1206	Extended Wd service
May-20	1128	84%	1255	93%	90	7%	1345	Extended Wd service
Jun-20	1252	83%	1420	**95%**	81	5%	1501	Extended Wd service

The impact of implementing the above was successful in maintaining the number of medicines reconciliations completed within 24 hours. The reduction in inpatient admissions had a positive impact by reducing the denominator and thus increasing the apparent % of MRs completed within 24 hours and overall. Nevertheless an overall improvement was shown in the reduction in the %MRs completed beyond 24 hours, this reflects the success of increasing the staff hours worked on wards at weekends by volunteers.

Whilst undertaking MRs is a vital patient safety initiative in relation to patients receiving their correct regular medication on admission (where appropriate) medication review is not a process unique to admission. All Pharmacy interventions and clinical advice provided from admission to discharge drive medication/patient safety and timely intervention by Pharmacy staff provides the Trust with greater assurance that medicines will not harm patients during their inpatient stay. Intervention evidence collated from the increased weekend ward pharmacy activity during COVID-19 suggests maintenance of such a service post-COVID-19 would be sensible if possible.

Medication Incidents

Table showing Quarterly Medication Incident Data for 2018/19 and 2019/20

			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	5* (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				1	0	0

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

The Medication Safety Officer or a senior pharmacist attends 72 hour reviews involving medicines and take part in serious incident investigations and the production of reports/approval/delivery of agreed actions.

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

Partnership for Patient Protection analyses have been used to support the development of medication safety improvement approaches within these areas.

A task and finish group called the Medicines Improvement Group was also established last year to monitor and progress 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.

Education and training related initiatives involving collaborative working between the MSO, the Medical Education Pharmacist and supported by members of the Pharmacy team include:

1. EPMA intravenous Sequence training with a particular focus to encourage prescribers to use this functionality.
2. Walkabouts and regular attendance at medical/surgical handovers for communication of medication matters
3. Presentation to the Elderly Care journal club where CBU specific errors/EPMA updates/Critical medicines were discussed
4. FY1 training included:

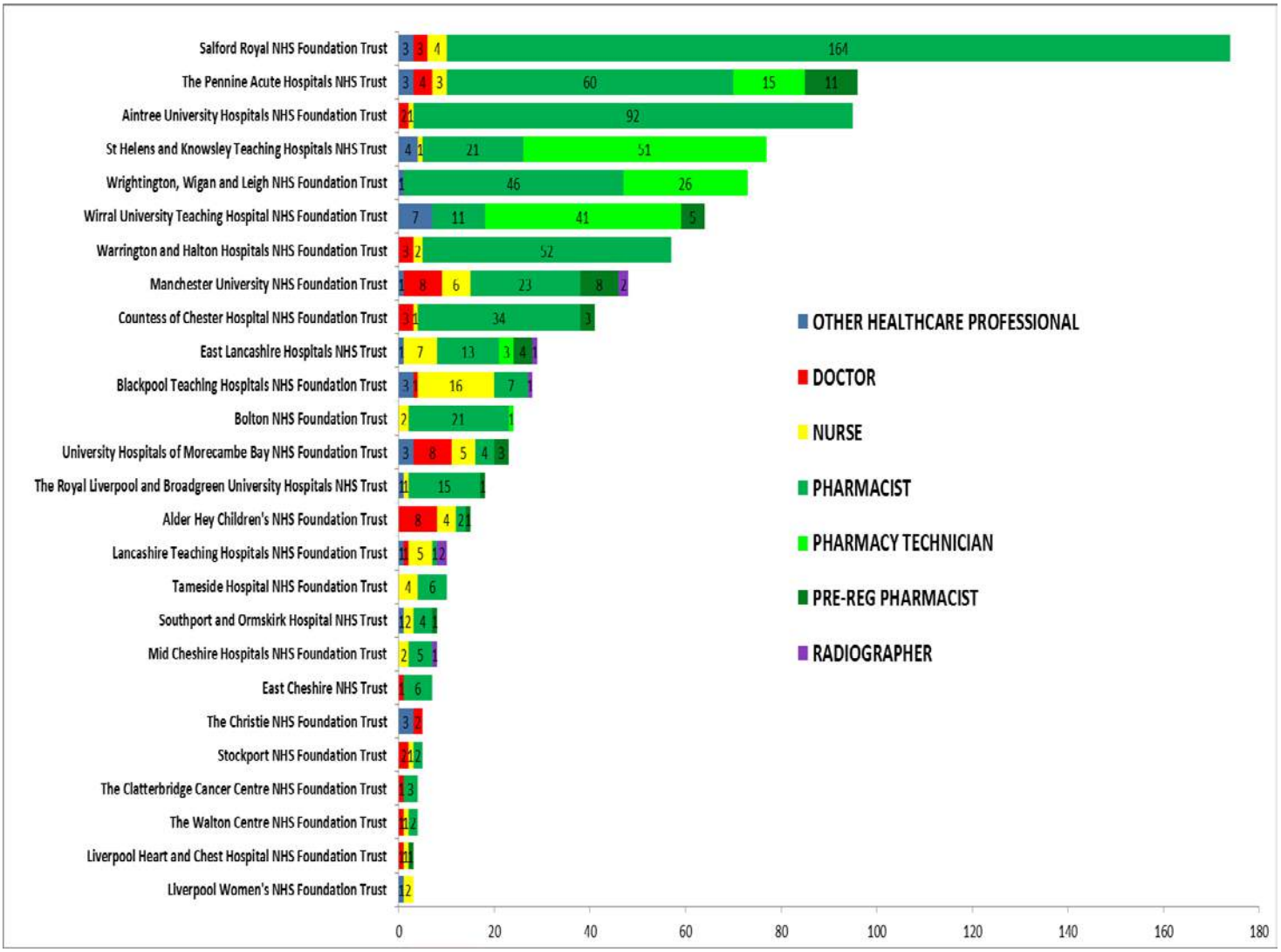
- critical and omitted medicines training
- Introduction to anticoagulation and discussion of incidents

5. FY2 training included:

- Refresh of anticoagulation knowledge and discussion of incidents

6. Preparation of AHCH resources to support safe practice of rotatating medical staff
7. Working with FY2s to introduce a formal structure to reflect on medication related practice / incidents for the foundation programme in collaboration with StHK
8. In March: provision of IV training and EPMA training to support redeployment of nursing staff
9. Publication of Safer Times newsletters
10. Production of a Prescriber Medicines Handbook

Secondary Care Adverse Drug Reaction Reporting (Q4 2019/20)

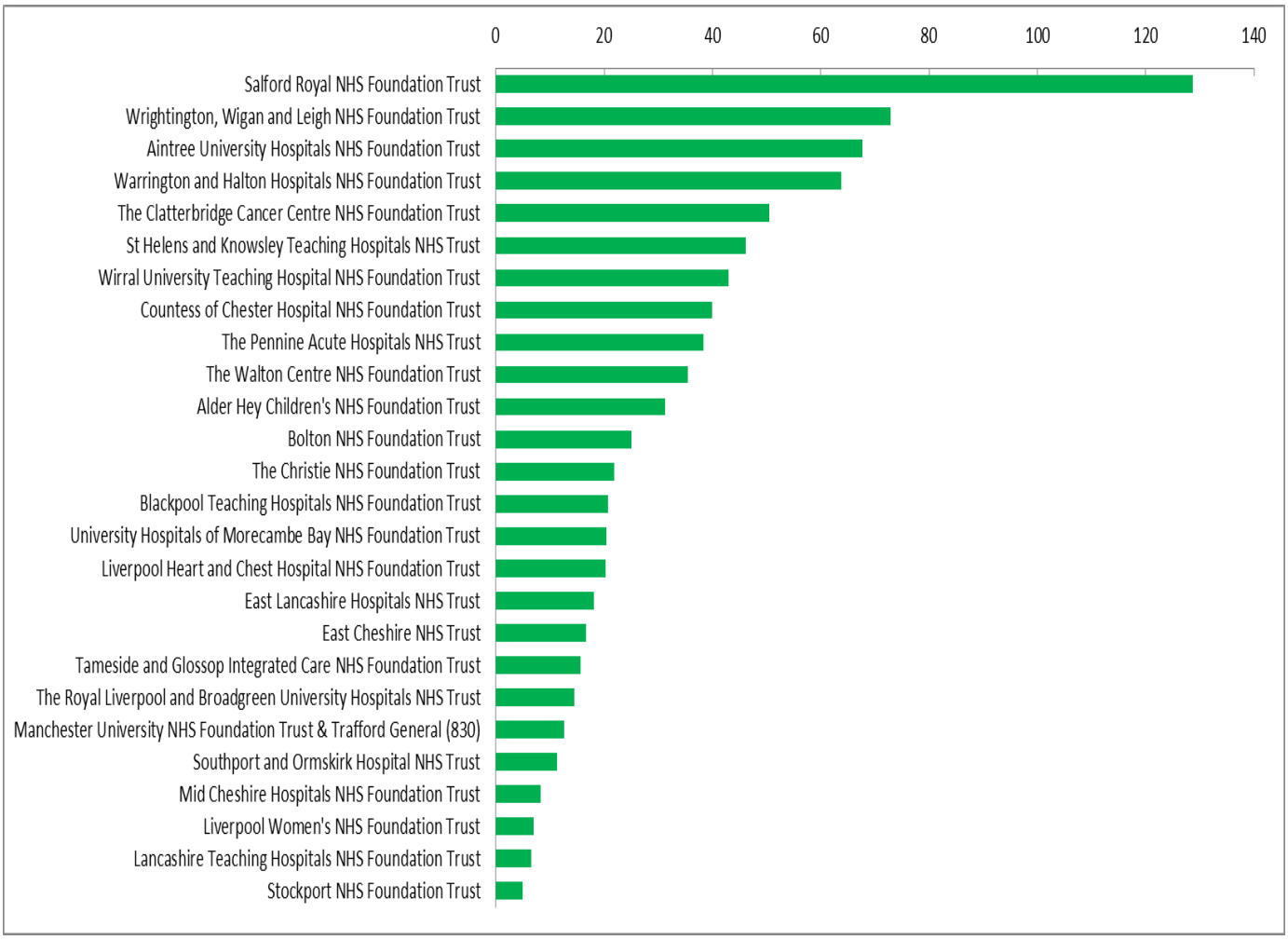


Adverse drug reaction reporting provides a measure of the medicines safety culture. Within the Trust support with reporting is provided by the Medicines Information Service within Pharmacy. Yellow card reporting is incorporated into medical student and junior doctor training.

Yellow card adverse drug reaction reporting for Quarter 4 is showing an improved position for the Trust, moving up to 7th position (see table above) with 57 yellow cards submitted. When the yellow card data is analysed in relation to activity (HES x100,000), the Trust moved up the rankings into 4th position (see table below).

In relation to yellow card submissions within Primary Care, NHS Warrington CCG is ranked second (n=17) behind NHS Wigan CCG and NHS Halton CCG is ranked fourteenth (n=2).

Secondary Care trust reporting per HES (x 100,000) reporting January – March 2020 (HES is 2018/19 data)



3. ACTIONS REQUIRED/RESPONSIBLE OFFICER

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,
    b. implementation of electronic outpatient prescribing,
    c. identification of how medicines can be supplied to patients who are seen using virtual media,
    d. re-submission of the pharmacy transformation business case for phases two and three,
    e. review of aseptic services,
    f. improve the use of antibiotics/antifungals through effective antimicrobial stewardship strategies,
    g. improve Trust performance against the medication questions in the National Inpatient Survey
2. Continue to monitor medication safety and implement safety measures where needed

4. IMPACT ON QPS?

The above actions are in keeping with the delivery of the Trust's quality, people and sustainability objectives

5. MEASUREMENTS/EVALUATIONS

1. The Trust progress is monitored by NHSE/I/X via the Model Hospital Dashboard.
2. The Trust has a program of audits the results of which are reported at Medicines Governance Committee

6. TRAJECTORIES/OBJECTIVES AGREED

As per Medicines Governance Committee recommendations and approval by Patient Safety and Clinical Effectiveness Committee

7. MONITORING/REPORTING ROUTES

As per Medicines Governance Committee recommendations and approval by Patient Safety and Clinical Effectiveness Committee

8. TIMELINES

As per Medicines Governance Committee recommendations and approval by Patient Safety and Clinical Effectiveness Committee

9. ASSURANCE COMMITTEE

Medicines Governance which reports to Patient Safety and Clinical Effectiveness Committee

10. RECOMMENDATIONS

The Committee is asked to note the content of the report and the proposed actions.

Appendix 1

SUBJECT	The Warrington and Halton Hospital Pharmacy Transformation Plan within the Local Delivery System and STP Context

The information contained in the following table outlines the key areas that are being monitored by NHS Improvement via the Pharmacy and Medicines Model Hospital metrics:

Metric	Trust Performance	National Median or Target	Progress / Assessment
Productivity			
Pharmacy staff & medicines costs per WAU 15/16->16/17->Oct-19	£296->£292 ->£293	£350->£354 - >£409	Strong performer
Medicines cost per WAU	£232->£232- >£231	£312->£320- >£369	Strong performer
High cost medicines per WAU	£ 75->£78- >£159	£112->£109- >£267	Strong performer
In tariff medicines per WAU	£158->£154- >£72	£196->£202- >£92	Strong performer
Money and resources			
Choice of paracetamol formulation (IV/Total) 15/16->16/17->19/20	54%->54%- >65%	56%->56%- >61%	Use of IV preparation has increased, % is affected by a reduction in the quantity of oral being issued to outpatients/at discharge
% spend on sevoflurane 15/16->17/18->19/20	89%->83%- >91%	66%->68%- >87%	Sevoflurane use increases with the proportion of day cases occurring
Top 10 medicines – savings 17/18->18/19->19/20	£1.17m-> £1.05m-> £1.72m	£1.01m-> £921.19K-> £1.37m	Strong performer-over-achieved targets 3 years running
Safe			
Total antibiotic consumption (DDD/1,000 admission) 15/16->16/17->18/19	4,074->3998 ->5278	4,512->4302 ->4756	Increase in DDD's required action. Training/ward rounds
% antibiotic prescriptions with evidence of review within 72hrs (Q1 17/18)->Q4 19	96%->96%	94%->96%	Strong performer
% diclofenac vs ibuprofen & naproxen Jun 16->Mar 18->Mar-20	23%->40%- >7.1%	9%->4.8%- >4.1%	Improved position & monitoring for signs of increasing use
% eChemotherapy (14/15->From 2017	0%->100%	50%	Fully implemented
% ePxing inpatient 15/16->From Nov-19	0%->over 90%	50%->5%	Remaining areas: ICU, Paediatrics & Maternity. Project planning halted during COVID-19, this has re-

			commenced
% ePxing OP 14/15->	0%	50%	100% in ED, LDE outpatient project tested the approach within an endocrine clinic. Full roll out to OPD is in Phase 5 of the Lorenzo optimization plan
% ePxing at discharge (14/15)	100%	60%	Fully implemented
Effective			
Clinical Pharmacy activity (Pharmacist Time on direct medicines optimization activities/governance/safety) 15/16->16/17->18/19	79%->79%->80%	67%->70%->77%	Currently over 80% with pharmacists around 70% with technicians & pharmacy assistants (30%) Adjusting work processes to have more technical staff on the wards **Target: 85%**
% Pharmacists actively prescribing 15/16->16/17->19/20	23%->35%->37%	20%->28%	Training plan in place and actively training, % has remained static as a result of the recruitment drive (not yet able to recruit staff with qualification). 37% of ward staff can prescribe, 67% of staff who have been in post more than 2 years can prescribe **Target: 85%**
% medicines reconciliation within 24hrs 15/16->Mar-20	40%->60%	73%	Achieved 60% prior to COVID-19, achieving 83% in Q1 **Target: 85%**
% use of SCR Aug 16 (Jan 18)	132% (220%)	52% (70%)	EPR electronic notes linked to SCR so readily accessible Trust now has access to the MIG shared record, GP Connect is in testing
Dose banded chemotherapy (doses delivered as standardised bands) 15/16->(16/17->17/18->18/19)	0% ->100%	42% (90%)	CQUINs achieved each year
No. medication incidents reported to NRLS per 100,000 FCE Mar 16	395	286	New measure in place
Medication incident rate per 1,000 beds Mar 17->Mar 19	3.9->6.1	3.9->4.3	Higher rate indicates strong safety culture->incident reporting culture
% medication incidents reported as causing harm or death/all medication errors	26.7%->22.9%->8.3%	9.7%->10.3%->10.7%	MSO appointed in 2018 works closely with Governance Managers and the Medical Education Pharmacist on Medication Safety
Number of days stockholding 16/17	18	20	Achieving and maintaining focus
Deliveries received into	16 Warrington	15 (15)	

pharmacy per day 15/16 (16/17)	3 Halton (14)		
e-Commerce 15/16 (16/17)	71% (96.8%) Alliance 62% (96.5%) AAH	90% (96.6%) 82% (94%)	Achieved
Data quality of NHSE submissions Nov 16 (Sep 17)	20 (25)	20 (23)	Retired
Caring			
National Inpatient Survey – medicines related questions 15/16->16/17->17/18	76.8%->69.5%->72.3%	73.1%->72%->72.8%	Requires renewed focus and action plan
Responsive			
Sunday on ward clinical pharmacy hours of service 15/16->Mar-20	0->11	4	Weekend ED Pharmacy admissions service introduced in Nov 20, switched to providing service to admissions across all wards during COVID-19 due to anticipated impact of additional ward based doctors
People, Management & Culture: Well-led)			
% sickness absence rate 15/16->16/17->18/19	4%->3.4%->4%	3.1%->3.2%->3%	Dept. manages staff in accordance with the Trust Attendance Management Policy, long term absences are impacting on %
% Staff with Appraisals completed 15/16->16/17->18/19	85%->93%->90%	85%->93%->91%	Currently 91%, ongoing focus on completing PDRs
% staff with statutory & mandatory training 15/16 (16/17)	95%->96%->90%	91%->93%->94%	Ongoing focus on training
% Staff turnover 15/16->16/17->18/19	9%->18%->18%	14%->14%->14%	Still feeling the impact of attrition in relation to the consultation and the availability of new roles for pharmacy staff in primary care.
% Staff vacancy rate 15/16->16/17->18/19	6%->12%->18%	6%->6%->7%	Fully recruited to most of the new posts, awaiting arrival of new starters.
Aseptic Services			
% injectable chemotherapy sourced pre-assembled/ready made 18/19	100%	38%	
% adult TPN sourced pre-assembled/ready made 18/19	100%	100%	
Aseptic Unit – pharmacists (WTE) 18/19	0	3	
Aseptic Unit – pharmacy	1	4	

technicians (WTE) 18/19			
Aseptic Unit – pharmacy assistants 18/19	1	5	
% vacancy rate 18/19	0%	9%	
% turnover rate 18/19	0%	3%	

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/20/07/81**		
SUBJECT:	**Annual Report to Quality Assurance Committee**		
DATE OF MEETING:	29 July 2020		
AUTHOR(S):	John Culshaw, Trust Secretary		
EXECUTIVE DIRECTOR SPONSOR:	Simon Constable, Chief Executive		
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	**SO1 We will.. Always put our patients first through high quality, safe care and an excellent patient experience.**	√	
	SO2 We will.. Be the best place to work with a diverse, engaged workforce that is fit for the future.		
	SO3 We will ..Work in partnership to design and provide high quality, financially sustainable services.		
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): **(*Please DELETE as appropriate)***	#1135 Failure to deliver an emergency and elective healthcare service caused by the global pandemic of COVID-19 resulting in major disruption to service provision. #1124 Failure to provide adequate PPE caused by failures within the national supply chain and distribution routes resulting in lack of PPE for staff. #115 Failure to provide adequate staffing levels in some specialities and wards. #1114 Failure to provide essential, optimised digital services in a timely manner in line with best practice governance and security policies, caused by increasing and competing demands upon finite staffing resources whom lack emerging skillsets, sub-optimal solutions or a successful indefensible cyber-attack, resulting in poor data quality and its effects upon clinical and operational decisions / returns and financial & performance targets, reduced operational efficiencies, denial of patient access to services, inferior quality of care including harm, failure to meet statutory obligations (e.g. Civil Contingency measures) and subsequent reputational damage. #224 Failure to meet the emergency access standard. #1126 Failure to potentially provide required levels of oxygen for ventilators caused by system constraints resulting in lack of adequate oxygen flow at outlets.		
EXECUTIVE SUMMARY *(KEY ISSUES):*	This report seeks to deliver assurance to the Trust Board that the Quality Assurance Committee 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:				
PREVIOUSLY CONSIDERED BY:	**Committee**	Quality Assurance Committee		
	Agenda Ref.	QAC/20/07/102		
	Date of meeting	7 July 2020		
	Summary of Outcome	Approved		

FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	Choose an item.

