TRUST BOARD - 27 January 2021

ITEMS FOR APPROVAL

ITEMS FOR NOTING FOR ASSURANCE

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/21/01/11**			
SUBJECT:	**Quality Assurance Committee Cycle of Business 2021-2022**			
DATE OF MEETING:	27 January 2021			
AUTHOR(S):	John Culshaw, Trust Secretary			
EXECUTIVE DIRECTOR SPONSOR:	Simon Constable, Chief Executive			
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	SO1 We will.. Always put our patients first through high quality, safe care and an excellent patient experience.			
	SO2 We will.. Be the best place to work with a diverse, engaged workforce that is fit for the future.			
	SO3 We will ..Work in partnership to design and provide high quality, financially sustainable services.			
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): **(*Please DELETE as appropriate)***	All			
EXECUTIVE SUMMARY ***(KEY ISSUES):***	In order to provide assurance to the Trust Board, all Committees of the Board are required to refresh their Cycle of Business and Terms of Reference (ToR) on an annual basis to assure itself that it will support the discharge of its duties before presenting to the Trust Board for formal ratification. Proposed changes to the Quality Assurance Committee Cycle of Business are highlighted on the attached Cycle of Business.			
PURPOSE: *(please select as appropriate)*	Information	**Approve √**	To note	Decision
RECOMMENDATION:	The Trust Board is asked to review and approve the 2021-2022 Cycle of Business for QAC.			
PREVIOUSLY CONSIDERED BY:	**Committee**	Quality Assurance Committee		
	Agenda Ref	QAC/21/01/08		
	Date of meeting	12/01/2021		
	Summary of Outcome	Approved		
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	Choose an item.			

Quality Assurance Committee Cycle of Business 2021-22

Item		Lead	Jan 21	Feb 21	03/21	04/21	05/21	06/21	07/21	08/21	09/21	10/21	11/21	12/21
OPENING BUSINESS														
Welcome, apologies, declarations, cycle business	**Assurance**	Chair	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Review Minutes and Action Log	**Decision**	Chair	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Review rolling attendance log	**Assurance**	Chair	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Patient Story	**Note**	Dep Chief Nurse	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Deep Dive Reviews **AS RQD**	**Assurance**	Chief Nurse	**Cyber def Feb**	**Cyber MM**	**ENT**	**MH/LD**	**Mort**	**DNACPR**	**S'Guard**	**TBC**	**TBC**	**TBC**	**TBC**	**TBC**
Moving to Outstanding Action Plan Update	**Assurance**	Chief Nurse/Dep Dir Gov	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Hot Topics			✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
COMPLIANCE & OVERSIGHT														
Quality Dashboard	**Assurance**	CN + DepC EO	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Review and Refresh of Trust KPIs	**Assurance**	CFO + Deputy CEO			✓									
SAFETY														
Maternity Update & Maternity Safety Champion	**Assurance**	Assoc CN Midwifery+ Obstet Champion	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Maternity SI Monthly Report	**Assurance**	Assoc CN Midwifery+ Obstet Champion	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
CNST Annual submission	**Approval**	CN+Dep CEO/Assoc CN (Midwifery)		✓										
SI + Complaints Quarterly Report	**Assurance**	Dep Dir Gov		**✓Q3**			**✓Q4**			**✓Q1**			**✓Q2**	
Safeguarding (Bi-Annual Report)	**Assurance**	Deputy CN											✓	
Safeguarding (Annual Report)	**Approval**	Deputy CN							✓					
Medicines Management/CD Annual Report	**Assurance**	Exec Med Director					✓							
Learning from Experience Report	**Assurance**	Dep Dir Gov			**✓Q3**		**✓Q4**				**✓Q1**			**✓Q2**
6 monthly staffing report	**Assurance**	Chief Nurse			✓						✓			
DIPC Infection Control (1/4 ly)	**Assurance**	Chief Nurse			**✓Q3**	**✓Q4**				**Q1**			**✓Q2**	
DIPC Infection Control Annual Report	**Assurance**	Chief Nurse							✓					
Health and Safety Annual Report	**Assurance**	Dep Dir Gov							✓					
~~Waiting List Oversight Report~~ Review of Waiting Lists and Clinical Harm Review Report	**Assurance**	COO	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
CLINICAL EFFECTIVENESS														