QUALITY ASSURANCE COMMITTE

AGENDA REFERENCE:	**QAC/20/07/102**			
SUBJECT:	**Annual Report to Quality Assurance Committee**			
DATE OF MEETING:	7 July 2020			
AUTHOR(S):	**John Culshaw, Trust Secretary**			
EXECUTIVE DIRECTOR SPONSOR:	Simon Constable, Chief Executive			
LINK TO STRATEGIC OBJECTIVE:	SO1: We will... Always put our patients first through high quality, safe care and an excellent patient experience.			
EXECUTIVE SUMMARY	This report seeks to deliver assurance to the Quality Assurance Committee that the Committee 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
RECOMMENDATIONS:	The Quality Assurance Committee is asked to review the document and ensure it meets its purpose.			
PREVIOUSLY CONSIDERED BY:	**Committee**	Not Applicable		
	Agenda Ref.			
	Date of meeting			
	Summary of Outcome			
NEXT STEPS: ***State whether this report needs to be referred to at another meeting or requires additional monitoring***	**Submit to Trust Board**			
FREEDOM OF INFORMATION STATUS (FOIA):	**Release in Full**			
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None			

QUALITY ASSURANCE COMMITTEE

SUBJECT	Annual Report of the Quality Committee 2019-20	AGENDA REF:	QAC/20/07/102

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 Quality Assurance Committee Annual Report which covers the reporting period 1st April 2019-31 March 2020.

The Quality Assurance Committee (the Committee) is accountable to the Board of Directors (the Board) for providing oversight and assurance on all aspects of quality, including strategy, quality improvement, delivery, clinical risk management and clinical governance, clinical audit and the regulatory standards relevant to quality and safety.

The Quality Assurance Committee is accountable to the Board for ensuring that the integrated quality governance framework is implemented throughout the organisation and that organisational strategic risks are managed appropriately.

This report details the membership and role of the Committee and the work it has undertaken during the reporting period.

During the reporting period, the Committee has been composed of 2 Non-Executive Directors with a quorum of 2 (including the Chair). Any Non-Executive Director is able to attend the Committee to cover any absence.

During the reporting period, there were 6 meetings. The Quality Committee attendance record is attached in **Appendix 1**.

Terms of Reference

The Committee's Terms of Reference were reviewed during Quarter 4 of 2019/20, as was the business cycle, to ensure there was a focus on integrated systems of quality and assurance and also in line with the roll out of the revised Trust meetings structure. The terms of reference are attached in **Appendix 2.** The Quality Assurance Committee continues to focus on assurance monitoring, with its reporting sub committees meeting on a more frequent basis to deliver the agenda. High level briefings are provided to the Quality Assurance Committee from the Executive Led Sub Committees for assurance purposes.

Frequency of Meetings and Summary of Activity

The Committee met 6 times during the year. A summary of the activity covered at these meetings follows:

- **Strategy Development**

  The Committee has had regular updates in relation to the Strategic Quality Priorities for the Trust. In addition updates of enabling quality strategies have been provided e.g. Mortality reports, Dementia Strategy, Patient Experience Strategy, Adult Palliative and End of Life Strategy, Risk Management Strategy, Safeguarding Strategy,

- **Risk Management**

  The Quality Assurance Committee oversees the Trust's strategic risks, as the designated Board Committee responsible for risk. The Committee has liaised closely with the Audit Committee to ensure the Strategic Risk Register and Board Assurance Framework drives the internal audit plan and to provide the Audit Committee assurance regarding systems of internal control.

  The Committee oversaw the streamlining of the Board Assurance Framework, with the number of strategic risks on the board assurance framework reducing significantly in year. In May 2019 there were 15 risks on the board assurance framework, which had reduced to 9 in March 2020.

  During the year, the first Corporate Risk registers were produced and shared across several Committees and Groups

  The Corporate risk register is a list of all the risks which may prevent the Trust from achieving its' Corporate objectives.

  The risk register is comprised of all risks on the CBU and corporate risk registers which are identified as likely to affect the organisation at a corporate level.

  The risk register is produced on a monthly basis and is presented at the following Committees:
  - Risk Review Group
  - Finance and Sustainability Committee
  - Strategic People Committee
  - Quality Assurance Committee
  - Patient Safety and Effectiveness Sub Committee
  - Operational Board

  along with any oversight Committees of Strategic/Corporate risks.

  The Risk Review Group continued to meet to ensure that there was scrutiny of departmental, speciality and Clinical Business Unit risk registers, and that appropriate escalation processes are in place to the Board.

- **Quality Dashboard**

  The Committee has overseen an ongoing review of quality Key Performance Indicators, which are monitored in the corporate Integrated Performance Dashboard. A report is received at each meeting of the Quality Dashboard to review performance and to determine assurance of mitigating actions as appropriate.

- **Assurance**

  The business cycle for the Committee has been reviewed, with focus on assurance monitoring. Reporting sub committees are constantly under review, ensuring ongoing scrutiny.

  The Committee approved several amendments to Quality Indicators on the Trust's IPR

  Key areas which have been monitored in year are Maternity, Complaints, Serious Incidents, Falls Prevention, Infection Prevention, IT, Safeguarding and VTE, Health & Safety and Brexit continuity plans,

- **Investigations and Lessons Learned**

  The Committee receives a regular update, to assure itself that investigations from Serious Incidents are being undertaken as per statutory and regulatory requirements. This also includes monitoring Duty of Candour

  The Committee receives regular updates on how the Lessons Learned Framework is being implemented, including having receipt and scrutiny of a Lessons Learned Audit, whereby actions and recommendations from Serious Incidents and Complaints are audited for assurance of completion.

  The Complaints Quality Assurance Group, which is chaired by the Trust Chairman, continue to meet. This monitors the quality of the complaints responses in the Trust and also how we are implementing learning and change as a result of patient and public feedback.

- **Quality Academy**

  Practitioner Quality Academy level training has taken place for 300 staff and the Innovation Hub was launched June 2019.

- **Deep Dives**
  Several Deep Dives have taken place as part of the assurance process. These include, Medicines Management, ED Review, Urology, Falls, DNACPR and Out Patients.

- **Regulatory and Statutory monitoring**

  The Committee continued to monitor the statutory and regulatory requirements relating to quality governance throughout the year. This included monitoring of the post Care Quality Commission Inspection Action plan, national audit activity, NICE guidance, national surveys, quality KPIs and complaints improvement..

  In 2019/20 the Committee has also overseen the monitoring of the specific CQC Urgent and Emergency Services Report and Action plan, reported via the Urgent + Emergency Care Committee

  Furthermore, the Committee receives and monitors the Trust's CQC Moving to Outstanding Framework and action plan

  The Quality Assurance Committee received, supported and approved a number of annual reports including, Health and Safety, Medicines Management + Controlled Drugs, Safeguarding, Risk Management.

- **Issues Carried Forward**

  There are a number of issues which the Committee will carry forward into 2019/20

  - Implementation of the Quality Priorities for the year
  - Deep Dives programme to March 2021 - Consent, Mental Health, IG/Cyber, Dementia, Mortality
  - Maternity Digital Improvement

Delivery of other quality improvement areas e.g. CQUINS, quality improvement targets will continue to be reviewed.

Summary

I as Chair of the Quality Assurance Committee encourage honest and open discussion, so that areas of success can be celebrated and areas of improvement escalated and actioned. To ensure that the patient voice is heard, each meeting commences with a patient story.

As part of a wide development programme of work with the Good Governance Institute (GGI), a review of the Committee membership, attendance, actions, reports and responsibilities were took place. A number of recommendations have already been implemented with others to take place throughout the year ahead.

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.

Margaret Bamforth
Chair of Quality Assurance Committee

We are WHH and we are PROUD to make a difference

NHS Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**To be reviewed virtually**	
SUBJECT:	**Microsoft N365 Licensing**	
DATE OF MEETING:	15/07/2020	
AUTHOR(S):	Matt Gardner, Deputy Chief Information Officer	
EXECUTIVE DIRECTOR SPONSOR:	Phillip James, Chief Information Officer	
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	SO1 We will.. Always put our patients first through high quality, safe care and an excellent patient experience. SO2 We will.. Be the best place to work with a diverse, engaged workforce that is fit for the future. SO3 We will ..Work in partnership to design and provide high quality, financially sustainable services.	 X
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): **(*Please DELETE as appropriate)***	#1114 Failure to provide essential, optimised digital services in a timely manner in line with best practice governance and security policies, caused by increasing and competing demands upon finite staffing resources whom lack emerging skillsets, sub-optimal solutions or a successful indefensible cyber-attack, resulting in poor data quality and its effects upon clinical and operational decisions / returns and financial & performance targets, reduced operational efficiencies, denial of patient access to services, inferior quality of care including harm, failure to meet statutory obligations (e.g. Civil Contingency measures) and subsequent reputational damage.	
EXECUTIVE SUMMARY ***(KEY ISSUES):***	The Trust Microsoft Enterprise License Agreement is due for renewal in October 2020. This coincides with cessation of extended support for Microsoft products in widespread use across the Trust including Microsoft Office 2010. The Trust Board approved in principle as part of the capital programme for FY20/21 an investment of £1,722,000 in March 2020 for the purpose of a "Microsoft Office Upgrade". In the intermediary period since, NHSX and NHS Digital announced a national deal on Monday 15th June 2020 with Microsoft entitled "N365" following approval by HM Government. N365 offers Microsoft licenses (including Windows and Microsoft Office) at a centrally negotiated and subsidised rate by leveraging the combined purchasing power of the NHS to secure preferential pricing. N365 will mitigate key challenges associated with running a legacy Microsoft environment. This includes widespread use of outdated Microsoft Office 2010 software across the Trust, in addition to legacy enterprise management and cyber security tooling. Migration to N365 is therefore a key mitigation strategy for Risk #1114 within the BAF as it addresses risks associated with running Trust systems on legacy enterprise platforms with no security updates, patches or support from the vendor as of 13th October 2020. The Executive Team approved submission of an Agreement In Principle in May 2020 indicating Trust support for the N365 national deal on this basis. It placed no contractual commitment on the Trust, but indicated support for the N365 concept. This approach was consistent with NHS peers nationally and affords access to a pricing structure that could not be competed with	

	through an alternative local arrangement bespoke to the Trust. The Trust has exercised further due diligence since its submission of an Agreement In Principle in May 2020 to ensure the proposed licensing model balances function and cost. The business case that follows in **Appendix 1** is the summation of this activity. The forecast cost for N365 over the 32 month term from 1st September 2020 to 30th April 2023 is **£1,239,448** inclusive of VAT. This includes a tolerance (reserve) of 10% to allow for fluctuations in headcount or variances in license types to support changing staff roles. This forecast is below initial estimates of £1,722,000 within the capital programme. However, due to the nature of the transaction the Trust will now recognise N365 licenses as revenue expenditure. This places a revenue pressure on the Trust in FY20/21 through to FY22/23 that will require prioritised investment in order to deliver this business critical scheme. Forecast expenditure within the capital programme is removed as a result. To formally participate in N365, the Trust is now requested to submit an N365 Participation Agreement that will commit the Trust to procuring Microsoft enterprise licenses as part of N365 through a local contract arrangement at the forecast cost of £1,239,449. This proposal has received the support of the Strategic Executive Oversight Group on Tuesday 14th July 2020.			
PURPOSE: ***(please select as appropriate)***	Information	**Approval**	To note	Decision
RECOMMENDATION:	It is recommended that the Trust Board approve the following key items: 1. Submission of the N365 Participation Agreement which will commit the Trust to procuring Microsoft enterprise licenses as part of the national N365 scheme. The term for the N365 Participation Agreement will be from 1st September 2020 through to 30th April 2023. **Appendix 1** contains the proposed N365 Participation Agreement response on behalf of the Trust. 2. Approve participation in N365 at a forecast cost of **£1,239,448** inclusive of VAT and inclusive of a 10% budgetary tolerance (reserve). This cost is wholly revenue expenditure. This compares with £1,722,000 originally forecast in FY20/21 as part of the capital programme approved by Trust Board in March 2020.			
PREVIOUSLY CONSIDERED BY:	**Committee**	COVID NED Assurance Committeee Strategic Executive Oversight Group		
	Agenda Ref.			
	Date of meeting	14/07/2020		
	Summary of Outcome	The Strategic Executive Oversight Group endorsed the proposal and recommend approval of the submission by the Trust Board.		
FREEDOM OF INFORMATION STATUS (FOIA):	Whole FOIA Exemption			
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	Section 43 – prejudice to commercial interests			

APPENDIX 1 – MICROSOFT N365 LICENSING BUSINESS CASE

Area: Digital Services	**Author:** Matt Gardner – Deputy CIO
	Executive Lead: Phillip James - CIO

Project: Microsoft N365 Licensing	**Date:** 13/7/20

Quality & Safety	✓	**Business Development**	✓	**Capital**	✕

1.0 Purpose

This business case is to propose an investment of **£1,239,448** for Microsoft enterprise licensing. This scheme was identified as business critical in the financial planning for FY20/21 due to the upcoming expiry and cessation of extended support for the current Microsoft products in widespread use across the Trust.

Trust Board has already approved in principle £1,722,000 of spend as part of the capital programme for FY20/21 under the "Microsoft Office Upgrade" scheme, though the Trust now recognises this requirement as wholly revenue due the nature of the expenditure.

The Executive Team is therefore asked to support this investment for approval by Trust Board as revenue only expenditure and authorise submission of an "N365 Participation Agreement" as represented within Appendix 1 and 2. Submission of the Participation Agreement commits the Trust to procure its Microsoft enterprise licensing via "N365" which offers preferential and centrally discounted pricing for core Microsoft products. The N365 term will run from 1st September 2020 through to 30th April 2023.

2.0 Background

The Executive Team was presented with a paper 'For Assurance' on Thursday 14th May 2020 regarding a proposed national deal with Microsoft. This is known as 'N365' and is designed to use the combined purchasing power of the NHS to negotiate competitive pricing with Microsoft for their enterprise products.

The Executive Team endorsed submission of an Agreement in Principle on Friday 15th May 2020, indicating Trust support to NHSX and NHS Digital for the N365 initiative. This activity placed no commitment on the Trust to contract for N365, as the national agreement was pending HM Government approval and was founded on provisional pricing as confirmed by NHS Digital in May 2020.

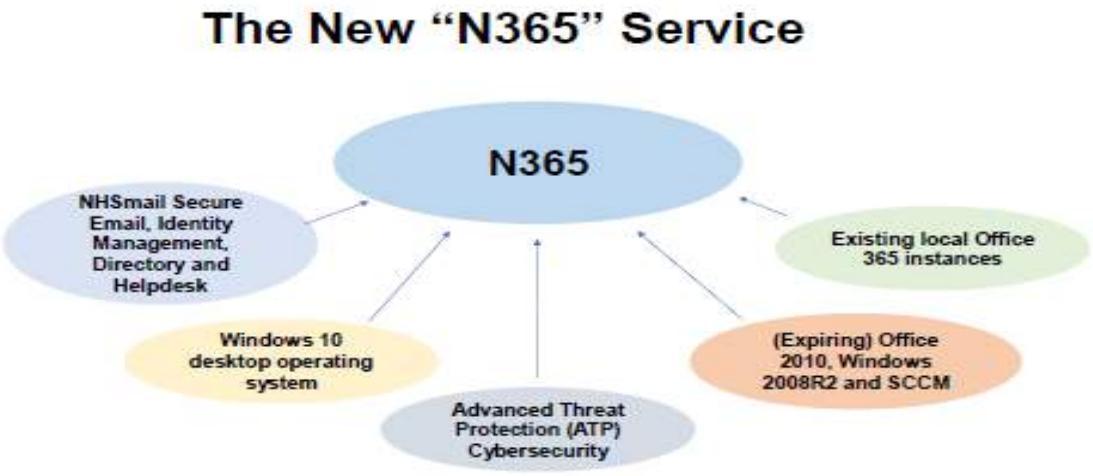
This business case represents the next step of the N365 commercial process. It recommends that the Trust formally commit to procuring licenses under the N365 national scheme through submission of an N365 Participation Agreement and the procurement process that follows.

Key Concepts and Status of N365

What is N365?

N365 is based on Microsoft's standard "M365" Enterprise E3 software package. N365 is essentially M365 for the NHS. Elements of this are already used across the Trust including Microsoft Office, NHSmail, and Microsoft Teams. N365 also provides the Windows 10 secure operating system, with additional options to support remote working and Advanced Threat Protection aiding cyber security.

The illustration below summarises the scope of the new N365 service:



Why is N365 required?

N365 mitigates key challenges associated with running a legacy Microsoft environment. This includes widespread use of outdated Microsoft Office 2010 software across the Trust, in addition to legacy enterprise management and cyber security tooling. On the 13th October 2020 Microsoft Office 2010 will go out of extended support for the NHS, heightening the risks associated with running on legacy enterprise platforms as no security updates, patches or support will be provided. Migration to N365 is a key mitigation strategy for Risk 1114 within the Board Assurance Framework.

N365 is the national answer to this problem. It enables NHS organisations including WHH to migrate services to the latest "Microsoft N365" platform, but with substantial discounts that would not be viable without the combined purchasing power of the NHS.

Where is N365 in the commercial process?

NHS Digital has now confirmed that HM Government has approved the new N365 service for all NHS organisations in England. Approval followed overwhelming support for the N365 concept with ~98% of NHS organisations indicating their intent to participate via an Agreement in Principle in May 2020, including WHH.

Trusts are now invited to commit to accessing centrally negotiated and subsided pricing for Microsoft licensing via preferred resellers through submission of an N365 Participation Agreement. This will place a contractual burden on WHH to procure the specified volume of licenses with a local reseller via a "Local Contract".

What is the impact to the Trust's current Microsoft Enterprise License Agreement (ELA)?

N365 supersedes legacy Microsoft ELAs for the products identified within the "New N365 Service". The Trust currently procures its own ELA through Softcat as an approved reseller. This ELA includes licensing for components within the scope of N365 but also covers additional items which remain a requirement of the Trust including:

- Microsoft SQL licensing (a database technology underpinning core systems)
- Microsoft Server 2012 and 2016 licensing + on premise SharePoint licensing
- Microsoft PowerBI licensing (used to underpin Trust-wide business intelligence reporting)

The effect of the Trust participating in N365 is therefore the creation of a new ELA with a preferred local

reseller to take account of the N365 scope and additional items required to deliver a key digital service. In effect:

£1,239,448 (subject matter of this business case)	**£153,733** (existing revenue budget for Microsoft ELA)	**[Total Balance]** (subject to negotiation with reseller)

The financial requirement for N365 *is in addition to* existing annual revenue expenditure for the "additional scope items" cited above. The total cost for the existing Microsoft ELA is **£153,733** inclusive of VAT though work will continue to identify savings in relation to this legacy enterprise license agreement as a result of some overlap with N365. The current Microsoft ELA is due for expiry in October 2020 and will form part of the all-encompassing ELA negotiated via a preferred reseller.

What is the alternative?
N365 represents the optimal return on investment for WHH. It allows access to preferential pricing for Microsoft products that are centrally subsidised (the subsidy is incorporated into the per user license pricing within this paper). Given the forthcoming expiry of Microsoft products at WHH, action is required in FY20/21 and the only alternative to N365 participation is to negotiate a unique agreement to WHH. This is highly unlikely to generate the same pricing available to WHH through N365, as represented through the uptake of N365 by NHS peer organisations.

What is the impact on Model Hospital, GIRFT and Use of Resources?
N365 will increase the associated expenditure on digital technology at WHH. This is however endemic to the NHS. Microsoft licensing has hitherto been licensed "in perpetuity" whereas new ELAs are operated as a service over a finite period. N365 is the national answer to this challenge. It is likely that all NHS organisations will therefore see an increase to Use of Resources costs per £100M turnover as a result of N365.

3.0 Proposed Service Development
In May 2020 it was proposed to the Executive Team that under N365:

- 90% of users would receive 1 type of license ("Apps for Enterprise")
- 10% of users would receive an enhanced license ("E3") to provide additional analytical tooling vital to delivering the Trust Information and BI capabilities.