Item		Lead	Jan 21	Feb 21	03/21	04/21	05/21	06/21	07/21	08/21	09/21	10/21	11/21	12/21
Learning From Deaths Review Quarterly report	**Assurance**	Exec Med Director			✓**Q3**		✓**Q4**			✓**Q1**			✓**Q2**	
Clinical Forward Audit Plan	**Assurance**	Dep Dir Gov			✓									
Clinical Audit Quarterly report	**Assurance**	Dep Dir Gov			✓**Q3**		✓**Q4**				✓**Q1**			✓**Q2**
Clinical Audit Annual Report	**Assurance**	Dep Dir Gov							✓					
PATIENT EXPERIENCE														
Dementia Strategy Annual Review	**Assurance**	Deputy CN			✓									
Dementia Strategy Quarterly Report	**Assurance**	Deputy CN			✓**Q3**	✓**Q4**					✓**Q1**			✓**Q2**
Complaints Annual Report	**Approval**	Dep Dir Gov				✓								
Patient Experience Strategy – Annual Review	**Assurance**	Deputy Chief Nurse			✓									
COMPLIANCE & OVERSIGHT														
Strategic Risk Register and Board Assurance Framework	**Approval**	Trust Secretary	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Quarterly Quality Priorities Report	**Assurance**	Dep Dir Gov			✓**Q3**		✓**Q4**			✓**Q1**				✓**Q2**
Quality Priorities 2020-21	**Approval**	Dep Dir Gov			✓									
Quality Strategy annual update	**Assurance**	Dep Dir Gov					✓							
Risk Management Strategy Annual Review	**Assurance**	Dep Dir Gov					✓							
Quality Impact Assessment Report for CIP plans	**Assurance**	CFO/Dep CEO			✓**Q3**		✓**Q4**			✓**Q1**				✓**Q2**
Quality Improvement Progress Quarterly Report	**Assurance**	Chief Nurse		**Q3**	✓	✓	✓	✓		✓**Q1**			✓**Q2**	
Enabling Strategy alignment 6 month Progress report	**Assurance**	Director of Strategy					✓						✓	
Terms of Reference	**Approval**	Chair/Trust Secretary										✓		
Cycle of Business	**Approval**	Chair/Trust Secretary	✓											
Committee Effectiveness Annual Review	**Assurance**	Chair/ Trust Secretary	✓**toMar**	✓										
Committee Effectiveness Bi-Annual Review	**Assurance**	Chair/Trust Secretary							✓**RepAu**	✓				
Committee Chair's Annual Report to the Board	**Approval**	Chair/ Trust Secretary							✓					
Infection Control Sub Committee	**Assurance**	Chief Nurse	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Patient Safety + Clinical Effectiveness Sub Cttee	**Assurance**	Exec Medical Director	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Safeguarding Committee	**Assurance**	Deputy Chief Nurse	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Health and Safety Sub Committee	**Assurance**	Dep Dir Governance	✓	✓		✓		✓		✓		✓		✓

Item		Lead	Jan 21	Feb 21	03/21	04/21	05/21	06/21	07/21	08/21	09/21	10/21	11/21	12/21
Complaints Quality Assurance Group	**Assurance**	Dep Dir Governance		✓		✓		✓		✓		✓		✓
Patient Experience Sub Committee	**Assurance**	Deputy Chief Nurse		✓		✓		✓		✓		✓		✓
Palliative and End of Life Care Steering Group	**Assurance**	Consultant Palliative Med /Dir Med Educ	✓		✓		✓		✓		✓		✓	
Risk Review Group	**Assurance**	Dep Dir Governance	✓		✓		✓		✓		✓		✓	
HLB Quality Academy Board	**Assurance**	Chief Nurse	✓			✓			✓			✓		
IG + Corporate Records Group incl GDPR Readiness Plan	**Assurance**	CIO	✓		✓		✓		✓		✓		✓	
Equality, Diversity & Inclusion Sub Committee	**Assurance**	Chief People Officer	**Def**	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
High Level Enquires (when notified)	**Assurance**	Dep Dir Governance	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Summary (assurances and risks to escalate to Board)	**Assurance**	Chair	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