Digital Services have used the intermediary period whilst HM Government approval was pending for N365 to refine the Trust approach to the licensing model based on the latest intelligence from NHS Digital.

The revised licensing approach uses the role of a member of staff to determine the suitable license. This is an approach consistent with NHS peers nationally, but also maximises the value for money of N365. All users within the Trust will therefore be allocated 1 of 3 types of N365 license (unbeknownst to the user):

License Type	User Count		Distinguishing Features and Rationale
	User Count	%	
Restricted E3	460	10	Basic user with no requirement for a local copy of Microsoft Office. Access to Exchange Online (NHSmail), Office Online

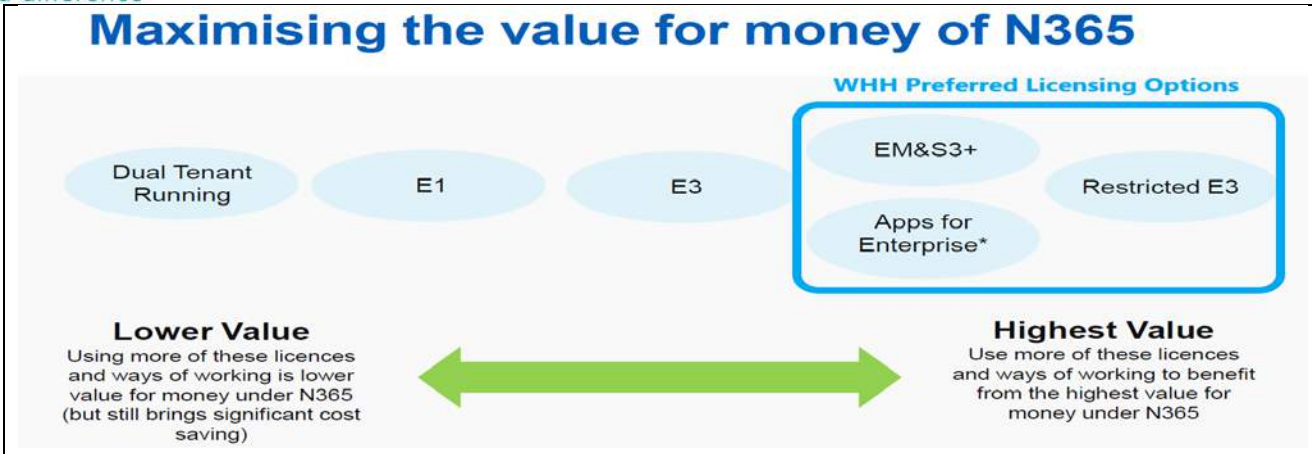
			and Desktop variant of MS Teams. User roles include: - Healthcare Assistant - Healthcare Support Worker - Porter - E&F roles including Housekeeper, Plumber, Painter / Decorator and Electrician. Evidence on inpatient wards is that users revert to generic accounts often, using Exchange Online for email access.
Apps for Enterprise	4040	89	Closest licensing option to what the majority of users enjoy now. All Restricted E3 services in addition to local copy of Microsoft Office. User roles include: - Senior Managers - Managers - Medical workforce (All grades) - Nurses (All grades) - AHPs (All grades) - Medical Secretaries and Secretaries - Majority of Corporate Staffing
E5	60	1	All Restricted E3 and Apps for Enterprise services in addition to PowerBI functionality for Information and BI publishing rights. User roles include (within Digital Services, Finance and HR&OD): - Technician - Analyst
	4560	**100**	

Table: Preferred Licensing Model for Microsoft N365 at the Trust

The Executive Team is asked to note the following salient points by progressing with this licensing model recommendation:

1. **It maximises value for money of N365.** The graphic below illustrates where the preferred license types sit within the available license options of N365 based on value analysis by NHS Digital. The Trust has selected those license types that deliver optimal value for money. E5 licensing is not included in the NHS Digital analysis as E5 licenses are not within the scope of N365 per se; rather existing pricing is expected to ensue when engaging with a local preferred reseller.

   All license types for N365, except for Restricted E3 licenses, require Enterprise Mobility & Security licensing to be purchased (represented as “EM&S3+” in the graphic below). This affords cyber security, application and enterprise device management to the Trust. This is integral for enterprise management, though has no bearing on the individual user experience per se.



2. **It mitigates challenges presented with a data migration, albeit temporarily.** The rationale for selecting Apps for Enterprise for the majority of users is to equip users with an updated Office suite, continue to use Microsoft NHSmail, and to utilise Microsoft Teams to its full potential for peer to peer collaboration. This license is more expensive than the N365 Restricted E3 "online only" option, but it postpones the requisite data migration to the national NHS OneDrive cloud which is beset by complexity if not approached carefully.

   It is proposed that over the 32 month term the Trust will gradually migrate user data and shared files (inclusive of H:/, P:/ and S:/ drives) to OneDrive starting initially with users on the WHHFT O365 tenancy and corporate users. This data migration is in anticipation of the Apps for Enterprise option being removed by April 2023 which will make "on premise" variants of Office considerably more expensive – please refer to the risks table for estimated financial impact.

3. **It assumes no substantial increase will occur to headcount at the Trust.** The user count of 4560 represents the rounded average headcount over the last 12 month period. Any substantial increase in headcount will require a separate impact assessment. For example: A prospective merger with NHS partners to form an integrated care system is likely to result in novation of N365 licenses on transaction thereby mitigating any potential financial impact.

4.0 Financial Appraisal

The table below estimates the costs per annum to the Trust for the Microsoft N365 deal. The forecast is that N365 will require a revenue investment of **£422,539** per annum. This represents a total investment of **£1,126,771** over a 32 month term based on the preferred licensing model for Trust users. This term will extend from 1st September 2020 through to 30th April 2023 at which point a new agreement with Microsoft will be negotiated.

For the purposes of budgeting it is recommended that the Executive Team endorse a tolerance of **10%** of the total cost over the 32 month term to mitigate risks associated with fluctuations in total workforce headcount or movement of users between license types. With a 10% budgetary tolerance, an additional 430 Apps for Enterprise licenses could be procured for the 32 month term *without* breaching the 10% budgetary tolerance limit. This would allow a sufficient tolerance within the budgetary upper limit for variances either in total workforce headcount or requirements of specific user roles (e.g. a HCA requiring local Office due to undertaking enhanced duties).

The Executive Team is therefore asked to support an allocation of **£1,239,448** for the Microsoft Office Upgrade business critical scheme for approval by Trust Board. Trust Board has already approved in principle £1,722,000 of spend as part of the capital programme for FY20/21 under the "Microsoft Office Upgrade"

scheme, though the Trust now recognises this requirement as wholly revenue due the nature of the expenditure.

A contract award recommendation will follow for Executive approval on submission and approval of the Trust's Participation Agreement and identification of a preferred reseller.

The following table captures the Microsoft N365 Licensing breakdown and associated pricing under N365. Pricing per user per license per month is extract from the N365 Participation Agreement which includes an allowance for reseller margin.

User Count	N365 Licensing Option	Monthly cost of Licence	Annual cost of Licence	Licence Volume Requirement	% of Total User Count	Net Cost Exc VAT	Total Cost Inc VAT
4560	N365 Restricted E3	£ -	£ -	460	10%	£ -	£ -
	N365 Office 365 E1 Step Up	£ 2	£ 25	0	0%	£ -	£ -
	N365 Apps for Enterprise + EM&S3+	£ 7	£ 82	4040	89%	£ 330,634	£ 396,760
	N365 Apps for Enterprise + EM&S3+ AND E1 Step Up	£ 9	£ 107	0	0%	£ -	£ -
	N365 E3	£ 11	£ 137	0	0%	£ -	£ -
	N365 E5	£ 27	£ 321	60	1%	£ 19,274	£ 23,129
	Audioconferencing for Teams	£ 2	£ 22	100	2%	£ 2,208	£ 2,650
	Total cost					**£ 352,116**	**£ 422,539**
	Effect from Anticipated Start Date in 1st September 2020 to 30th April 2023						**£ 1,126,771**
	TOLERANCE						£ 112,677 10%
	Costs of Licences from 1st September 2020 to 30th April 2023 including tolerance of 10%						**£ 1,239,448**

Table: Summary of Microsoft N365 Licensing Pricing Over 32 Month Term

The expenditure for N365 compares favourably with early estimates within FY20/21, with **£1,722,000** allocated within the capital programme following Trust Board approval in March 2020 based on standard Microsoft licensing pricing. It is however marginally higher than the estimate presented to the Executive Team in May 2020 wherein £1,200,000 was forecast for the 32 month term. This is a result of confirmed pricing from NHS Digital and variances in the license options available and the optimal approach for the Trust following further due diligence as; this includes the addition of audioconferencing for a limited volume of Microsoft Teams accounts.

NHS Digital has advised that accounting treatment of N365 costs is a local matter in terms of recognising expenditure as capital or revenue, and there appears to be no consensus nationally. Earlier discussions at WHH suggest that the expenditure cited here will qualify as revenue expenditure only.

Procurement Process and Status

The illustration below summarises the timelines and current progress to date for N365 contracting. The next step following Executive Team approval of this business case is to submit the Participation Agreement committing the Trust to purchase Microsoft licensing at discounted rates via the N365 Service.

At the point the Trust's involvement in N365 is approved by NHS Digital, allowing access to preferential pricing, the Trust will proceed with engagement of preferred resellers to identify which offers the best return on investment (in practice the reseller with the lowest margin). The Executive Team will then be presented with a contract award recommendation to formally contract for a new all-encompassing Microsoft ELA that covers the N365 requirements identified within this paper and those requiring renewal

under the existing ELA.

There is no requirement for a waiver. Resellers will be engaged via a pre-competed framework with access to preferential pricing enabled through N365 following submission and approval of the N365 Participation Agreement.

Participation Agreement and its Contractual Implications

Appendix 1 contains the N365 Participation Agreement. Particular attention is drawn to page 9 of the Agreement which will commit WHH (the "Recipient Body") to purchasing the identified licenses within 'Section 3.0 Proposed Development' of this paper. For visibility the salient terms within the Agreement are as follows:

> "1.4 Following signature of this Participation Agreement the Recipient Body shall execute a contract with the its [sic] own appointed License Service Provider ("Local License Service Provider") for the purchase of the required N365 Service licenses ("Local Contract").
>
> "1.5 The Recipient Body has expressed its interest in receiving the N365 Service. By executing this Participation Agreement, the Recipient Body agrees to purchase the licenses detailed in Appendix B and agrees to the terms of this Participation Agreement which shall govern such purchase."

Under "Part 1 – Service Of The Software" within the participation Agreement it states:

> "2.3 The Recipient Body shall execute its Local Contract by no later than 15 September 2020, purchasing the licenses listed in Appendix B as a minimum. The Recipient Body shall thereafter pay for all committed licenses for itself and all Service Consumers via the Local License Service Provider until the End Date
>
> "2.4 If the Recipient Body does not comply with its obligations in clause 2.3, then the Authority may recover its costs from the Recipient Body (which the Recipient Body undertakes to pay) and the Recipient Body shall no longer be entitled to receive the N365 Service…"

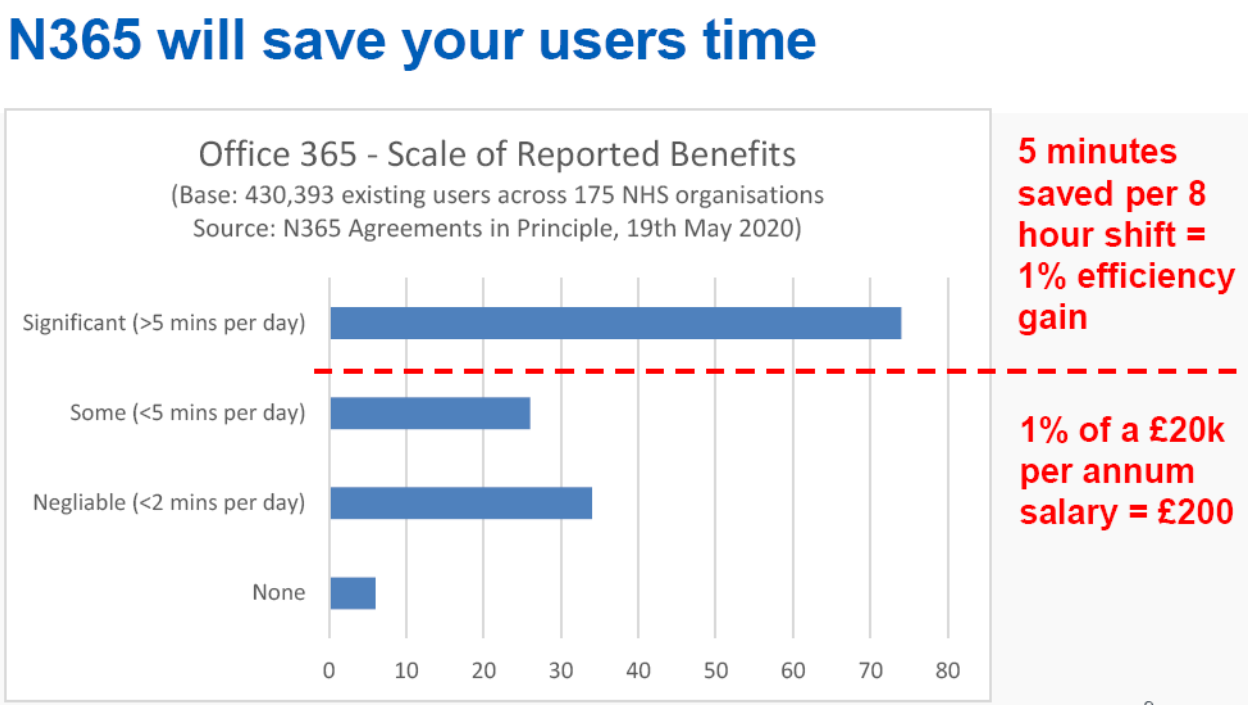
Appendix 4 lists the proposed responses to the N365 Participation Agreement for WHH. For the purposes of the cited contractual terms above, this will form the basis of the commitment in clause 2.3 regarding "purchasing the licenses in Appendix B as a minimum".

5.0 Benefits

The following benefits are anticipated on migration of the Trust to the new Microsoft N365 Service. Further work will continue with Estates and Facilities to identify benefits including the potential reductions in office and car parking space as a result of agile working practices that will be enabled through N365:

Benefits	Measurable Output
Supported use of Microsoft products across the Trust. As of 3th October 2010 the Trust will be operating on legacy and unsupported Microsoft platforms.	Microsoft and NHS Digital support for Trust use of Microsoft products including Windows 10 operating systems, Office 365, and cyber security and enterprise device management tooling.
Heightened security and enterprise device management through up-to-date software that is supported by the vendor.	N365 provides the latest in cyber security and enterprise device management tooling. This supports reduction of risks associated with cyber vulnerabilities as measured through Risk 1114 within the BAF.
Potential reduction in on premise storage requirements following migration of user data (part of the plan to April 2023) to OneDrive as part of N365.	Reduction in on premise storage utilisation as a result of data migration to N365. This will be explored as part of an 'invest to save' proposal on contracting of N365.

In addition a review of all Agreements in Principle submitted by NHS organisations interested in partaking in N365 illustrated potential non-cash releasing time savings in utilising Microsoft N365 products as represented by the graphic below:



6.0 Risks

Risks to the current service/Trust if the development is not approved include:

Description	Mitigation	Initial Risk Score (SeverityxImpact)	Source
FAILURE TO provide essential, optimised digital services in a timely manner in line with best practice governance and security policies, CAUSED BY increasing and competing demands upon finite staffing resources whom lack emerging skillsets, sub-optimal solutions or a successful indefensible cyber-attack, RESULTING IN poor data quality and its effects upon clinical and operational decisions/returns and financial & performance targets, reduced operational efficiencies, denial of patient access to services, inferior quality of care including harm, failure to meet statutory obligations (e.g. Civil Contingency measures) and subsequent reputational damage.	The following actions are pertinent for the mitigation of the BAF risk in the context of Microsoft N365 and wider ELA licensing: 1) Upgrade all windows 7 to Windows 10. 2) Migrate all Windows Server 2003 and 2008 to 2016 3) Migrate from Office 2010	16 (4x4)	BAF (Risk 1114)
FAILURE TO deliver essential Digital services, CAUSED BY a successfully executed Cyber Attack, resulting in loss of access to data and vital IT systems, RESULTING IN potential patient harm, loss in productivity, damage to the Trust reputation and possible income losses and regulatory fines of up to 4% of the Trusts annual turnover.	Mitigate cyber vulnerabilities through use of modern technologies including Windows 10 and modern Microsoft Office applications. The latter is contingent on a new ELA.	12 (3x4)	Corporate (Risk 143)
FAILURE TO provide for a tolerance / contingency fund to make allowances for variances in workforce headcount or fluctuations in user roles that changes N365 license suitability, RESULTING IN costs exceeding current estimates for N365 licensing.	Mitigate through provision of a budgetary tolerance.	12 (3x4)	Corporate (NEW)
FAILURE TO migrate user data reliant on Microsoft Office 365 to OneDrive by April 2023 allowing users to have an “online only” enterprise license RESULTING IN potentially significant costs on renewal of the Microsoft ELA after April 2023 due to continuing requirements to have “on premise” installs. Estimated financial impact if risk materialises: £268,191. Assumes current Apps for Enterprise and E3 costs remain. Impact represents the difference between Apps for Enterprise and E3 licensing for the 4040 identified as having this license type.	Mitigate risk of failed data migration by engaging subject matter experts in a data migration to OneDrive and Office 365 online. Enabled through potential redirection of funds from cost recovery / avoidance post-N365 contracting for the Trust’s existing Microsoft ELA. Subject to approval by the Executive Team of a subsequent Business Case.	5 (1x5)	Corporate (NEW)

The Executive Team are asked to also note a number of fundamental assumptions for assurance to reach this licensing proposal for N365:

1. The N365 pricing in section 2.3 included an allowance for reseller margin based on an NHS Digital assessment. It is assumed that once a preferred reseller is identified through a competitive procurement exercise that this falls within the tolerances of the pricing used.

2. It is assumed that the Trust head count remains broadly within the tolerance of 4560 users. Head count rather than WTE is the key metric as licenses are on a per user basis. The provision of a 10% budgetary tolerance safeguards against any but the most substantial increases in headcount or variances in user roles.

3. It is assumed that the headcount data from ESR is an accurate representation of the Trust workforce. ESR was used as the single source of truth for identifying user roles and volumes.

4. It is assumed that PowerBI (which drives the Trust's performance dashboards) can be consumed by users without a full E5 license. Only those with a requirement to develop or author new reports require the E5 license. There is continuing dialogue with national peers regarding licensing scope.

5. It is assumed that pricing for E5 licenses does not vary substantially from that estimated. License pricing was not indicated as a result of the N365 process. Similarly no costs are available for generic accounts. If costs arise, these will need to be considered as part of the 10% tolerance figure proposed within this paper.

6. It is assumed that the Trust will procure services not within the N365 scope (as per section 2.2) independently as part of a wider and new Enterprise License Agreement. Recurrent revenue expenditure of £153,733 inclusive of VAT remains valid and over and above any dialogue or proposal to participate in the N365 agreement. This is already budgeted for as part of current Microsoft enterprise licensing arrangements.

7. It is anticipated that there will be an opportunity for a cost reduction under the Trust's existing ELA which is budgeted for annually at £153,733 due to anticipated overlap of some components with N365. This will be reconciled as part of the Local Contract process with the preferred reseller.

6.1 Impact Assessment

Impact	Mitigation
Digital Services implementation resource for N365.	Prioritisation of N365 implementation already completed for FY20/21 as part of business planning for the year.

7.0 Recommendations

The recommendation is for the Executive Team to support the following for approval by Trust Board:

1. Submission of the N365 Participation Agreement which will commit the Trust to procuring Microsoft enterprise licenses as part of the national N365 scheme. The term for the N365 Participation Agreement will be 1st September 2020 through to 30th April 2023.

2. Approve participation in N365 at a forecast cost of **£1,239,448** inclusive of VAT and inclusive of a 10% budgetary tolerance. This cost is wholly revenue expenditure. This compares with £1,722,000 originally forecast in FY20/21 as part of the capital programme approved by Trust Board in March 2020.

The Executive Team will be presented with a contract award recommendation following approval of its N365 Participation Agreement by NHS Digital and the subsequent local contract negotiation with a preferred reseller. A benefits realisation paper will be presented to the Executive Team to measure the N365 outputs at varying intervals through 2020-2023, with the initial paper due in October 2020.

Amendment History

Issue	Date	Author	Reason
Version1	10/07/20	M Gardner	Initial Business Case
Version2	13/07/20	M Gardner	Amendments after Chief of Finance and Deputy Chief Executive review

Appendix 1 – N365 Participation Agreement

N365 Participation Agreement - Version

Appendix 2 – N365 Service Description

N365 Service Description - Version

Appendix 3 – Table of Microsoft N365 Licensing Pricing Over 32 Month Term

User Count	N365 Licensing Option	Monthly cost of Licence	Annual cost of Licence	Licence Volume Requirement	% of Total User Count	Net Cost Exc VAT	Total Cost Inc VAT
4560	N365 Restricted E3	£ -	£ -	460	10%	£ -	£ -
	N365 Office 365 E1 Step Up	£ 2	£ 25	0	0%	£ -	£ -
	N365 Apps for Enterprise + EM&S3+	£ 7	£ 82	4040	89%	£ 330,634	£ 396,760
	N365 Apps for Enterprise + EM&S3+ AND E1 Step Up	£ 9	£ 107	0	0%	£ -	£ -
	N365 E3	£ 11	£ 137	0	0%	£ -	£ -
	N365 E5	£ 27	£ 321	60	1%	£ 19,274	£ 23,129
	Audioconferencing for Teams	£ 2	£ 22	100	2%	£ 2,208	£ 2,650
	Total cost					**£ 352,116**	**£ 422,539**

	Effect from Anticipated Start Date in 1st September 2020 to 30th April 2023	**£ 1,126,771**
	TOLERANCE	£ 112,677
		10%

	Costs of Licences from 1st September 2020 to 30th April 2023 including tolerance of 10%	**£ 1,239,448**

Appendix 4 – N365 Participation Agreement Online Responses for WHH

Ref	NHS Digital N365 Question	WHH Response	Additional Remarks from N365 Participation Agreement
1	Primary Contact details (Mandatory)	Simon Whitfield IT Deployment Team Manager Email: simon.whitfield:nhs.net	
2	Alternative Primary Contact details (Optional)	Tracie Waterfield IT Service Delivery Manager Email: Tracie.Waterfield@nhs.net	
3	Senior Responsible Manager details (Mandatory):	Matthew Gardner Deputy Chief Information Officer Email: m.gardner@nhs.net	
4	Which N365 Service Option will your organisation use?	My organisation will use the NHS Shared Tenant (nhs.net domain)	
5	How many Restricted E3 licences does your organisation require now?	Number of Licenses Already Owned: 0 Number of Licenses To be Purchased: 460 for Restricted E3 only; 4560 if considered as a base for all license options on the N365 Shared Tenancy.	The Restricted E3 licence is used by organisations choosing the NHS Shared tenant (nhs.net) option. Please confirm your actual current number of licences required for the actual number of users in your organisation today. Please do NOT include any estimate for future growth.

6	How many E1 licences will your organisation purchase before the due date?	Number of Licenses Already Owned: 0 Number of Licenses To be Purchased: 0	E1 licences are available on both own individual tenant or the NHS shared tenant. On the own individual tenant they provide the basic online service. On the NHS shared tenant they can be used to provide additional storage. If your organisation has already purchased E1 licences please detail these separately to any other E1 licences that you are committing to purchase.
7	How many Apps for Enterprise (formerly known as Office 365 Professional Plus) will your organisation purchase before the due date?	Number of Licenses Already Owned: 0 Number of Licenses To be Purchased: 4040	
8	How many Office 365 E3 licences will your organisation purchase before the due date	Number of Licenses Already Owned: 0 Number of Licenses To be Purchased: 0	
9	How many Office 2016/2019 perpetual licences will your organisation purchase	Number of Licenses Already Owned: 0 Number of Licenses To be Purchased: 0	Office 2016 or 2019 perpetual licences do not receive additional discounts under N365, however they may be used to enable desktop installations of Office removing the need to purchase additional licences under N365
10	How many Enterprise Mobility & Security (EM&S3+) licences will your organisation purchase before the due date?	Number of EM&S3 licences already owned: 0 Number of CoreCAL Step Up to EM&S3+ to be purchased: 0 Number of ECAL step up to EM&S3+ to be purchased: 0 Number of full EM&S3+ licences to be purchased: 4040+60 (4100)	EM&S3+ licences can be obtained by "stepping up" from existing CoreCAL or Enterprise CAL licences, or purchased in full
10a	How many M365 licences does your organisation already own?	0	Please enter the number of full M365 licences owned (E3 and E5 together in total). Please ensure that these are not double counted with any figures

			for O365 and EM&S submitted separately above
11	How many Audioconference for Teams licences will your organisation purchase by the due date?	Number of licences already owned: 0 Number of Licenses To be Purchased: 100	
12	How many Windows E5 per user step up licences will your organisation purchase by the due date?	Number of licences already owned: 0 Number of Licenses To be Purchased: 60	Understood to be required for PowerBi
13	How many Windows E5 Virtual Desktop (VDA) per user step up devices will you purchase by the due date?	Number of licences already owned: 0 Number of Licenses To be Purchased: 0	
14	How many F1 licences will your organisation purchase by the due date?	Number of licences already owned: 0 Number of Licenses To be Purchased: 0	Whilst F1 licences are not additionally discounted under N365 it is important to understand the number used by your organisation.
15	Please confirm your anticipated total number of users over the next 3 years	As of April 2021: 4560 As of April 2022: 4560 As of April 2023: 4560	
16	Please confirm your anticipated number of EM&S3+ licences over the next 3 years:	As of April 2021: 4560 As of April 2022: 4560 As of April 2023: 4560	
17	Please confirm your anticipated number of N365 full desktop licences over the next 3 years?	As of April 2021: 4560 As of April 2022: 4560 As of April 2023: 4560	Consider reduction year on year to account for migration to Cloud model.
18	What proportion of your estate will have migrated to Office 365 by end June 2020. Please select one option from the list below.	0%	

19	What proportion of your estate will have migrated to Office 365 by end September 2020. Please select one of the options from the list below:	50%	
20	What proportion of your estate will have migrated to Office 365 by end December 2020. Please select one option from the list below:	80%	
21	What proportion of your estate will have migrated to Office 365 by end March 2021. Please select one option from the list below:	100%	
22	What proportion of your estate will have migrated to Office 365 by end June 2021?	100%	
23	What proportion of your estate will have migrated to Office 365 by 13th October 2021? (Migration Deadline date)	100%	
24	What proportion of your estate will be technically or operationally impossible to migrate to Office 365 by 13th October 2021 (Migration Deadline date)	0%	
25	Please confirm your organisations confidence level that the plan as outlined above is achievable	Very Confident	

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/20/07/83**			
SUBJECT:	**Charitable Funds Committee Governing Document (ToR)**			
DATE OF MEETING:	29th July 2020			
AUTHOR(S):	Pat McLaren, Director of Communications & Engagement			
EXECUTIVE DIRECTOR SPONSOR:	Pat McLaren, Director of Communications & Engagement			
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	SO1 We will.. Always put our patients first through high quality, safe care and an excellent patient experience. SO2 We will.. Be the best place to work with a diverse, engaged workforce that is fit for the future. SO3 We will ..Work in partnership to design and provide high quality, financially sustainable services.			
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): **(*Please DELETE as appropriate)***	#145 a. Failure to deliver our strategic vision.			
EXECUTIVE SUMMARY ***(KEY ISSUES):***	The Charitable Funds Committee Governing Document (terms of reference) has been updated and approved for submission to the Corporate Trustee. • This ToR has been renamed 'Governing Document' and includes an additional 'introduction and describption of purpose at item 0. This is to comply with requests from grant-makers for Governining document at time of application, some of whom cannot accept 'terms of reference'. • Following approval by the Corporate Trustee this will be uploaded to WHH Charity website			
PURPOSE: *(please select as appropriate)*	Information	Approval X	To note	Decision
RECOMMENDATION:	That the Trust Board, in its capacity at Corporate Trustee, approve the Governing Document for			
PREVIOUSLY CONSIDERED BY:	**Committee**	Charitable Funds Committee		
	Agenda Ref.	CFC 20 06 19		
	Date of meeting	4th June 2020		
	Summary of Outcome	Approved, submit to Board		
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None			

Registered charity number 1051858

CHARITABLE FUNDS COMMITTEE

GOVERNING DOCUMENT

0. THE CHARITY

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

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

Its values are:

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

1. PURPOSE

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

2. AUTHORITY

The Committee is authorised to:

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

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

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

3. REPORTING ARRANGEMENTS

The Committee will have the following reporting responsibilities:

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

4. DUTIES & RESPONSIBILITIES

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

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

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

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

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

- Ensure that individual fund objectives and spending plans are in keeping with the objectives, spending criteria and priorities set by the donors.
- Obtain plans for all individual funds and approve if/when appropriate.
- Ensure that donations and investment income or losses are attributed to individual funds appropriately.
- Ensure the sources of income and the terms on which donations are received are acceptable to the Trustees.
- Ensure that all funds are correctly allocated as restricted, unrestricted or designated, and accounted for accordingly. This analysis will differentiate between restricted, specific and the General charitable fund.
- Recommend an investment advisor – where market conditions are favourable - to the Corporate Trustee following appropriate tendering procedures and regularly monitor and review their performance.
- Ensure that the investment policy for Charitable Funds set by the Corporate Trustee is implemented and that sufficient funds are kept readily available to meet planned requirements.

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

5. MEMBERSHIP

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

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

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

Members can participate in meetings by two-way audio link including telephone, video or computer link (excepting email communication). Participation in this way shall be deemed to constitute presence in person at the meeting and count towards the quorum. Should the need arise, the Committee may approve a matter in writing by receiving written approval from all the members of the Committee, such written approval may be by email from the members Trust email account.

6. ATTENDANCE

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

- Director Communications and Engagement
- Head of Fundraising
- Deputy Director of Finance and Commercial Development
- Financial Planning Accountant

- Nominated Governor (Public Constituency)
- Any Senior Trust employees with clinical and operational expertise as nominated by the Trust Board at the invitation of the Committee

7. QUORUM

A quorum shall be:

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

8. FREQUENCY OF MEETINGS

The Committee will meet on a quarterly basis.

9. ADMINISTRATIVE ARRANGEMENTS

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

10. REVIEW / EFFECTIVENESS

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

DATE: June 2020

NEXT REVIEW: June 2022

Registered charity number 1051858

GOVERNING DOCUMENT - REVISION TRACKER

Name of Committee:	**CHARITABLE FUNDS COMMITTEE**
Version:	Issue No 9
Implementation Date:	June 2020
Review Date:	24 Months from the approval date ie June 2022
Approved by:	Charitable Funds Committee
Approval Date:	Charitable Funds Committee 4 June 2020 and Trust Board (insert)

REVISIONS			
Date	**Section**	**Reason on Change**	**Approved**
June 2018	**Attendance**	- **Delete** Corporate Affairs from Director of Communications + Engagement title	
March 2019	**Membership**	- The Committee shall comprise the individuals responsible for ensuring that corporate Trustee duties of the Trust are fulfilled. They shall be appointed by the Trust Board and will normally include: - All the non-executive directors of the Trust (with the exception of the Trust Chairman) one of whom will be appointed as Chair of the Committee by the Trust Board - Up to (three) voting Executive directors to include the Director of Finance and Commercial Development or their nominated deputies	CFC 7.03.2019 Trust Board 31.05.2019
March 2019	**Attendance**	- Director Community Engagement and Fundraising - Deputy Director of Finance - Head of Financial Services - Nominated Governor (Public Constituency) - Any Senior Trust employees with clinical and operational expertise as nominated by the Trust Board at the invitation of the Committee	CFC 7.03.2019 Trust Board 31.05.2019
March 2019	**Quorum**	A quorum shall be: (2) non-executive directors (2) executive directors (or their nominated deputies)	CFC 7.03.2019 Trust Board 31.05.2019
June 2020	**Attendance**	• Replace Head of Financial Services with • Financial Planning Accountant • Amend title to read - Deputy Director of Finance and Commercial Development	Issue 9 CFC 04.06.2020 Trust Board 29.07.2020

Registered charity number 1051858

		• Amend title of DoF + Commercial Development to read Chief Finance Officer • Add Head of Fundraising • Amend title of Director Community Engagement & Fundraising to Director Communications and Engagement	
June 2020	**Charitable Purpose**	To update the charitable purpose following Cttee approval in December 2019	Issue 9 CFC 04.06.2020 Trust Board 29.07.2020
June 2020	**Naming of document**	The ToR has been renamed Governing Document to comply with requests for this to accompany grant applications/corporate sponsorship	CFC 04.06.2020 Trust Board 29.07.2020

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

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/20/07/85**	
SUBJECT:	**Emergency Preparedness Resilience and Response (EPRR) Annual Report 19/20**	
DATE OF MEETING:	29th July 2020	
AUTHOR(S):	Emma Blackwell, EPRR Manager (2019-2020) Rachel Clint, EPRR Manager (2020-2021)	
EXECUTIVE DIRECTOR SPONSOR:	Chris Evans, Chief Operating Officer	
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	SO1 We will.. Always put our patients first through high quality, safe care and an excellent patient experience. SO2 We will.. Be the best place to work with a diverse, engaged workforce that is fit for the future. SO3 We will ..Work in partnership to design and provide high quality, financially sustainable services.	√
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF):	#1135 Failure to deliver an emergency and elective healthcare service caused by the global pandemic of COVID-19 resulting in major disruption to service provision. #1124 Failure to provide adequate PPE caused by failures within the national supply chain and distribution routes resulting in lack of PPE for staff. #115 Failure to provide adequate staffing levels in some specialities and wards. #1134 Failure to provide adequate staffing caused by absence relating to COVID-19 resulting in resource challenges and an increase within the temporary staffing domain. #1114 Failure to provide essential, optimised digital services in a timely manner in line with best practice governance and security policies, caused by increasing and competing demands upon finite staffing resources whom lack emerging skillsets, sub-optimal solutions or a successful indefensible cyber-attack, resulting in poor data quality and its effects upon clinical and operational decisions / returns and financial & performance targets, reduced operational efficiencies, denial of patient access to services, inferior quality of care including harm, failure to meet statutory obligations (e.g. Civil Contingency measures) and subsequent reputational damage. #224 Failure to meet the emergency access standard. #1126 Failure to potentially provide required levels of oxygen for ventilators caused by system constraints resulting in lack of adequate oxygen flow at outlets.	
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 our response to incidents which have occurred during 2019-20. • Describe our respoinse to COVID-19 and highlight the associated work to be prioritised in 2020-21. • Summarise our planned work streams and priorities for the year ahead.	

PURPOSE: ***(please select as appropriate)***	Information √	Approval	To note	Decision
RECOMMENDATION:	The Board is asked to note the work and achievements undertaken during 2018-19 and the planned work programme for 2019-20 in support of the Trust's objectives.			
PREVIOUSLY CONSIDERED BY:	**Committee**	Choose an item.		
	Agenda Ref.			
	Date of meeting			
	Summary of Outcome			
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 2019/20	AGENDA REF:	BM/20/07/86

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, we have 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 we have had our resilience tested on a number of occasions over the last year, most notably in the form of the COVID-19 pandemic, notwithstanding other pressures including severe weather, outbreaks of infection, IT and telecommunication failures and demand management pressures. Our plans and procedures and the commitment of our staff have enabled us to manage such 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 Hospitals NHS Foundation Trust.
- Outline the work that has been undertaken in the area during the past 12 months.
- Describe our response to incidents which have occurred during 2019-20.
- Summarise our 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

- Chris Evans- 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 was supported by Emma Blackwell, Resilience Manager (until 1st July 2020) and subsequently Rachel Clint.

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 all Clinical Business Units, clinical representation and corporate services.

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 were provided to the Trust Operational Board prior to March 2020. Corporate plans, approved at the EPG, were formally ratified by the Trust Operational Board.

The monthly Event Planning Group was paused following the outbreak of COVID-19, when a Coronavirus Management Board (Appendix 1) was introduced March 2020 and a Silver Command structure was put in place to manage the Level 4 incident. This Coronavirus Management Board was reviewed and replaced by the COVID-19 Tactical and Recovery Management Board (Appendix 2) in June 2020.

EPRR External Structure:

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 Partnerships (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?

Training

The Trust has an ongoing programme of exercises and training events to test and validate emergency plans. Details of all of the training events are reported in Appendix 3.

Assurance Process

The Trust is required to undertake an annual self-assessment against the 65 NHS England Core Standards for EPRR. This was last undertaken in August 2019. This included a 'deep dive' focusing on severe weather response.

In September the Board were informed that the Trust had achieved 'Substantial' compliance against the EPRR Core Standards. This was an improvement in last year's compliance and highlighted the work that had been undertaken in the past 12 months specifically around business continuity and EPRR staff training and exercising.

It is not clear whether the annual self-assessment will take place in 2020, we await further instruction from NHSE.

5. MEASUREMENTS/EVALUATIONS

Incidents & Exercises

During 2019-20 the following significant incidents and exercises are of note:

24th April 2019 and 22nd May 2020 – Emergency Department Desk Top Major Incident Exercises

The ED Major Incident desktop exercises were an opportunity to provide training to the Senior ED Clinicians and exercise elements of the Trust major incident plan and update the ED department's local major incident plan based on the new department footprint.

Staff were briefed on current major incident definitions, discussed recent incidents, hospital initial decision making and the Cheshire and Merseyside mass casualty planning matrix, triage and blast injuries.

6th June 2019 – Exercise Roving Storm

Members of the Trust IT and Communications team attended a Local Resilience Forum (LRF) exercise in June which explored the potential multi-agency impact of a significant Cyber Attack in the local area.

26th June 2019 – Major Incident Standby – Daresbury Hotel

The Trust was informed via Cheshire Police of a large scale disturbance at the Daresbury Park Hotel. Initial reports suggested up to 40 casualties and the Trust declared a Major Incident standby. The Emergency department staff effectively cleared the department and prepared

to receive casualties, the On-Call team attended site and Switchboard completed a notification cascade. There was some learning from the incident and a debrief took place on the 27th June.

25th June 2019 – Exercise Snow Leopard

This was a whole system exercise to review the escalation action cards by testing them against severe winter pressures. This was attended by Trust and CCG staff and learning from the exercise formed part of whole system winter planning for 2019/20.

17th October 2019 – VHF Desktop exercise

This was a desktop exercise based on a self-presenting casualty, who along with his 8 year old son, attended the Emergency department with potential symptoms of a Viral Haemorrhagic Fever (VHF). The exercise focused on the patient's journey in the Emergency department.

Prior to the start of the exercise, participants were briefed on the transmission, signs and symptoms, diagnosis and current treatment of the Ebola virus.

Learning from this exercise was factored in to the early planning for the coronavirus pandemic, specifically the use of Primary Care as an isolation area.

27th November 2019 – Pandemic Flu Desktop Exercise

This was a desktop exercise focusing on a surge of suspected flu patients, primarily paediatric patients, who required treatment and high care admission. The approach was to work with the actual demands, staff and space available on the day using real time information from Lorenzo.

The exercise was an opportunity to test out the operational elements of the WHH Pandemic Influenza Plan looking at how we would cohort patients, the number of ventilators that are available and how we would manage a surge in paediatric admissions within our existing capacity.

Learning from the exercise was factored into the planning for the coronavirus pandemic, specifically the use of Theatre's for critical care patients.

18th December 2019 – Trauma Symposium and Major Incident Walkthrough

The Trust wide trauma meeting was used in December to run a mass casualty major incident exercise. This was an opportunity to brief Consultant General and Orthopaedic Surgeons. The feedback was very positive and learning will need to be picked up as part of the work plan for 2020/21.

EU Exit

The Trust Board was kept regularly updated 2019/20 of the Trust preparation for a no deal EU Exit. An EU Exit Team was established led by the AEO and EPRR Manager and with subject matter experts for all critical areas including Procurement, Pharmacy, Workforce, Overseas Visitors and IT. The EU Exit operational response included:-

- Front line communication to Trust staff – EU Exit was the weekly 'hot topic' at the Trust wide safety briefings.
- EU Exit was included in Team brief for September and October.
- Monitoring national guidance using an EU Exit operational readiness tracker.
- Service level business continuity plans in place across all CBUs.
- Letter to all Clinicians from Prof Simon Constable requesting their support for the supply of medicines, supplies and devices.
- One single point of contact for escalating any potential EU exit issues – whh.brexit@nhs.net
- Facilitation of a Warrington and Halton system wide EU Exit meeting.
- Completion of daily SitReps.