	Jan	Feb	Mar	Ap	May	June	July	Aug	Sept	Oct	Nov	Dec
Infection Control Sub Committee **DATES TBC**												
Patient Safety + Clinical Effectiveness Sub Committee	26th	23rd	30th	27th	25th	29th	27th	31sth	28th	26th	30th	
Safeguarding	20th	17th	24th	21st	19th	23rd	22nd	19th	22nd	20th	17th	15th
H&S Sub Committee	21st		23rd		20th		20th		23rd		23rd	
Complaints Quality Assurance Group	~~13th~~	10th	10th	10th	12th	9th						
Patient Experience Sub Committee	12th	9th	9th	13th	11th	8th	13th	10th	14th	12th	9th	14th
Palliative and End of Life Care Steering Group **DATES TBC**												
Risk Review Group	11th	1st	1st	12th	10th	7th						
HLB Quality Academy Board March/June/Sept/December 2021			✓			✓			✓			✓
ED&I Sub Committee Monthly	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
IG + Corporate Records Group		9th		13th		8th						

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/21/01/13**	
SUBJECT:	**Amendment to the Constitution – Appointment of Partner Non-Executive Director**	
DATE OF MEETING:	27 January 2021	
AUTHOR(S):	John Culshaw, Trust Secretary	
EXECUTIVE DIRECTOR SPONSOR:	Simon Constable, Chief Executive	
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	SO1 We will.. Always put our patients first through high quality, safe care and an excellent patient experience. SO2 We will.. Be the best place to work with a diverse, engaged workforce that is fit for the future. SO3 We will ..Work in partnership to design and provide high quality, financially sustainable services.	✓ ✓ ✓
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): **(*Please DELETE as appropriate)***	All	
EXECUTIVE SUMMARY *(KEY ISSUES):*	The Trust's Constitution states: *45. Amendment of the constitution* *45.1. The Trust may make amendments to its constitution if:* *45.1.1 more than half of the members of the Board of Directors of the Trust voting approve the amendments; and* *45.1.2 more than half of the members of the Council of Governors of the Trust voting approve the amendments.* To support the Trust's wish to have diversity of experience amongst Non-Executive Directors and support the Trust's ambition to achieve 'University Teaching Hospitals' status, the paper sets out a proposal to allow, by way of amendment of the Trust's Constitution, the appointment of one Non-Executive Director from the University Of Chester The proposal was supported at the Governor Nomination & Remuneration Committee (GNARC) held on 11th December 2020 and approved by the Council of Governors following circulation via email on 8th January 2021	

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

RECOMMENDATION:	The Board is asked to consider the proposed amendment to the constitution and to approve. These amendments which will be entered to create v3.9	
PREVIOUSLY CONSIDERED BY:	**Committee**	Council of Governors
	Agenda Ref.	VCOG/21/1/001
	Date of meeting	Circulated via email on 8th January 2021

	Summary of Outcome	Approved
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None	

REPORT TO BOARD OF DIRECTORS

SUBJECT	**Amendment to the Constitution – Appointment of Partner Non-Executive Director**	**AGENDA REF:**	**BM/21/01/13**

1. BACKGROUND/CONTEXT

The Trust's Constitution states:

45. Amendment of the constitution

45.1. The Trust may make amendments to its constitution if:
45.1.1 more than half of the members of the Board of Directors of the Trust voting approve the amendments; and
45.1.2 more than half of the members of the Council of Governors of the Trust voting approve the amendments.