COVID-19

3rd March 2020 - PHE announced Level 4 Incident

The Trust initiated responses inline with guidance from NHSE.

11th March – WHO declared outbreak of COVID -19 as a pandemic

The Trust continue to exercise the Phase One response to COVID-19.

13th March 2020 – Grand Round – Trust Response to COVID-19

The Trust wide brief was used to inform all staff of the phase one response to COVID 19. This was an opportunity to capture staff across departments and share key information about the initial response to the pandemic. The session was supported by Dr Janet Purcell and Dr Toong Chin (Consultant Microbiologist), Emma Blackwell (Emergency Planning Officer), Caroline Eardley (Lead Nurse Manager Staff Health and Wellbeing) and Lesley McKay (Associate DIPC and Associate Chief Nurse). This was followed by a Q&A session and subsequently Trust wide communication supported the sharing of national updates and guidelines.

Since March 2020, The Trust Board has been regularly updated on the Trust response to COVID-19. A Coronavirus Management Board was established and led by the AOE following the PHE announcement of the Level 4 Incident and the World Health Organisations declaration of a pandemic.

The COVID-19 Tactical and Recovery Groups consist of senior stakeholders from all CBUs, HR and Workforce, Infection Prevention and Control, Procurement, Pharmacy and Executive and clinical representation exists. The COVID-19 Tactical and Recovery responses include:-

- Overseeing the first and second phase of the Trust response to COVID-19.
- Reviewing and managing Clinical Pathways and ensuring safe and effective services for patients.

- Overseeing Business Continuity Planning across all CBUs and services.
- Management of incidents and formulating / communicating the escalation plan.
- Reviewing and managing patient flow safely, effectively and efficiently.
- Reviewing current staffing levels to provide a patient focused service.
- Receiving, logging, reviewing and implementing the latest NHSE & PHSE guidance.
- Reviewing stock and supplies levels and arrangements.
- Overseeing the second phase of the hospital response to COVID-19.
- Supporting the establishment of the Elective Recovery Board to initiate plans for the step up of urgent elective services.
- Ensuring there is consideration of availability of medicines, PPE, consumables and equipment for all of the above.
- Planning and delivery of Wellbeing, OD and HR work streams to support workforce recovery.
- Coordination and completion of daily SitReps.
- Governance in relation to service changes and the recovery of services.

An Incident Management Team was established to support the Trust response to COVID-19. The response included:-

- A single point of contact for receiving, cascading and communicating national and regional updates – whh.controlroom@nhs.net available as a seven day service 8am-8pm 17th March – 30th June, 8am-6pm from 1st July (remote out of business hours 11th July onwards).
- A seven day onsite Control Room function to support staff with PPE requirements, IPC advice, daily plans and a single point of contact for COVID-19 related enquiries.
- Coordinating the COVID Consultant on-call rota.
- Governance of Tactical and Recovery Board meetings.
- Logging of documentation from NHSE, PHE, regional guidelines, updates from regulatory bodies and internal updates.
- Death Notification Processes and CPNS reporting.
- Collaboration with Information to complete daily SitReps.
- Regional network reporting and sharing key information.
- Supporting the procurement and specialist PPE functions.
- Communication of key information, safety alerts and national updates.
- Initiating a COVID Framework to assess compliance against the NHS Framework

For 2020/21 the Control Room / Incident Management function will be flexed up / down based on the national situation and guidance from NHSE / LHRP / Regional ICC.

6. TRAJECTORIES/OBJECTIVES AGREED

Work undertaken in 2019/20

The following work streams were completed during the year under review:

- The Major Incident Plan, Business Continuity Plan, Full Capacity Plan and Severe weather plans were all reviewed and updated to reflect local and national developments. All were approved by the Event Planning Group.
- In accordance with the national framework, preparation for a no deal European Union exit was managed via the EPRR leads within the Trust. A large amount of work was undertaken which involved establishing a Brexit Working Group, completing actions given by the DHSC on the EU Exit Readiness Guidance and Supplies Self-Assessment tools. The Board was regularly updated of the Trusts preparedness and situation reports were also submitted to DHSC on a daily basis for a period of time.
- Major Incident and CBRN training was delivered weekly to Emergency Department Staff.
- The Trust participated and contributed fully in all Local Health Resilience Partnership meetings and work streams.
- Membership and terms of reference of the Event Planning Group have been reviewed and updated to ensure all teams are now represented.
- Close liaison has been maintained with partner agencies in planning for local mass gathering events i.e. Warrington Neighbourhood Event and Creamfields festival.

Work programme for 2020/21

In 2019-20 the focus has been on reviewing and updating our key Emergency/Major Incident and Business Continuity plans, along with managing the COVID-19 pandemic.

EPRR in an ongoing cycle of planning, training, testing and improving. In 2020-21 the early emphasis will be on lessons learned during the COVID-19 pandemic, preparing for local outbreaks / a second wave and completing a debrief based on Phase 1 and Phase 2 responses to the COVID-19 pandemic. 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 this, the following work plans will be undertaken:

- Exercise the Major Incident and Business Continuity plans in the form of table top exercises with the operational teams.
- Review the Escalation process, including Full Capacity policy and action cards to support the Trust's winter planning preparedness.
- Ensure the Trust is prepared to stand up our EU Exit plans when required.
- Deliver training to key staff in Emergency Preparedness and Incident Management.
- Develop specific plans for local COVID-19 outbreaks to anticipate and meet potential demand management pressures in the health care system.
- Develop specific plans for managing winter pressures alongside COVID-19.
- Review of the Pandemic Influenza Policy alongside the management of COVID-19.
- Collaborate with the Procurement department and the Infection, Prevention and Control team to support a reliable supply of PPE and management of resources.

- Review the Trust On-Call documentation for Senior Managers and Executives.
- 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.
- A review of the Communications plan as part of our lessons learned from COVID-19.
- EPRR education of CBUs and workforce in light of lessons learned and COVID-19 experiences.
- Monitor the lessons learned from COVID-19 and other incidents in the UK.

7. MONITORING/REPORTING ROUTES

The NHS England led LHRP meets 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 2020 NHS EPRR Core Standards Audit is yet to be confirmed by NHSE.

Reviewing and implementation of the latest NHSE & PHSE guidance occurs through Tactical meetings. The Tactical Board and Recovery Board functions remain in place to oversee the management of incidents and escalation planning. Appropriate items are escalated to the Strategic Executive Oversight Group.

8. TIMELINES

This report is presented annually to the board.

9. ASSURANCE COMMITTEE

The EPRR Manager escalates issues to Tactical and Recovery Board meetings in the current absence of Trust Operational Board. The Event Planning Group will report any issues or updates via Trust Operational Board when this group is re-established.

10. RECOMMENDATIONS

The Board is asked to note the significant work and achievements undertaken during 2019-20 and the planned work programme for 2020-21 in support of the Trust's objectives.

Appendix 1- Coronavirus Management Structure

COVID-19 Management Structur

Appendix 2- COVID-19 Tactical and Recovery Management Board

COVID-19 and Recovery Managemer

Appendix 3 – Training events in 2019-2020

Event	Organiser	Date	Staff Involved	Purpose
On-Call Managers Emergency Preparedness and Incident Response briefing	WHH	Various dates during the year	Jo Hazlehurst Rachel Smith Debbie Mallett Kate Brizell Janet Pye Carol McEvoy Linda Ellison	Provide a briefing and update of Major Incident potential and the challenges roles and responsibilities of the Trust.
Loggist Training	WHH	15/05/19	4 members of the Administration team.	To train a cadre of administration staff to be incident Loggists for the Trust.
Lessons learnt from Manchester Arena Attack	NHS England	11/6/19	Emma Blackwell, EPRR Manager	Multi-agency review of the lessons learnt from the Manchester Arena attack.

Major Incident/CBRN Training	WHH	Weekly throughout June	Natalie Whitehead Jayne Yates Karl Dolman Kim Harker Ashley Halliday Frances Mendoza Joanne Bull Heather Brownlow Joanne Fenney Erin Dobson Rachel Walton Claire Grice Malcolm Andrew Bell Petra Hawthorn	Staff Nurse Sister Staff Nurse Staff Nurse Staff Nurse Staff Nurse Sister Staff Nurse Sister Staff Nurse Staff Nurse Sister Sister Staff Nurse	Overview of Trust and ED major incident plans and CBRN walkthrough.

We are WHH & We are PROUD to make a difference

Coronavirus Management Board

NHS Warrington and Halton Teaching Hospitals NHS Foundation Trust

COVID-19 STRATEGIC GROUP

Chair: Chief Executive Simon Constable

Daily Meeting at 12:00pm

Function: Strategic Executive oversight of all Covid-19 related meetings. It is a decision making forum. All Executives attend.

COVID-19 TACTICAL GROUP

Chairs: Chief Operating Officer Chris Evans **DIPC and Chief Nurse** Kimberley Salmon-Jamieson

Daily Meeting at 08:00am

Function: Reviewing and managing Clinical Pathways and ensuring safe and effective services for patients. Management of incidents and escalation plan. Reviewing and managing Patient Flow safely, effectively and efficiently. Reviewing and Managing current staffing levels to provide a patient focused service. Receiving, reviewing and implementing the latest NHSE & PHSE guidance. Review of stock and supplies levels and arrangements. Reviewing and formulating Communications plans. Reviewing information requests

Nursing Staffing Command

Chair: Deputy Chief Nurse John Goodenough

Daily Meeting at 10:00am

Function: Oversight of all rotas, safe staffing of nursing, midwifery and AHP, oversight of Hub redeployment, oversight of NWBN redeployment, oversight of Helping Hands, escalation to Tactical Group, oversight of training of critical care training including respiratory training

Operational Cell

Chairs: Deputy Chief Operating Officer Dan Moore

Deputy Chief Nurse John Goodenough

Daily Meeting at 11.00am

Function: Logistics, Estates and Facilities, conjunction with the Nursing Staffing Command, Incident Management, SMOC role, Business Continuity Plans, Risk Assessment

Medical Cell

Chairs: Dr Alex Crowe / Dr Anne Robinson

Daily Meeting at 09:00am

Function: Day incident management, consultant on-call, review working practice, management of swabbing, medical rota management, oversight clinical team, overnight redeployment

Governance / Legal / Statutory

Chair: Deputy Director of Governance Layla Alani / Jon Culshaw

Daily Meeting at 09:30am

Function: Oversight of new governance processes, oversight of incident and harm agenda, oversight of all CBU governance arrangements, liaise with CCG/ NHSI/ patient safety regarding governance

Infection Control

Chair: Associate DIPC and Associate Chief Nurse

Lesley McKay

Function: Trustwide advice, education and training on infection control procedures

Supplies / PPE

Chair: Associate Director of Procurement

Alison Parker

Function: To support and be responsive to the demands of the organisation with the delivery of appropriate stock and equipment, escalating shortages, and sourcing alternative supply routes if necessary

Welfare

Chair: Director of Strategy

Lucy Gardner

Function : Staff wellbeing, welfare and support, including accommodation, nutrition, childcare, and mental health and emotional support

HR Occupational Health

Chair: Deputy Director Human Resources & OD

Debs Smith

Function : Mobile working, training and development, volunteers and students, staff support, BC planning and flexible working

Digital / IM&T

Chair: Chief of Information Officer

Phill James

Function: Responsive changes to IT changes, data capture related to COVID and decreases in performance management of routine or other activity. Digital solutions for remote working to support self-isolated patients, hot spot reporting

Communications and Engagement

Chair: Director of Community Engagement & Corporate Affairs

Pat McLaren

Function: Manage sharing of key information, manage media interest, review information for consistency/ guidance, ensure national/regional NHS approach, support systems

Women's and Children's

Chair: Stephen Bennett

Function:

Chair: CBU Manager Stephen Bennett

Daily incident reporting . Management of incident and escalation planning . Reviewing and managing Clinical Pathways across each service. Oversight of each clinical team. Management of sharing of key information across the CBU and wider teams. Reporting and management of daily actions to maintain services. Daily staffing sit-reps for the CBU – nursing and medical. Medical rota management

COVID-19 and Recovery Management Board

Warrington and Halton Teaching Hospitals NHS Foundation Trust

STRATEGIC GROUP

Chair: Chief Executive Simon Constable

Tuesday and Thursday 12:00pm

Function: Strategic Executive oversight of all Covid-19 and recovery related meetings. It is a decision making forum. All Executives attend.

COVID-19 TACTICAL GROUP

Chairs: Chief Operating Officer Chris Evans **DIPC and Chief Nurse** Kimberley Salmon-Jamieson

Monday Meeting at 08:00am and Friday Meeting at 3.30pm

Function: Reviewing and managing Clinical Pathways and ensuring safe and effective services for patients. Management of incidents and escalation plan. Reviewing and managing Patient Flow safely, effectively and efficiently. Reviewing and Managing current staffing levels to provide a patient focused service. Receiving, reviewing and implementing the latest NHSE & PHSE guidance. Review of stock and supplies levels and arrangements. Reviewing and formulating Communications plans. Reviewing information requests

RECOVERY BOARD

Chairs: Chief Operating Officer Chris Evans **DIPC and Chief Nurse** Kimberley Salmon-Jamieson

Tuesday and Thursday Meeting at 08:00am

Function: To oversee the second phase of the hospital response to COVID19. The step up of non Covid19 urgent services as soon as possible. Review capacity for routine non-urgent elective care. Ensure consideration of availability of medicines, PPE, consumables and equipment. Planning and delivery of Wellbeing, OD and HR work streams to support workforce recovery.

Nursing Staffing Command

Chair: Deputy Chief Nurse John Goodenough

Daily Meeting

Function: Oversight of all rotas, safe staffing of nursing, midwifery and AHP, oversight of Hub redeployment, oversight of NWBN redeployment, oversight of Helping Hands, escalation to Tactical Group, oversight of training of critical care training including respiratory training

Operational Cell

Chairs: Deputy Chief Operating Officer Dan Moore **Deputy Chief Nurse** John Goodenough

Daily Meeting

Function: Logistics, Estates and Facilities, conjunction with the Nursing Staffing Command, Incident Management, SMOC role, Business Continuity Plans, Risk Assessment

Medical Cell

Chairs: Dr Alex Crowe / Dr Anne Robinson

Daily Meeting

Function: Day incident management, consultant on-call, review working practice, management of swabbing, medical rota management, oversight clinical team, overnight redeployment

Governance / Legal / Statutory

Chair: Deputy Director of Governance Layla Alani / Jon Culshaw

Daily Meeting

Function: Oversight of new governance processes, oversight of incident and harm agenda, oversight of all CBU governance arrangements, liaise with CCG/ NHSI/ patient safety regarding governance

Elective Planning

Chair: Director of Operations and Performance Dan Moore

Daily Meeting

Function: Oversight of elective planning in collaboration with CBU leads and clinicians. Patient safety, risk assessment of patients, pre-op plans and post-op plans. Staff swabbing and infection prevention and control guidance. Collaboration with Spire.

Infection Control

Chair: Associate DIPC and Associate Chief Nurse

Lesley McKay

Function: Trustwide advice, education and training on infection control procedures

Supplies / PPE

Chair: Associate Director of Procurement

Alison Parker

Function: To support and be responsive to the demands of the organisation with the delivery of appropriate stock and equipment, escalating shortages, and sourcing alternative supply routes if necessary

Welfare

Chair: Director of Strategy

Lucy Gardner

Function : Staff wellbeing, welfare and support, including accommodation, nutrition, childcare, and mental health and emotional support

HR Occupational Health

Chair: Deputy Director Human Resources & OD

Debs Smith

Function : Mobile working, training and development, volunteers and students, staff support, BC planning and flexible working. Risk assessments and PPE testing

Digital / IM&T

Chair: Chief of Information Officer

Phill James

Function: Responsive changes to IT changes, data capture related to COVID and decreases in performance management of routine or other activity. Coordination of SITREP reports. Digital solutions for remote working to support self-isolated patients, hot spot reporting.

Communications and Engagement

Chair: Director of Community Engagement & Corporate Affairs

Pat McLaren

Function: Manage sharing of key information, manage media interest, review information for consistency/ guidance, ensure national/regional NHS approach, support systems

Women's and Children's

Chair: Stephen Bennett

Function:

Chair: CBU Manager Stephen Bennett

Daily incident reporting . Management of incident and escalation planning . Reviewing and managing Clinical Pathways across each service. Oversight of each clinical team. Management of sharing of key information across the CBU and wider teams. Reporting and management of daily actions to maintain services. Daily staffing sit-reps for the CBU – nursing and medical. Medical rota management

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/20/07/86**	
SUBJECT:	**Learning from Experience Report - Q4 2019/20**	
DATE OF MEETING:	29th July 2020	
AUTHOR(S):	Layla Alani, Deputy Director Governance	
EXECUTIVE DIRECTOR SPONSOR:	Kimberley Salmon-Jamieson, Chief Nurse + Deputy Chief Executive	
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	SO1 We will.. Always put our patients first through high quality, safe care and an excellent patient experience. SO2 We will.. Be the best place to work with a diverse, engaged workforce that is fit for the future. SO3 We will ..Work in partnership to design and provide high quality, financially sustainable services.	x
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF):		
EXECUTIVE SUMMARY *(KEY ISSUES):*	The following report provides an overview of the Learning from Experience Report. The information within the Learning from Experience report is extracted from the Datix system and other clinical governance reports for Incidents, Complaints, Claims, Health & Safety, Mortality and Clinical Audit related to Quarter 4, 2019/20.	

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

RECOMMENDATION:	The Board of Directors is asked to note the report.	
PREVIOUSLY CONSIDERED BY:	**Committee**	Quality Assurance Committee
	Agenda Ref.	QAC/20/07/108
	Date of meeting	7th July 2020
	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	Learning from Experience Report - Q4 2019/20	AGENDA REF:	BM/20/07/6

1. BACKGROUND/CONTEXT

This report relates to the period 1st January – 31st March 2020 (2019/20 Q4). It contains a quantitative and qualitative analysis (using information obtained from the Datix risk system) including incidents, complaints, claims and inquests. The report includes a summary of key issues identified in Quarter 4 with specific recommendations based upon the findings.

The purpose of the report is to:

- Identify themes arising from; Incidents, Complaints, Claims, Health & Safety, Mortality and Clinical Audit data that have been reported during Quarter 4.
- Make recommendations to the CBUs highlighting areas of focus for improvement.
- Provide a summary of incidents, complaints and claims reported during the review period, highlighting any trends apparent from the review of the data.

2. KEY ELEMENTS - ITEMS FOR ASSURANCE FROM Q4

2.1. Incident Reporting

- There was a decrease in incident reporting within the Trust in Q4 (2618 in Q3 vs 2309 in Q4), with notable reductions in reporting in February and March 2020 – partly attributed to the Covid-19 pandemic. In light of this, the 'Report to Improve' campaign will be relaunched across the Trust in July 2020 and will continue for the remainder of the calendar year to ensure incident reporting increases back to normal levels following the response to the pandemic. Incident reporting is essential for demonstrating an open and honest culture that is committed to learn and improve.

2.2. Learning and Actions from Incidents

- Medication - An adult patient with insulin dependent diabetes mellitus did not have his insulin prescribed on admission which resulted in missed doses. When the patient's insulin was prescribed, Toujeo insulin was incorrectly prescribed as twice a day. Examples of learning and actions from the 72 hour review included:
  - The incident was shared at Medical/Surgical Handover, Trust Safety Huddle and Ward Safety Huddle.
  - The Hot Topic at the Trust Safety Huddle was used to provide learning on diabetes and insulin.

- The Trust Desktop was used to provide learning about the different types of insulin.
- Single point lessons on prescribing insulin and insulin infusions were circulated via the Trust Safety Huddle and to all clinical staff.

- Medication - A 97 year old patient who weighed 31kg was prescribed and administered oral paracetamol 1 gram four times a day for 6 days. The patient developed paracetamol toxicity which had to be treated with an acetylcysteine IV infusion. The following actions were taken / agreed as a result of this:

  - A Safety Alert with recommendations for prescribing and administering oral and IV paracetamol for adult patients if body weight is less than 50kg was sent across the Trust.

  - Trust guidance for dosing oral paracetamol in adult patients if body weight is less than 50kg is to be produced with the involvement of the pain team.

  - A 72 hour review was held and a concise root cause analysis is now being completed for the incident to identify further learning and actions.