2. KEY ELEMENTS

Following discussions at the Governor Working Parties in September and October 2020, and approval at the Governor Nomination & Remuneration Committee (GNARC) in December 2020 and subsequently the Council of Governors in January 2021; to support the Trust's wish to have diversity of experience amongst Non-Executive Directors and support the Trust's ambition to achieve 'University Teaching Hospitals' status, it is proposed that the Trust's Constitution is amended to add section 21.6 as follows:

21. **Board of Directors – composition**

21.1 The Trust is to have a Board of Directors, which shall comprise of both Executive and Non-Executive Directors.

21.2 The Board of Directors shall comprise as a minimum of:

21.2.1 a Non-Executive Chair.

21.2.2 five other Non-Executive Directors; and

21.2.3 five Executive Directors.

21.3 The number of members of the Board of Directors may be increased, provided always that at least half the Board, excluding the Chair, comprises Non-Executive Directors.

21.4 One of the Executive Directors shall be the Chief Executive.

21.5 The Chief Executive shall be the Accounting Officer.

21.6 One Non-Executive Director will be appointed from the Senior Management Team of the University of Chester in line with the Trust's strategy. The appointment would form part of a Memorandum of Understanding (MOU) with the University of Chester. In the event the MOU is disestablished, the role of the Non-Executive Director would also be disestablished.

21.7 One of the Executive Directors shall be the Finance Director.

21.8 One of the Executive Directors shall be a registered medical practitioner or a registered dentist (within the meaning of the Dentists Act 1984).

21.9 One of the Executive Directors is to be a registered Nurse or a registered Midwife.

3. RECOMMENDATIONS

The Board is asked to consider the proposed amendment to the constitution and to approve. These amendments which will be entered to create v3.9

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/21/01/14**		
SUBJECT:	**Amendment to the Constitution – Amendment to the Governor Code of Conduct**		
DATE OF MEETING:	27th November 2021		
AUTHOR(S):	John Culshaw, Trust Secretary		
EXECUTIVE DIRECTOR SPONSOR:	Simon Constable, Chief Executive		
LINK TO STRATEGIC OBJECTIVE: (*Please select as appropriate)*	SO1 We will.. Always put our patients first through high quality, safe care and an excellent patient experience.	✓	
	SO2 We will.. Be the best place to work with a diverse, engaged workforce that is fit for the future.	✓	
	SO3 We will ..Work in partnership to design and provide high quality, financially sustainable services.	✓	
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): (*Please DELETE as appropriate)*	All		
EXECUTIVE SUMMARY *(KEY ISSUES):*	The Trust's Constitution states: *45. Amendment of the constitution* *45.1. The Trust may make amendments to its constitution if:* *45.1.1 more than half of the members of the Board of Directors of the Trust voting approve the amendments; and* *45.1.2 more than half of the members of the Council of Governors of the Trust voting approve the amendments.* The paper sets out a proposal to allow, by way of amendment of the Trust's Constitution, the strengthening of the Governors' Code of Conduct. The Governors' Code of Conduct forms part of the Trust's Constitution in Annex 5B The proposal was approved by the Council of Governors following circulation via email on 8th January 2021		
PURPOSE: *(please select as appropriate)*	Information	Approval ✓	To note	Decision
RECOMMENDATION:	The Board is asked to consider the proposed amendment to the constitution and to approve. These amendments which will be entered to create v3.9		
PREVIOUSLY CONSIDERED BY:	**Committee**	Council of Governors	
	Agenda Ref.	VCOG/21/1/002	
	Date of meeting	Circulated via email on 8th January 2021	
	Summary of Outcome	Approved	
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full		
FOIA EXEMPTIONS APPLIED: *(if relevant)*	None		

REPORT TO BOARD OF DIRECTORS

SUBJECT	**Amendment to the Constitution – Amendment to the Governor Code of Conduct**	**AGENDA REF:**	**BM/21/01/14**

1. BACKGROUND/CONTEXT

The Trust's Constitution states:

45. Amendment of the constitution

45.1. The Trust may make amendments to its constitution if:
45.1.1 more than half of the members of the Board of Directors of the Trust voting approve the amendments; and
45.1.2 more than half of the members of the Council of Governors of the Trust voting approve the amendments.