- Highlighted learning / actions from Pressure Ulcer incidents:
  - Select wards are trialling 'turning clocks' as part of the pressure ulcer collaborative to ensure timely repositioning of patients in order to prevent pressure ulcer development / deterioration.
  - A new Tissue Viability Nurse has been appointed to increase the team's capacity to provide training and support in pressure ulcer prevention.

- Information Governance - The IT Team became aware that the NHS was being targeted with a number of COVID-19 related scams, fake websites and phishing emails. The following actions were taken:
  - Alerts issued to staff containing instructions not to open suspicious emails or to click on links contained in them. Images of the fake websites were also circulated.
  - The IT Department have arranged for NHS Digital to perform simulated Phishing attacks on the email accounts of the Trust's staff in order to further increase awareness.

- Aortic dissection – Patient attended with vomiting, abdominal and sternal pain. There was documentation of a plan for ECG but no evidence this was done. Assessment and management plan was for a Gastrointestinal related diagnosis based on the patients'

symptoms. Observations were normal, pain settled and the patient was discharged after a few hours. The patient sadly passed away in the community 24 hours after discharge and the cause of death at post-mortem was aortic dissection. Learning points:

- Aortic dissection is rare and clinical presentation may not be typical of cardiac triggers. No single clinical feature will lead to a diagnosis of aortic dissection.
- A heightened awareness of the potential diagnosis to increase the ability to make the conclusion.
- ECGs should be requested on ICE.

2.3. Complaints and PALS

- Over the 2019/20 financial year, all CBUs made significant improvements for responding to complaints on time. There were no breached complaints throughout 2019/20 Quarter 4.
- There was a decrease in complaints opened Trust wide in Q4 (104 in Q4 versus 107 in Q3). The Trust currently has one complaint over 6 months old due to the Covid-19 pandemic, though timeframes were paused.
- Themes identified in complaints mirror those found across PALS and incident reporting; delays in treatment, appointments issues and communication issues.
- Actions from complaints are monitored via the speciality governance dashboards and the Clinical Governance Department, reporting to the Complaints Quality Assurance Group. Complaints actions reports are also made available Trustwide on a weekly basis.
- The Trust currently has 4 open PHSO cases. The PHSO finalised 2 investigations during Q4; both were partially upheld.

2.4. Mortality

- As part of the mortality review process, 67 cases were discussed at MRG in Quarter 4. Most of these cases were rated “Good” with some “Adequate” also being discussed. 2 SJRs reported the overall care grading as ‘poor’.
- Comparing to Quarter 3, DoLS/LD has reduced and the ‘patients Under 55; was the highest trigger for an SJR in Quarter 4.
- The Summary Hospital Mortality Indicator (SHMI) and Hospital Standardised Mortality Ratios (HSMR) are within expected range.
- The Mortality Review Group has become a virtual meeting due to Covid-19. Deaths are being reviewed and discussed at the group which continues to have external representation from our Commissioning bodies.

2.5. Clinical Audit

- There are a number of audits ongoing across the Trust. For Q4 this briefing makes reference to the National Neonatal Audit Programme. WHH are required to complete 3 actions by the end of 2020/21 Q3 which will improve neonatal care in the organisation. This is being monitored by the Clinical Audit team.

- A Prostate Biopsy Audit was completed in Quarter 4 to ensure good quality of care ensuring reports are available within the recommended time frame and include all of the relevant information. The result of this audit provided the Trust with "Significant" assurance.

3. KEY LEARNING FROM SI INVESTIGATIONS CONCLUDED IN Q4

- **Patient falls resulting in fractured neck of femurs - Lessons Learned**
  - Staff should update falls risk assessments when there are identified changes in a patient's clinical status.
  - Documentation of assessments should be updated and completed in full to enable completion of nursing management plans.
  - Staff involved update on training in relation to the importance of completing a lying and standing blood pressure assessment for all patients over 65 years of age admitted to hospital.
  - Staff on Ward B12 to have targeted updated training on MCA and DoLS.

- **Radiology Delayed Diagnosis SIs - Lessons Learned**
  - Process amended for organising follow up imaging recommended by Radiology for both suspected lung cancer and other patients who require follow up imaging.
  - Review of the procedure for actioning Radiology alerts for inpatient imaging, to include documenting any action taken on Lorenzo.
  - Learning through individual reflection and further peer discussion at the local REAL meeting.

- **Never Event: Wrong site procedure - Lessons Learned**
  - A robust 'prosthesis pause' checking procedure for surgical implants has been implemented with appropriate training for staff and a SOP.
  - Learning from this incident has been shared with the staff involved, at the theatre and anaesthetic meeting and via a monthly learning newsletter.
  - Include the prosthetic checking process at the theatre and orthopaedic induction.
  - Ensure all items in the theatre stockroom are clearly labelled and easy to locate.
  - Continue to progress the 'Shout S.A.F.E.' – a project to improve quality and safety in theatre.

4. ITEMS FOR ESCALATION FROM Q4

4.1. Clinical Incidents

- There was an increase of 10 incidents causing Moderate to Catastrophic harm in Q4 (27 in Q3 vs 37 in Q4).
- The Trust reported 294 incidents open in CBUs in Q3. To date this has decreased to 224, with significant improvements in incident management noted across the organisation.
- The number of no harm incidents reported fell by 13.2% in Q4, with notable reductions in reporting in February and March 2020 – partly attributed to the Covid-19 pandemic. In response to this, the 'Report to Improve' campaign will be relaunched and led by the Patient Safety Manager and Senior Governance Manager. Reporting of no harm incidents is essential for learning and analysis of clinical and non-clinical issues across the organisation.

4.2. Non-Clinical Incidents

- From 1st January 2020 to 31st March 2020, there were 348 non-clinical incidents reported. The top 2 categories were Security Incidents and Infrastructure / Health & Safety Incidents. Injury to staff was one of the top sub-categories for Health & Safety Incidents – this is being monitored by the Health & Safety team for themes and trends.

4.3. Complaints

- Staff attitude and behaviour complaints shown a further increase in Q4.
- Training on First Impressions and Customer Care continued to be rolled out across the Trust in Q4, however has been unable to take place since due to the Covid-19 pandemic.
- Complaints around clinical treatment have reduced in Q4 - mirroring Q4 incident reporting which saw clinical care issues reduce.

4.4. Claims

- Payments for clinical claims settled with damages totalled: £ 1,722,670.27 excluding costs; and
- Payments for non-clinical claims settled with damages totalled £7,000.00. Learning from individual claims continues to be disseminated.

4.5. Mortality

- Medical Care, Integrated Medicine and Community and Urgent and Emergency Care continue to report the highest number of mortalities, though this is not disproportionate when considering the type and number of patients cared for in these areas.

5. RECOMMENDATIONS

The Board of Directors is asked to note this report.

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/20/07/87**	
SUBJECT:	**Patient Experience Strategy**	
DATE OF MEETING:	29 July 2020	
AUTHOR(S):	John Goodenough, Deputy Chief Nurse	
EXECUTIVE DIRECTOR SPONSOR:	Kimberley Salmon-Jamieson, Chief Nurse & Deputy Chief Executive	
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	SO1 We will.. Always put our patients first through high quality, safe care and an excellent patient experience. SO2 We will.. Be the best place to work with a diverse, engaged workforce that is fit for the future. SO3 We will ..Work in partnership to design and provide high quality, financially sustainable services.	
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): **(*Please DELETE as appropriate)***	#1135 Failure to deliver an emergency and elective healthcare service caused by the global pandemic of COVID-19 resulting in major disruption to service provision. #1124 Failure to provide adequate PPE caused by failures within the national supply chain and distribution routes resulting in lack of PPE for staff. #115 Failure to provide adequate staffing levels in some specialities and wards. #134 Financial Sustainability a) Failure to sustain financial viability, #1134 Failure to provide adequate staffing caused by absence relating to COVID-19 resulting in resource challenges and an increase within the temporary staffing domain. #1114 Failure to provide essential, optimised digital services in a timely manner in line with best practice governance and security policies, caused by increasing and competing demands upon finite staffing resources whom lack emerging skillsets, sub-optimal solutions or a successful indefensible cyber-attack, resulting in poor data quality and its effects upon clinical and operational decisions / returns and financial & performance targets, reduced operational efficiencies, denial of patient access to services, inferior quality of care including harm, failure to meet statutory obligations (e.g. Civil Contingency measures) and subsequent reputational damage. #224 Failure to meet the emergency access standard. #125 Failure to maintain an old estate caused by restriction, reduction or unavailability of resources resulting in staff and patient safety issues, increased estates costs and unsuitable accommodation. #145 a. Failure to deliver our strategic vision. #145 b. Failure to fund two new hospitals. #1126 Failure to potentially provide required levels of oxygen for ventilators caused by system constraints resulting in lack of adequate oxygen flow at outlets. #241 Failure to retain medical trainee doctors in some specialties by requiring enhanced GMC monitoring resulting in a risk service disruption and reputation.	
EXECUTIVE SUMMARY *(KEY ISSUES):*	This strategy sets out how we are working to deliver an outstanding patient experience, every time. This is a key quality priority which will help us achieve our mission: To be outstanding for our patients, our communities and each other. It has been developed following a period of engagement and involvement from patients, staff, and other key stakeholder	

	groups. The completion was paused, temporarily because of COVID-19. All voices need to be heard whenever there is service development or re-design that could impact on patients and this strategy commits to involve people who use services at WHH and their carers. This has been set out in WHH Patient and Public Participation and Involvement Strategy which supports the delivery of the updated Patient Experience Strategy.			
PURPOSE: ***(please select as appropriate)***	Information	Approval	To note x	Decision
RECOMMENDATION:	The Board of Directors are asked to note the Patient Experience Strategy approved by the Quality Assurance Committee			
PREVIOUSLY CONSIDERED BY:	**Committee**	Quality Assurance Committee		
	Agenda Ref.	QAC/20/07/91		
	Date of meeting	7 July 2020		
	Summary of Outcome	Approved		
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None			

NHS
Warrington and Halton Hospitals
NHS Foundation Trust

We are WHH & We are
PROUD
to make a difference

PATIENT EXPERIENCE STRATEGY 2020 - 2023

Our mission is to be **OUTSTANDING** for our patients, our communities and each other.

Hello & Welcome

I am delighted to welcome you to our Patient Experience Strategy. This strategy sets out how we are working to deliver an outstanding patient experience, every time. This is a key quality priority which will help us achieve our mission: To be outstanding for our patients, our communities and each other

We believe that our WHH community, both in our hospitals and externally, is pivotal in deciding what an 'outstanding' patient experience looks and feels like. Therefore, we pledge to actively seek, listen and act on feedback received from our patients, staff, and other key stakeholder groups such as our Foundation Trust Governors, Healthwatch, our valued Volunteers and Carer organisations plus the extensive number of advocacy groups that work with us to make things better for their service users.

This Patient Experience Strategy has been co-produced with our patients, our staff and our partners who have been asked "What matters to You?" and it reflects the needs of our local population.

It is important to recognise the achievements the Trust has made over the last three years, driven by the previous Patient Experience Strategy and which provide the foundations for this next chapter. We continue to actively and inclusively engage with and involve our patients and their carers; we create platforms for joint working and co-production with our patients' supporters and advocates and we continue to listen, learn and act on feedback – improving and refining as we continue towards our mission of being an 'Outstanding' organisation.

Prof Simon Constable FRCP
Chief Executive

Our Patient Experience Strategy

I am proud to present our Patient Experience Strategy for 2020-23, a core element in the delivery of our Quality, People and Sustainability organisation objectives (QPS).

It is first and lasting impressions that make the difference between good and outstanding patient care. We acknowledge that our patients' and families perceptions of a good experience is as essential as receiving effective and safe care - this starts from the moment our patients have their first contact with our services.

We are committed to continually improving the quality of the experience of our patients and provide our staff with the skills, quality improvement (QI) knowledge and training necessary to deliver safe, effective and high quality patient care.

We believe that all voices need to be heard whenever there is service development or re-design that could impact our patients and we have committed to involving our service users and their carers and have set this out in our WHH Patient and Public Participation and Involvement Strategy which supports the delivery of the Patient Experience Strategy. This is not a standalone document and needs to be considered alongside related WHH strategies.

Kimberley Salmon-Jamieson
Chief Nurse

Our Mission, Vision, Values, Aims and Objectives

Our Mission: We will be OUTSTANDING for our patients, our communities and each other

Our Vision: We will be the change we want to see in the world of health and social care

Our Aims/Objectives:

Quality

We will... **Always put our patients first** through high quality, safe care and an excellent patient experience

People

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

Sustainability

We will... **Work in partnership** to design and provide high quality, financially sustainable services

We will do this by:

Continuously improving, exploring new opportunities and technology and being creative and innovative in redesigning and developing all we do.

Our 3 strategic objectives under the **Quality** domain are:

1. **Patient Safety** We are committed to developing and enhancing our patients' safety through a learning culture where quality and safety is everyone's top priority.
2. **Patient Experience** By focussing on patient experience we want to place the quality of patient experience at the heart of all we do, where "seeing the person in the patient" is the norm.
3. **Clinical Effectiveness** Ensuring practice is based on evidence so that we do the right things the right way to achieve the right outcomes for our patients.

Our 3 strategic objectives under the **People** domain are:

1. **Employee Wellbeing & Engagement** Create the conditions to promote wellbeing and enable an engaged workforce to improve patient and staff experience.
2. **Attraction, Retention, Development & Inclusion** Attract and retain a diverse workforce aligned to our culture and values, to ensure that we have the staff with the skills to deliver excellent patient care.
3. **Leadership & Organisational Learning** Develop a collaborative, compassionate and inclusive culture of collective leadership and organisational learning.

Our 3 strategic objectives under the **Sustainability** domain are:

1. Play a central role in our healthcare economies to support integrated place based care.
2. Work with other acute care providers to ensure that those services which need to be provided in an acute environment are the best they can be and are clinically and financially sustainable.
3. Provide our services in an estate that is fit for purpose, supported by technology, and aligned to the needs of our developing populations.

Our Values

Working Together: We will work together to ensure patients come first and our staff feel valued.

Excellence: We will provide excellent care

Accountable: We will take responsibility to do the right thing in the right way at the right time

Role Models: What others observe in us will inspire them to do better

Embracing change: We are always learning and improving for our patients, the public and each other

Our values shape the way that we deliver high quality, safe healthcare for patients

The Patient Experience Strategy for 2017-20 set out five Belief and Promise statements under the following sub-groups:

Looking back at what we have achieved

1 Listening, Learning and Leading change:

"We believe every patient should have the opportunity to give feedback about their experience and we promise to use this to improve care and services"

Examples of our *achievement*

- ✓ Patient stories at the commencement of key Trust meetings.
- ✓ Warrington Hospital entrance redevelopmentNew Birth Centre- facilities co-designed with support groups and experts by experienceProcured 23 recliner chairs/ beds for parents staying in children's ward.

2 Communicating in line with our values

We believe our patients should be first in everything we do and we promise to communicate based on what matters most to you."

Examples of our *achievement*

- ✓ Introduced alerts on electronic patient record system (Lorenzo) identifying patients who required reasonable adjustments before attending ophthalmology appointments.
- ✓ Created Twitter and Facebook accounts to promote engagement and feedback from service users.
- ✓ Maternity Voices – listening to women's experiences of care.

3 Partnership working and needs-based care

"We believe our patients should always experience care that is based on their specific needs and we promise to work in partnership with you and your carers to achieve best possible outcomes"

Examples of our *achievement*

- ✓ Created a Wayfinder role for our volunteers to support visitors
- ✓ Frailty Assessment Unit created to make the patient journey for our frail, elderly population streamlined and integrated, reducing unnecessary admissions.
- ✓ Listened to what patients thought a (WREN) re-enablement unit should look like.

4 Healing Environments

"We believe every patient should experience care and treatment in the right environment and we promise to continuously improve what you can see, do, hear and feel during your stay"

Examples of our *achievement*

- ✓ Made our adult areas more child friendly with activities and distractions.
- ✓ Implemented Welcome to the ward boards and Patient Experience boards showcasing "you said, we did" based on feedback from our service users.
- ✓ Engaged patients in What Matter to you? Conversation Cafes and used their feedback to improve our services.

5 Simplifying patient focused processes

"We believe that our processes should be designed to support our patients and we promise to develop these so that everything is simple, done in a timely manner and easy to understand"

Examples of our *achievement*

- ✓ Allied Health Professionals (AHPs) led innovative initiatives 'team around the patient' to enhance patient experience:
  - Radiographers and Always Events® project in Main X-ray
  - Therapists and medical staff *Morning Movers* and #Endpjparalysis
  - Nursing, volunteers, therapy assistants & activity co-ordinator - The Reader® project

Always Events® group

How do we collect feedback on patient experience?

Children and Young People Collaboration events

Where they tell us what is important to them and their families and how we can ensure they transition safely and seamlessly into the care of the adult services.

Friends and Family test - written, telephone, text

Some patients like to leave feedback in different ways.... one gentleman drew each stage of his patient journey in the hand clinic.

Maternity Blog

WHH Maternity Blog brings real life pregnancy/labour/ birth experiences and sharing each experience is a way to connect, support and empower women in their journey

Conversation Cafes - What Matters to you?

Healthwatch - Listening events

Monthly Carers Café

Lorem ipsum dolor sit amet, consectetur adipiscing elit. Nullam nec venenatis nunc. Nulla facilisi. Nullam a mi sit amet nibh dapibus congue. Aliquam volutpat quis velit eu imperdiet. Nulla at augue tellus. Donec ut tortor nec eros varius.

National Surveys and CQC Insight reports

- ✓ Urgent & Emergency Care / Urgent Care Centre
- ✓ Children & Young persons
- ✓ Maternity
- ✓ National Inpatients
- ✓ National Cancer Patient Experience
- ✓ Survey

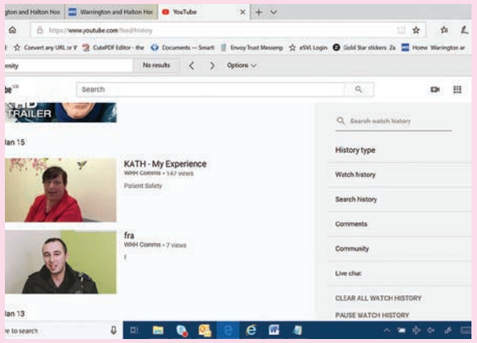
Locally - ward, department and service surveys

Involvement opportunities -

linked to quality improvement collaboratives such as Falls and Pressure Ulcers and events to support the development of Trust strategies such as Equality, Diversity & Inclusion and/Carers.

Compliments and Complaints/ PALS

Patient/Carer stories, videos



NHS Choices

WHH staff will give feedback, sometimes on behalf of what a patient has said or in the scope of Freedom to Speak Up (FTSU)

There are numerous engagement forums eg WDP Staying Connected Forum, Maternity Voices, Warrington Speakup, Halton Speak Out, Warrington Health Forum

Voluntary and Charity contribution

We are extremely fortunate to receive additional 'above and beyond' support both through voluntary effort and funding to help us deliver some amazing initiatives that have enhanced the experiences of our patients, carers and relatives.

WHH Volunteers

Halton & St Helens
Voluntary and Community Action

WHH Volunteers: nearly 500 wonderful volunteers give up their time to support our patients on the wards, helping them find their way around the hospital, entertainment through hospital radio and our chaplaincy volunteers helping patients continue to enjoy their faith while in hospital.

The League of Friends of Warrington Hospital

provide a meet and greet service and fund equipment and facilities to the tune of £80K per year.

Warrington Disability Partnership (WDP) Mobility and Independent Living Service

Based within the hospital, aims to facilitate and support hospital discharge, as well as supporting patients and families with information, advice and guidance. The Trust is involved with the Disability Awareness Day (DAD) and DAD week annually as part of engagement with the wider community, to engage with those affected by disabilities affected by disabilities and long term conditions.

WHH Charity

Our own hospitals' charity fundraises to provide equipment, training or environmental enhancements beyond that which the NHS provides.

In the last financial year our charity and its supporters completed phase 2 of our Forget me Not memory garden for the enjoyment of our patients living with dementia and concluded a £100K campaign to provide an outdoor play space on our children's ward.

The League of Friends of Halton Hospital not only raise money for the hospital but provide a meet and greet service, run a small shop and a tea bar! There are more than 50 dedicated volunteers with hundreds' of years volunteering between them.

The League of Friends of Warrington Hospital provide a meet and greet service and fund equipment and facilities to the tune of £80K per year.

photos of the childrens toys and recliners

TY award photo from the LoF 2019 awards

We are WHH & We are PROUD to make a difference

Developing *Our* strategy

We developed our strategy in partnership with our patients, carers, visitors, WHH Governors, charities, alongside volunteers and advocacy groups, e.g. WDP, Red Cross, Wired Carers Centre, Healthwatch Warrington Speakup and our staff. Our most engaging model for this work is through our 'What Matters to Me?' workshops where a diverse, but invested, audience is brought together to address three key themes which address most of our services:

1. **What matters to me when undergoing emergency/ unplanned care?**
2. **What matters to me when undergoing planned care?**
3. **What matters to me as an outpatient?**

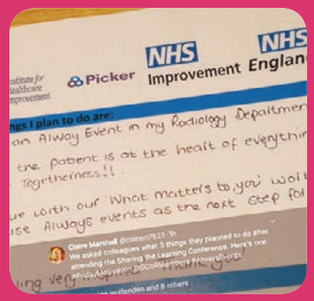
Rich feedback emerged from these session which have informed not just this but other work streams, including patient and public participation and involvement, the patient letters service improvement work and the development of the Trust's accessible information standard policy.

Six key themes emerged from these workshops and involvement sessions:

1. **Caring staff who know about me**
2. **Involvement in decisions and information about my care**
3. **Environment**
4. **Communication**
5. **Having an efficient service**
6. **Options and choice**

Multiple engagement and involvement events were held including:

Experience of Care week in April, Behind the Scenes at CMTC April, Conversation Cafés April, Ward 'roadshows' with patient questionnaire during July, Listening event July, Open day September, Dining event September, Ophthalmology listening event October, (multi-agency) Patient Experience group October, Jan 2020 Always Event Radiology.



Pledge 1: We will listen, learn and lead change

We will support every patient/service user, carer or family member (hereafter 'people') to give feedback about their care and experience so we can understand 'what matters to you most' and use this to improve our services.

What we will do	How we will know we have succeeded?	How we will monitor?
Increase our capacity and capability to effectively and inclusively collect feedback in a way that suits people best. Support the CQC public campaign, part of their Emergency Support Framework, to encourage people to feedback on care, working with Healthwatch, 'Experts by Experience', people who use services and voluntary and community organisations.	As part of the revised Friends and Family Test guidance – Sept 2019, evidence of increased FFT participation and improved recommendation rates. Patient/service user profile in FFT/other local feedback demonstrates reduced gaps in data capture (see pledge 5 for more detail).	Monthly Trust Dashboard. Clinical Business Unit (CBU) reports to Patient Experience Subcommittee (PESC).
Introduce new techniques and technology to enable more people to give feedback, such as iPads and age-appropriate apps and programmes, print materials and audio including easy read and language-specific formats.	Clinical Business Units (CBU's) embracing new technology, when collecting patient feedback and this is evident in reports. Increase in feedback from hard to reach groups.	CBU reports and action plans monitored through PESC and other Governance reporting mechanisms.
Promote opportunities for patients to provide feedback such as posters and display boards advertising national surveys and FFT, digital platforms and social media.	Visible evidence of promotions in public areas, wards and departments across the organisation. When asked, patients will be able to state they know how to provide feedback.	Results from senior staff walk rounds, Governor Observation visits, Quarterly Engagement dashboard.
Support and work with staff to develop near real time feedback and promote the importance of gaining service user feedback.	Evidence in staff appraisals that focus on patient experience is embedded in their practice.	Ward accreditation results, feedback from Governors ward/ department visits. National Survey indicators.
Develop a process that supports the analysis and triangulation of patient feedback with other Quality measures eg Complaints, PALS, Clinical Incidents.	Evidence of triangulation of feedback with other Quality measures in CBU high level briefing papers.	PESC meetings -monitor CBU reports and action plans.
Develop a trust-wide methodology to collect, measure and celebrate compliments.	There is evidence in CBU reports of reporting compliments in addition to complaints/PALS. Compliments are displayed in public facing places in the Trust and in social media.	PESC meetings -monitor results from Engagement Dashboard reports and CBU reports with action plans.
Display patient experience feedback on wards and clinic/ department areas so all service users can view it easily.	Feedback is displayed in a visible location and people who use our services can read and understand any changes that have been made.	Ward accreditation results, Governors visits, senior staff walk rounds, CQC inspections.
CBUs will establish a process to ensure there is shared learning from themes and trends from feedback and pro-actively implement quick wins, short and long term improvements.	Improved measures eg reduction in numbers of Pressure Ulcers and Falls reported. Reduction in complaints and PALS eg relating to care and treatment, staff attitude, food, discharge planning	CBU Governance reports, Patient Safety and Clinical Effectiveness (PSCE) committee reports, QAC.

Pledge 2: We will communicate in line with our values

We believe that our patients/service users, their carers or family members ('people') are first in all we do. We know that time is the most important commodity to people and we promise to listen, communicate based on 'what matters most to you' and to deliver care in a way that allows you the time to spend your time the way you want to'

What we will do	How we will know we have succeeded?	How we will monitor?
Continue to develop, deliver, promote and measure the effects of bespoke Customer Experience Training.	Evidence of staff numbers accessing customer experience training. Complaints and PALS reports will demonstrate a reduction in themes and trends relating to staff attitude and ineffective communication.	Reports to Quality Assurance Committee
Relaunch the nationally renowned #HelloMyNameIs initiative.	People who use our services will be able to name their healthcare professional, using 'Ask 5' method.	Themes within complaints and compliments in CBU reports
Support our CBU's to develop QI innovations that improve communication between people and our clinicians in a way that suits our patients. Use of health passports, and have conversations based on 'This matters to me today!'	Services will evidence that staff understand the concept of 'what matters most' to our people and include this as standard in care giving.	Quality Academy reports and celebration events
Continue to drive quality improvements that reduce length of stay, plan for discharge on admission, promote early mobilisation and improve mental and physical wellbeing; such as #EndPJParalysis, #1000lastdays, Morning Movers, Single Handed Care.	Evidence of celebrating successes that recognise safe, effective care and an excellent patient experience. Examples include local and national awards, publications, sharing successes at conferences.	Patient Stories presented at Trust Board, Quality Assurance Committee and PESC meetings that demonstrate evidence of listening, learning and actions that have changed people's experience for the better
Support QI programmes that are designed to streamline handover, improve person and professional communication by supporting joint decision making and ensuring appropriately managed discharge.	Documentation audits will demonstrate clear clinical information regarding our patient/service users' journeys and evidence safe, clinically effective care planning.	Audit committee assurance reports
Develop and launch our Carers Strategy.	Evidence that carers feel empowered to have the information and support, to enable to participate in making the best decisions for the person they care for.	PESC meeting reports including monitoring of PALS, complaints and complaints. Healthwatch reports and feedback from other external stakeholders
Staff will evidence that people are empowered and active participants in their care, given consistent information, listened to and next steps in their care discussed.	WHH feedback mechanisms, including FFT, complaints, national surveys will demonstrate a reduction in themes and trends relating to staff attitude, ineffective communication and poor discharge experience.	PESC committee reports and high level briefing paper to Quality Assurance Committee
Clinics and departments will review how people are told about waiting times and if there are any issues or delays. They will ensure that this process is implemented and delivered consistently every time, ensuring inclusivity each time.	Feedback and experience data shows evidence of a reduction in negative comments/poor recommendation rate for services.	CBU briefing papers to PESC

Pledge 3: Personal, needs-based care based on Always Events®/Co-creation

'We believe our patients/service users, their carers or family members ('people') should always receive care that is based on their specific needs. We will champion Always Events® to enable a partnership-based approach so that people are given every opportunity to be involved in the co-creation of their care and experience.'

What we will do	How we will know we have succeeded?	How we will monitor?
Work with Quality Academy and Quality Improvement (QI) resources to develop collaborative care and communication models based on Always Events®.	Evidence that frontline staff are engaging with QI training and that their validated ideas and suggestions are being supported and implemented in service improvements. Staff always state that they consult people who use our services every time a change is proposed.	Quality Academy reports monitoring uptake of QI training. Appraisals. Evidence of Patient Experience innovations in the Trust.
Through organisational development ensure that staff have the capabilities and skills to consistently ask for and include people's requirements in their care and experience while in our care.		
Support Clinical Business Units to deliver patient centred, co-designed, locally agreed Always Events® and seek the support of NHS England to establish and embed Always Events® across the organisation.	An Always Events® model will be developed and deployed and Clinical Business Units adopt a minimum of one Always Event® project per year.	CBU reports and action plans to PESC- progress of Always Event project®.
Support the deployment of the Patient & Public Participation and Involvement (PPPI)strategy to ensure that people can influence how we plan and deliver care including the development of a panel of Lived Experience Connectors (LECs).	Deployment of PPPI strategy – reports evidence patient and public participation and that their views are being incorporated into service change programmes. Evidence that engagement and involvement pre any formal consultations of change in any services.	Quarterly PPPI strategy update report to PESC. Minutes from Governors Engagement Group (GRG) meetings. External stakeholder reports eg Healthwatch.
Engage and involve partners that can support this pledge as well as our diverse panel of advocates and their service users.		
Change the narrative with our people by asking 'What matters to you?' rather than just 'What is the matter with you?'.	People consistently report their experience of a warm welcome, kindness and compassion, being treated with dignity and respect and cared for as an individual.	National surveys. Feedback.
Use people's requests and requirements to continually evolve and improve how we deliver care and experience.	Reduction in the number of complaints where it has been reported that people did not feel that they were consulted and included in decisions about care and treatment.	Complaints and PALS report.
By using evidence-based research, communicate with people to consistently consider and support their personal needs such as pain assessment, nutritional requirements, spiritual and psycho-social wishes.	Evidence that research based practice and national guidance is incorporated into all care practice.	Ward accreditation results and audits. Celebration events. Bright Spots. Media. Shared practice and recognition at awards .

Pledge 4: Healing Environments

We believe every patient/service user should experience care and treatment in the right environment and we will continuously improve what you can see, do, hear and feel during your stay.

What we will do	How we will know we have succeeded?	How we will monitor?
Ensure 'Right Patient in the Right Place' every time with minimal disruption or bed moves by consistent application of the existing Patient Transfer and Eliminating Mixed Sex Accommodation(MSA) policies.	No patients cared for in mixed sex areas (apart from areas exempt). Patients state "Yes" when asked "did hospital staff explain reasons for being moved?".	Trust Dashboard and CBU reporting/data mechanisms are published and there is evidence of agreed improvement plans and monitoring through established governance processes.
Wards, clinics and departments will be clean, safe and have facilities that meets the needs of our people such as easy access to TV, reading materials and refreshments.	Evidence of increased positive feedback reported on social media, website enquiries and feedback and NHS Choices/Care Opinion/PLACE inspections/Governor visits.	PPPI and Governor visit reports to PESC and minutes from FT Governor meetings. E&F report to PESC.
WHH volunteer programme to be developed further, creating innovative roles such as 'Volunteer Baton Bleep Holder' and 'Dining Companions'.	Breadth of volunteer roles implemented within the organisation with evidence of positive feedback on the roles from patients, visitors, volunteers and staff.	Volunteer report to PESC and evidence of meeting trajectory for recruitment and annual volunteer report.
Build on the existing 'Way-finder' role to ensure basic accessibility standards, such as wheelchair availability at entrance points to support access and wayfinding.	Reduction in complaints and PALS relating to themes of accessibility within the Trust.	Equality, Diversity & Inclusion (E,D&I) strategy report (patients). Healthwatch and external stakeholder reports.
Deploy complementary initiatives that are designed to promote a sense of wellbeing such as Pets as Therapy® and The Reader Project®.	Evidence of existing and new initiatives introduced in all areas (as appropriate). Positive feedback from patients, staff and families/ carers.	CBU reports on Patient Experience to PESC.
Support the deployment of the Trust's Nutritional Care Strategy by working with the catering department to achieve work plan objectives and the PPP&I strategy to address diverse dietary requirements.	Above-peer scores in NHS-mandated national surveys relating to hospital food when asked to rate the food and choice.	National Survey action plans, E&F report monitored at PESC meetings. Nutritional Care Strategy action plan via Nutritional Steering. Group and PESC meetings.
Evidence that all staff create an environment where people feel rested and able to participate in their recovery such as reduced noise at night.	Reduction in complaints/PALS and negative feedback via FFT and national and local surveys about noise and disturbances at night.	Complaints and PALS report through PESC and QAC.
Staff will consistently and promptly assist people with feeding, toileting and the administration of pain relief.	Above-peer scores in NHS-mandated national surveys relating to care and treatment.	National Survey action plans. Local ward audits/Ward accreditation and Governor visit .
Foster and support a multi- disciplinary approach to ensure people have access to games, social interactions, volunteer buddies, mobility and stimulation activities.	Evidence of volunteers on all wards/departments. Patients report they have been able to participate in activities.	CBU reports on Patient Experience to PESC.
Staff will continue to provide excellent, person-centred care.	Evidence of initiatives such as hosting weddings, birthday parties and recognition of national celebration days in addition to spiritual, pastoral, end-of-life and bereavement care.	CBU reports on Patient Experience to PESC. Engagement Dashboard reports.

Pledge 5: Making Care, Treatment and Experience Accessible

We believe that our processes should be designed around our patients. We will develop these so that everything is accessible, simple, timely manner and easy to understand.

What we will do	How we will know we have succeeded?	How we will monitor?
Deploy methods that support face-to-face interactions to provide support and gather feedback such as 'Conversation Cafes', focus groups and Healthwatch Enter and View visits.	Evidence of varying methods employed to gain feedback from patients and sharing of results and implementing changes. CBU staff increasing the way they gain face to face feedback, bespoke to their service group.	Enter and view reports from Healthwatch and monitoring WHH action plans in response to findings CBU reports to PESC.
Deploy the Equality, Diversity and Inclusion (ED&I) Strategy patient pledges and priorities, ensuring that equality, diversity and inclusion are embedded in our community engagement, consultation and decision making.	CBUs capturing and recording equality information about service users accessing our services and actions if inequality is identified. Reported evidence of patient and public involvement and participation and contributions to service change programmes, including proactively supporting the involvement of hard-to-reach and those with protected characteristics. WHH achieves positive ratings in the Equality Delivery System 2 (EDS2) assessment.	Monitoring reports through ED&I subcommittee. Healthwatch reports. Estates and Facilities reports with evidence of completed actions or progress to achieve. Community engagement and Governors reports.
Implement and deploy the Accessible Information Standard AIS) across the Trust making patient letters and service information and facilities clear, age appropriate and accessible.	Patients will state their appointment letters were clear and unambiguous with information that supported them to access services comfortably, safely and in time. Evidence of increased numbers participating in co-design and especially in patient letters and information. Stakeholders will say they have been able to work with the Trust eg, estates and facilities team developing environments that are accessible, such as 'dementia and mobility friendly' and that there is clear, accessible signage.	PPPI strategy assurance reports to PESC. CBU reports to PESC.
Provide training for staff to support access and equality of care for people with protected characteristics and their carer's, by understanding and implementing reasonable adjustments.	Staff will be able to evidence reasonable adjustments, adopting a mind-set of 'What is possible? What is the right thing to do? and 'Just do it!'. Patients and carers report positive feedback and state they have received excellent patient experience and reasonable adjustments were implemented.	Mandatory training figures (Equality & Diversity). Staff appraisals. CBU reports – compliments and complaints/PALS.
Support services to develop innovative ways to streamline out-patient visits so that people can have consultation and diagnostics completed via a 'one stop shop' approach and where more follow ups are undertaken through 'virtual' clinics to minimise people's need to come to hospital.	Evidence of support services setting up video platforms such as 'Attend Anywhere' for outpatient consultations and for patients to provide positive feedback on the service. Evidence that patients are being consulted about appointments and referrals that are suitable to their needs.	Clinical Support Services governance reports and Patient Experience report to PESC.
We will work to meet patients' needs around times of appointments by gaining a detailed understanding of themes of DNAs and building these into service change.	Analysis of reasons for DNA's is reviewed and patient's feedback is incorporated into action plans.	Clinical Support Services governance reports and Patient Experience report to PESC.
Translation and Interpreting services will be booked in advance of patients attendance as per Trust policy.	Every patient who has interpreting needs, will receive the required support and know in advance of appointments that it has been put in place. All staff can demonstrate knowledge of the Trust process for booking interpreting and translation services. Reduction in Datix reporting regarding no booking of interpreters	Datix reports to PSC&E meeting. CBU reports. ED&I committee reports.

Working with *Our* partners

We work with a wide range of partners, some are commissioners/ providers of care and some voluntary/third sector. We remain indebted to these organisations and groups for their continued input and support on behalf of the populations of Halton and Warrington.

- The Red Cross
- Halton Carers
- Wired Carers
- Deafness Resource Centre
- Warrington Disability
- Speak Up, Warrington
- Speak Out, Halton
- Halton and St Helen's VCA
- Wellbeing Enterprise
- Healthwatch Warrington
- Healthwatch Halton
- Council of Faiths
- Age UK Mid Mersey
- MIND
- WHH Maternity Voices
- Room at the Inn Y Project
- Warrington Voluntary Action

- Older Persons Forum
- Livewire Warrington
- The Stroke Association
- Macmillan Cancer Support
- Warrington Wolves Charitable Foundation
- The Royal Voluntary Service
- League of Friends of Halton Hospital
- League of Friends of Warrington Hospital
- Bridgewater Community Healthcare NHS FT
- North West Boroughs Healthcare (mental health) NHSFT
- NHS Halton CCG
- NHS Warrington CCG
- North West Ambulance
- Warrington Borough Council

- Halton Borough Council
- Warrington Together
- One Halton
- Cheshire and Merseyside Health and Care Partnership

Page 189 of 203

Contact us:
Communications and Engagement Team
Kendrick Wing
Warrington and Halton Hospitals
Lovely Lane, WA5 1QG

01925 664222

whh.communications@nhs.net

www.whh.nhs.uk

If you would like to receive this document in another format, please do not hesitate to contact us.

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

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

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

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

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

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

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/20/07/88**	
SUBJECT:	**Morality Review Q4 report**	
DATE OF MEETING:	29 July 2020	
AUTHOR(S):	Layla Alani, Deputy Director Governance	
EXECUTIVE DIRECTOR SPONSOR:	Alex Crowe, Executive Medical Director	
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	SO1 We will.. Always put our patients first through high quality, safe care and an excellent patient experience. SO2 We will.. Be the best place to work with a diverse, engaged workforce that is fit for the future. SO3 We will ..Work in partnership to design and provide high quality, financially sustainable services.	x
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF):		
EXECUTIVE SUMMARY *(KEY ISSUES):*	This report provides an overview of the Trust mortality data including: • Total number of deaths of patients. • Number of reviews of deaths. • Number of investigations of deaths. • Lessons learned, actions taken, improvements made. During Quarter 4, 2019/20: • 327 deaths occurred within the Trust. • 30 Structured Judgement Reviews (SJRs) were completed. 1 review was subject to investigation using root cause analysis (RCA) methodology. The Trust Mortality Review Group has continued to review deaths during the COVID pandemic; further details can be seen in section 3.5 of this report. The Trust is not an outlier for HSMR or SHMI. An update on the process for reviewing Learning Disability deaths during the COVID pandemic can be seen in section 3.6 of this report. The business case for the Medical Examiner and Medical Examiner Officer roles is undergoing final review. Once approved the positions will be advertised. The Trust aim to have recruited before the end of July 2020, further details can be seen in section 3.7 of this report.	

PURPOSE: *(please select as appropriate)*	Information	Approval	To note x	Decision
RECOMMENDATION:	The Board of Direc tors is asked to note the report.			
PREVIOUSLY CONSIDERED BY:	**Committee**	Quality Assurance Committee		

	Agenda Ref.	QAC/20/07/112
	Date of meeting	7 July 2020
	Summary of Outcome	Quality Assurance Committee asked to note the report
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	Choose an item.	

REPORT TO BOARD OF DIRECTORS

SUBJECT	Mortality Review Q4 report

1. BACKGROUND/CONTEXT

The National Quality Board report published in March 2017: National Guidance on Learning from Deaths; A Framework for NHS Trusts and NHS Foundation Trusts on identifying, reporting, investigating and learning from deaths in care stated that;

"Following events in Mid Staffordshire, a review of 14 hospitals with the highest mortality noted that the focus on aggregate mortality rates was distracting Trust boards "from the very practical steps that can be taken to reduce genuinely avoidable deaths in our hospitals".