2. KEY ELEMENTS

Following the appointment of several new Governors in November 2020 and subsequent review of the Governors' Code of Conduct, it is proposed that the Annex 5B – Governors' Code of Conduct is amended to add the following highlighted in red:

ANNEX 5B – GOVERNORS' CODE OF CONDUCT

Introduction

This Code has been drawn up in accordance with the Constitution and it is intended to support and complement the Constitution and its Annexes.

Its purpose is to make clear the appropriate conduct for Governors and address the requirements of the office of Governor on the Governors Council. As an elected or appointed Governor, it is important that Governors are in no doubt about the standards of conduct and personal behaviour expected of anyone who holds public office or works within the Trust.

Governors' attention is also drawn to a number of Trust polices and documents regarding the Trust's values, confidentiality and the use of information and social media:

- Information Governance Policy
- Freedom to Speak up Policy
- Media & Social Media Policy
- Equality, Diversity & Inclusion Policy
- Trust Values

Whilst these policies have been drawn up principally for staff, the principles of these policies should be adhered to by Governors. Any query regarding the content or interpretation of any Trust policy should be directed to either the Chair of the Trust or the Trust Secretary.

Guiding Principles

The principles underpinning this Code of Conduct are drawn from the 'seven principles of public life', as defined by The Nolan Committee Report (1996). These principles are as follows:

- **Selflessness.** Governors must take decisions solely in terms of the public interest. Decisions must not be made to gain financial or material benefit for themselves, their family or friends. Governors must not attempt to use their status to gain advantage within the Trust or any other organisation.

- **Integrity.** Governors must not place themselves under any financial or other obligation to outside individuals or organisations that might influence them in the performance of their official duties.

- **Objectivity.** In carrying out public business, including making appointments, awarding contracts or recommending individuals for rewards and benefits, Governors must make their choice based on merit.

- **Accountability.** Governors are accountable for their decisions and actions to the public and must submit themselves to whatever scrutiny is appropriate for their office.

- **Openness.** Governors must be as open as possible about all the decisions and actions they take, and must give reasons for decisions, restricting information only when the wider public interest clearly demands.

- **Honesty.** Governors have a duty to declare any private interests relating to their public duties and to take steps to resolve any conflicts arising in a way that protects the public interest.

- **Leadership.** Governors should promote and support these principles by leadership and example.

The NHS Core Principles (as published by the Department of Health) also inform the Code of Conduct, and should guide the activities of the Board of Governors. These principles dictate that the NHS will:

- Provide a universal service for all based on clinical need not the ability to pay.

- Provide a comprehensive range of services, shaped around the needs and preferences of individual patients, their families and their carers.

- Respond to the different needs of different populations.

- Work continuously to improve quality services and to minimise errors.

- Support and value its staff.
- Ensure public funds for healthcare are devoted solely to NHS patients.
- Work together with others to ensure a seamless service for patients.
- Help keep people healthy and work to reduce health inequalities.
- Respect the confidentiality of individual patients and provide open access to information relating to services, treatment and performance.

Code of Conduct

A Governor must observe the Governors' Code of Conduct whenever he/she conducts the business of the Trust and/or the Board of Governors or acts as a representative of the Trust and/or the Board of Governors.