This report followed the findings of the CQC report published in December 2016 - Learning, Candour and Accountability: A review of the way NHS trusts review and investigate the deaths of patients in England. The report found that none of the Trusts contacted by the CQC were able to demonstrate best practice in identifying, reviewing and investigating deaths or in ensuring that learning was implemented. The purpose of the publication was *'to help to initiate a standardised approach, which will evolve as we learn'*.

All Trusts were tasked with reviewing their processes and to implement systems to review, understand and learn from deaths that occurred. National Guidance set the requirements of this:

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

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

2. KEY ELEMENTS

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

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

- The total number of deaths of patients.
- The number of reviews of deaths.
- The number of investigations of deaths.
- The themes identified from reviews and investigations.

- The lessons learned, actions taken, improvements made.

3. MEASUREMENTS/EVALUATIONS

Total number of deaths and investigation levels

During 1st April 2019 to 31st March 2020, 1,111 of WHH patients passed away. This comprised the following number of deaths which occurred in each quarter of that reporting period:

- 254 in the first quarter
- 238 in the second quarter
- 292 in the third quarter
- 327 in the fourth quarter

By 31st March 2020, 135 care record reviews (SJR) had been completed. 182 cases had been allocated to a reviewer and 5 investigations (Serious Incidents) were carried out in relation to 1,111 of the deaths included above. They occurred in each quarter of that reporting period as follows:

- 36 SJRs allocated, with 35 being completed and 1 Serious Incident
- 44 SJRs allocated, with 40 being completed and 1 Serious Incident
- 60 SJRs being allocated with 43 being completed and 2 Serious Incident (1 case was subject to both an SJR and Serious Incident Investigation)
- 42 SJRs being allocated with 14 being completed and 1 Serious Incident

Details of the SJRs and RCAs can be seen later within this report.

Investigations of deaths

Structured Judgement Reviews of deaths - Structured Judgement Reviews are presented to the Mortality Review Group (MRG), to present an assessment of problems in care. Any actions or lessons to be learned are sent to the appropriate forum. Particular groups of patients are reviewed at the MRG. The criteria for review is detailed in **Appendix 1.**

During Quarter 4, 30 Structured Judgement Reviews were completed by members of the MRG between 1st January and 31st March 2020. The table below details their overall care rating:

Jan / Feb / Mar 20	Overall Assessment Care Rating Following SJR					Total
	1: Very Poor	2: Poor	3: Adequate	4: Good	5:Excellent	
	0	**2**	17	45	3	67

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

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

Focused Reviews - The MRG analyses data in relation to Mortality and where is it indicated that there is a high SHMI/HSMR (i.e. greater than expected number of deaths) in a diagnosis group, a request is made for a Focused Review to be undertaken. During Quarter 4 there were no Focused Reviews undertaken. However, at the time of writing this report a terms of reference is being created in order to undertake a Focused Review of COVID-19 deaths within the Trust.

3.3 Cases subject to Root Cause Analysis investigation:

Where MRG have concerns that problems in care may have attributed to a persons' death, discussion is held with the Governance Department and where appropriate a Root Cause Analysis (RCA) investigation is undertaken. Some cases may be referred from the Mortality Review Group to ensure a Root Cause Analysis investigation is undertaken. RCAs are also shared with patients/families, commissioners and where applicable HM Coroners and regulators/external agencies such as NHS Resolutions.

Appendix 2 provides an update on cases from 2019/20 that were deemed to have identified problems in care which may have contributed to death or are still outstanding.

3.4 Learning from Deaths

A summary of learning from deaths for Quarter 4 can be seen in **Appendix 3.**

3.5 COVID Pandemic and the Mortality Review Group

Mortality meetings are most effective where the focus of discussion is on process and system change, with the aim of developing recommendations to prevent a similar adverse outcome in the future. The meeting is aimed at identifying learning and quality improvement.

In light of the COVID pandemic discussions were held between the members of the Mortality Review Group and the Deputy Director of Governance in relation to the continuation of reviewing deaths during the pandemic. It was agreed by all that the process should continue as it can highlight potential patient safety issues and is a good opportunity to learn and improve patient care.

It was agreed that during the COVID 19 pandemic the quorum for the meeting would be the chair plus two other members. An amended Terms of Reference and standard operating procedure has been created to reflect the new process which includes the reduced membership and that the meeting will be hosted virtually via Microsoft Teams until further notice.

From June 2020 we have reinstated the full group but we continue to meet virtually via Microsoft Teams for the foreseeable future.

3.6 Learning Disability Deaths

The adult safeguarding team support Learning Disability (LD) patients across the Trust and have noted any COVID related deaths during the recent months of the pandemic. It is important to note that all patients with a Learning Disability diagnosis who die whilst in our care are referred to the Learning Disabilities Mortality Review (LeDeR) Programme. It is the first national programme of

its kind aimed at making improvements to the lives of people with learning disabilities. The programme is funded and run by NHS England.

Patients who have died during the COVID period have been prioritised for LeDeR review, in line with NHSE/I guidance; these are required to be completed by 8/7/20.

The Trust LD Lead and Head of Adult Safeguarding attend the local Clinical Commissioning Group monthly LeDeR panel, this is attended by multi-agency partners who robustly review each case. This now takes place via Microsoft Teams. Any lessons for the Trust are to be fed back from the LeDeR panel via the Trust Mortality Review Group for further review and discussion. At present we have not been asked to review a case any further than via our structured judgement review process.

To date there are no outstanding LeDeR reviews to be completed from the COVID period.

3.7 Medical Examiner

The business case for the Medical Examiner and Medical Examiner Officer roles is with the Executive Team for review. Once the business case has been approved we will advertise for the positions.

The recruitment process for the Medical Examiner will be conducted with the support of the local Coroner and a representative from the National Medical Examiner office.

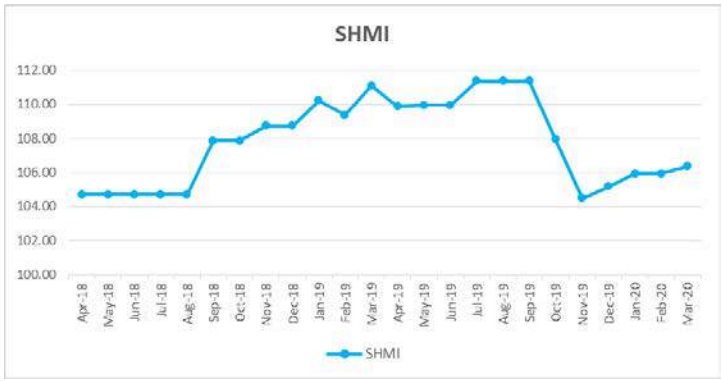
The overall aim is to have recruited to both the Medical Examiner and Medical Examiner Officer roles before the end of July 2020 in-line with national requirements.

4. TRAJECTORIES

SHMI / HSMR Summary
In 2010 the Department of Health endorsed the national review of HSMR commissioned by the NHS Medical Director who committed to implementing SHMI as the single hospital level of mortality indicator to be used across the NHS. Therefore, although we continue to consider HSMR, it is the SHMI which is being used and evaluated nationally as the mortality indicator.

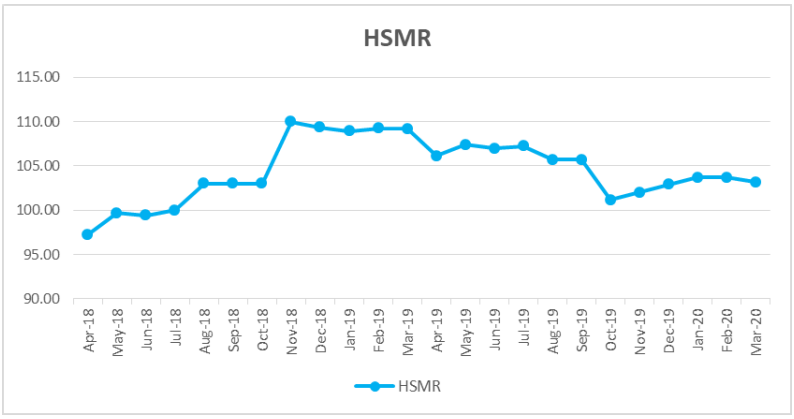
SHMI (Summary Hospital Mortality Indicator)
All observed deaths in hospital and within 30 days of discharge. Adjustments are made only for age, admission method, comorbidities. Still births, specialist community, mental health and independent sector hospitals, day cases, regular day and night attenders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

The table below shows the Trust position since April 2018 and demonstrates the current position as 106.36 compared to our peer group at 105.22; we are not an outlier for SHMI.



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

Table 4 shows the Trust position since April 2018 and demonstrates our current position at 103.16. Our peers' average is 100.23. The Trust is not showing as an outlier in any of the diagnosis groups that are monitored by HSMR.



The committee are asked to note that the above results are based on data up to December 2019. NHS Digital have not provided data in relation to 'out of hospital deaths'. This has been acknowledged and they are working to provide a file to HED who provide the mortality reports. As a result the SHMI module has not been updated and therefore is not the most up to date position.

5. MONITORING/REPORTING ROUTES

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

6. IMPACT ON QPS?

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

7. TIMELINES

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

8. ASSURANCE COMMITTEE

Reports to both the Patient Safety and Clinical Effectiveness Sub-Committee and the Quality Assurance Committee.

9. RECOMMENDATIONS

The Board of Directors are asked to note this report.

Appendix 1

SJR Review Criteria:

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

Appendix 2

STEIS Reference	INC Description	Deemed as having problems in care

2019/20 – Q1 – Of the 3 cases in Q1, 2 are awaiting Inquest and the remaining case was found to have no problems in the care provided to the patient.		
2019/8122	The patient was admitted to Warrington Hospital on 31/03/2019 after a fall at home, shortness of breath and increased confusion. The patient was admitted to AMU. On 02/04/2019 the patient had an unwitnessed fall and was found on the floor at the end of the bed. Following a brief loss of consciousness the patient displayed acute confusion, pain to right shoulder, laceration to right arm and hematoma to right temporal region. The x-ray confirmed the patient also sustained a fractured clavicle. The CT scan showed a large right hemispheral, falcine and left tentorial subdural haematoma which had progressed since the previous imaging. In the right front parietal region there was an impression of extension of haemorrhage. The CT results however were not documented in the patient's records until 04/04/2019. The patient's condition deteriorated and the patient sadly passed away on 08/04/2019. *This case was not subject to an SJR as a 72 hour review was already underway.	*Subject to inquest – no date set as yet.
2019/11932	Patient care reviewed in MRG. A brief summary of the issues found; The patient died of Sepsis and Pneumonia following a fall Relatively little medical input for 3 days Went for 3 days without repeated bloods Problems with pain management Considered for discharge but she had an overwhelming infection No IV access for 3-4 days *This case was subject to an SJR and MRG requested that this be reviewed by Governance. This was subsequently deemed to be a Serious Incident.	*Subject to inquest – no date set as yet
2019/13089	In July 2015, an ultrasound scan was completed and reported seeing a probable haemangioma in the right lobe of the liver. The patient attended both her own GP and out of hours GP numerous times, before attending the Spire for a privately funded scan on 28th January 2016. This revealed multiple liver metastases and Histology later confirmed neuroendocrine carcinoma. The review, following this incident being raised following a claim, concluded that it could not be assured that the original probable haemangioma was not actually metastases, as there was one later noted in exactly the same location on the later scan. The patient sadly died on 16th May 2016. *This case is historical and before we undertook SJRs.	*No problems in care.
2019/20 – Q2 - Of the 3 cases in Q2 1 investigation is complete and it was deemed no problems in care and 2 are awaiting Inquest.		
2019/15506	On 03/07/19, the patient was admitted for an endoscopic retrograde cholangiopancreatography (ERCP). A pancreatic stent was inserted during the procedure following failed attempts to cannulate the common bile duct (CBD). The patient was observed following the procedure for 4 hours. The patient's observations were reported to be stable following the procedure and had tolerated diet and fluids. At 17:15, on the same day following the procedure, the patient telephoned the hospital and spoke to an endoscopy nurse, complaining of vomiting, feeling unwell and some discomfort. The patient was readmitted with a diagnosis of post-procedure pancreatitis and initially referred to the medics. On 04/07/19 at 00:13, the patient was accepted by the surgical registrar. The patient's condition deteriorated - the patient was admitted to HDU at 14:00 and a CT scan was performed. On 05/07/19 at 10:00, there was a discussion with the patient's family and the patient's current condition was discussed. The patient was in multiple organ failure (MOF) for his kidneys, liver, lungs and heart - the patient was not responding to current treatment. A planned withdrawal of treatment was agreed. At 11:35, the patient sadly passed away. The patient's death has been referred to HM	*No problems in care.

	Coroner. *The case was not subject to an SJR as it did not meet the criteria for review.	
2019/15878	The patient attended Warrington Hospital Emergency Department (ED) by ambulance at their GPs request. The patient arrived in ED 18.41 and remained in the hub as there was no space in the 'majors' or 'resus' areas. On review of the incident, the patient should have been accommodated in one of these areas. Full triage occurred at 19.11, and observations on ambulance documentation and triage documentation are reported to be the exact same. Observations were later taken at 20:15 (NEWS score=3), 21:30 (NEWS score=6) and at 23:30 (NEWS score=3) - Although on review of the incident, NEWS at 23:30 was calculated as scoring 5. The following observations were at 02:45. Bloods were taken at 21:05; HB had dropped further to 45 (blood pressure was trending downward since admission, saturations dropped and respiration rate had increased). Although the medical registrar reviewed the patient's blood results, documentation of this could not be found on review and planned antibiotics and fluids do not appear to have been administered. The patient went into cardiac arrest at around 02:45 and was reviewed by ITU - But was not for ITU admission due to commodities and the recent cardiac arrest. The patient had a further cardiac arrest in the department at around 04:50 and sadly passed away. *This case was not subject to an SJR as a 72 hour review was already underway.	*No problems in care.
2019/16094	Patient was sat at the side of the bed with the Occupational Therapist. Patient went to reach down to put slippers on, lost her balance and started to fall forward. Occupational Therapist attempted to facilitate balance, but the patient continued to fall forward. Patient assisted to the floor. *This case was not subject to an SJR as a 72 hour review was already underway.	*Subject to inquest – no date set as yet.
2019/20 – Q3; 4 cases. All investigations are complete and it was deemed there were problems in care with two of the cases but no problems in care for the remaining two.		
2019/23948	Patient had a chest x-ray, which was highlighted to ward A7 on 20th July 2019 as a follow up CT scan was recommended. Not requested until 13th Aug and then as a non-urgent scan, so that the scan took place on 16th Sept 2019. The CT scan findings showed a mass which was suspicious for lung cancer.	*Problems in care.
2019/24357	Patient previously fit and well except for being overweight, died the day after discharge from ED (on 4th June). The patient had complained of retrosternal and epigastric pain radiating to the back, which had been constant all day. These are features of possible aortic dissection, which is a possible cause of her sudden death. If the diagnosis is considered, there is a small chance these patients can survive if they are transferred to LHCH and remain stable. Potential missed diagnosis which requires investigation.	*No problems in care.
2019/25094	On 8th October 2019 the patient was admitted to hospital following a GP referral. On 16th October, the patient was transferred to the respiratory ward and a chest drain was inserted for therapeutic aspiration. The patient remained unwell and was transferred to ICU. On 20th October the patient's condition deteriorated and was sedated and ventilated. A second chest drain was inserted for treatment of pleural effusion. The procedure was noted as 'uneventful', however the patient became unstable overnight – bloods showed an Hb drop. The patient was stabilised and a scan took place to find the source of bleeding. On 22nd October, the attending doctor took a call from a Consultant Liver Surgeon at Aintree Hospital who had reviewed the images. The Consultant Liver Surgeon believed that the drain was not in the liver, but may have grazed the liver on entry	*No problems in care.

	- an intercostal vessel that bled thought to be most likely. The plan was for removal on the following day. On 31st October the patient's condition again deteriorated and became unresponsive.	
2019/26167	On 15th January 2019, the patient attended for a chest x-ray following a referral from the GP with a history of persistent cough, COPD and ex-smoker. The x-ray was reported by the Radiology Consultant as 'No acute pulmonary pathology'. On 9th August 2019, the patient attended the Trust again for a chest x-ray following a further referral from the GP, following significant weight loss. Imaging showed mediastinal lymphadenopathy. At the review it was agreed that the mediastinal lymphadenopathy which was seen on the x-ray from August 2019 was also present on the earlier x-ray in January 2019. It was also reported that there was likely already advanced node involvement at the time of the first x-ray in January 2019 which would not have been curative at that time either and it is unlikely that there would have been anything other than standard palliative chemotherapy offered. There was a delay in diagnosis of approximately 6 months which then caused a delay in treatment.	• Problems in care.
2019/20 – Q4 - Of the 3 cases in Q4 investigations are on-going for 1 case and 2 cases are subject to Inquest.		
2020/700	On 24/09/19, the patient was admitted for elective open sub-total colectomy and a plan for post-operative management in HDU. The operation took place as planned. There were no documented intraoperative issues and the patient was transferred to HDU/ITU for post-operative management as planned. The patient remained on ITU until 30/09/19 with observations stable and occasional episodes of an elevated temperature, with one complaint of increasing abdominal distension and constipation. 6 days following surgery, the patient became unstable and rapidly deteriorated. The patient was reviewed and an urgent CT scan was booked. It was identified that the patient had suffered abdomen perforation and an anastomotic leak. The patient suffered a cardio-respiratory arrest and sadly passed away on 30/09/19 at 17:55.	*Subject to inquest – no date set as yet
2020/5852	The patient was admitted through ED on to AMU with confusion and weakness. He had a witnessed seizure in ED and was treated initially for hyponatraemia and hyperkalaemia. As part of a retrospective MRG review of the patient's care leading up to his death the MRG raised concerns regarding the post take ward round not giving a definitive plan regarding the patient's hyperkalaemia and hyponatraemia. A review was completed considering the MRG concerns and it was felt that this needed further investigation and escalation.	Investigation in progress
2020/4597	Called to AED for adult trauma call at approx. 00:30 hrs. with 2nd on call anaesthetist. Patient arrived and transferred over onto trolley and vac-mat. Assisted the anaesthetist with IV cannulation and was dismissed from the call by the AED trauma team leader DR. Received further call from 2nd on call anaesthetist at 02:00 stating patient had deteriorated and was for trauma transfer to Aintree. Attended AED, patient peri-arrest required intubation. Anaesthetist wanted central line before proceeding. Attempt failed, so preceded with intubation. After insertion of cvp and arterial line, patient arrested. ROSC after 6 minutes. Pelvic Binder was applied by ODP and 1st on call anaesthetist post arrest approx. 03:50. Surgeon, anaesthetist and AED doctor decided patient was for	*Subject to inquest – no date set as yet

	resuscitative laparotomy at 03:55. Patient arrested on operating table further 2 times and ROSC was achieved. Decision made by cons surgeon and cons anaesthetist to not resuscitate if patient was to arrest again.	

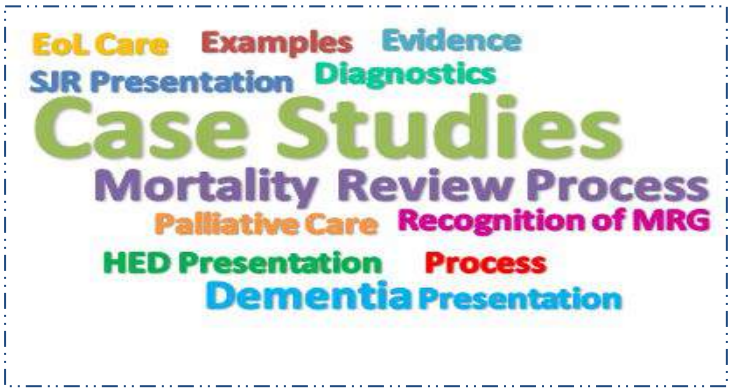
Appendix 3 – Learning from deaths

In February 2020 the Mortality Review Group hosted a multi-agency shared learning event. The objectives of the event were as follows;

- ✓ To understand how we review mortality at the Trust;
- ✓ Why it is important to understand how and why our patients die;
- ✓ What can we do to improve practice and processes to ensure our patients die well.

Feedback was obtained from attendees and we have formulated their responses to the questions below and presented them in the form of the word clouds;

What was Most Useful About the Session?



What Action You Will Carry Out as a Result of this Event?