As a Governor of WARRINGTON AND HALTON TEACHING HOSPITALS NHS FOUNDATION
TRUST I will:

1. Act as an ambassador for the Trust and represent both members and the general public.
2. At all times comply with the Constitution and its Standing Orders, the Standing Financial Instructions and all other policies and procedures of the Trust.
3. Uphold the Seven Principles of Public Life as set out by the Nolan Committee.
4. Abide by the NHS Core Principles.
5. Actively support the Trust's vision, aims and priorities ensuring the needs and best interests of the public, service users, relatives, carers and staff are foremost when making decisions.
6. Adopt a team approach, working with the Board of Directors, Trust staff and partner organisation to achieve the success of the Trust.
7. Support and assist the Trust's Chief Executive in his/her responsibility to answer the regulatory body, commissioners and the public in fully and faithfully declaring and explaining the use of resources, and the performance of the Trust in enacting national policy, and delivering national targets.
8. Seek to ensure that no-one person or group is unlawfully discriminated against because of for example religion, belief, race, colour, gender, marital status, disability, sexual orientation, age, social or economic status or national origin.

9. Treat with dignity and respect the public, service users, relatives, carers, people who work within the Trust, and partners in other organisation.

10. Seek to ensure that my Governor colleagues are valued, and that judgements about them are consistent, fair, unbiased and properly founded.

11. Note that WARRINGTON AND HALTON HOSPITALS NHS FOUNDATION TRUST is an apolitical organisation.

12. Recognise that if I am a member of any trade's union, political party or other organisation, (other than where a Governor has been appointed to the Governors Council by an appointing organisation), I will not be representing that organisation or the views of that organisation.

13. Ensure that no political, religious or sectarian views influence any decisions I am party to.

14. Properly disclose and declare any actual or perceived personal, pecuniary or conflict of interest in any matter under discussion or consideration and refrain from any decision or vote on the matter, unless I am invited to participate by the Chair.

15. Not expect or seek any privileges, preferential or special treatment arising from being a Governor for either myself or my family or friends.

16. Ensure that when acting in my official capacity, or any other circumstances, I conduct myself in a way that will not bring the office of Governor, the Council of Governors or the Trust into disrepute.

17. Not make, permit or knowingly allow to be made any untrue misleading statement relating to my own duties or the functions of the Trust.

18. Maintain a high level of confidentiality and not disclose any information given to me in confidence by anyone, or disclose information acquired which is or which I believe to be of a confidential nature without the consent of a person authorised to give it, unless I am required to do so by law. I will also not prevent another person from gaining access to information to which that person is entitled by law.

19. Raise any concerns regarding any matter relating to the activities of the Council of Governors, the Board of Directors or services within the Trust through the proper internal channels and within the terms of clause 42 of the Constitution.

20. At no time or for any reason speak to the press or media in relation to any Trust business or its employees or Board of Directors <u>any</u> official capacity unless authorised to do so by the Board of Directors or the Trust's Communications Department; and if approached by the press or media

direct all enquiries to the Trust's Communications Department.

21. Ensure that the membership of the whole Constituency I am elected to represent, or the organisation I am appointed to represent is properly informed and their views are properly represented.

22. Exercise my responsibility in a corporate manner and ensure decisions are taken collectively with the Council of Governors acting as a unitary body, and support decisions taken by the Governors Council even where I may not personally agree with the decision taken.

23. Not act individually or in informal groupings to take decisions on Council of Governors business outside the constitutional framework of Council of Governors meetings and Committees.

24. Undertake any training identified as required and receive guidance in respect of my responsibilities.

25. Attend all meetings of the Council of Governors and its Committees wherever possible in order to carry out my role as Governor.

26. Not, when acting as a Governor, visit any non public area or setting in which treatment is provided, except where such a visit has been arranged by the Board of Directors or its representative.

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Personal Declaration

I (full name) …… have read, understood and agree to comply with the WARRINGTON AND HALTON HOSPITALS NHS FOUNDATION TRUST's Code of Conduct for Governors, and I also agree to inform the Trust Secretary if at any time I become unable to comply with the Code or any part of the Code.

If during the course of my duties as a Governor I become involved with, or aware of any confidential information, including that relating to any person for example service users, carers, visitors, members of staff; or information relating to any Trust business, I will not at any time during or after my term of office as a Governor use or disclose such information inappropriately.

I understand that a breach of this code and the general obligation of confidentiality will be considered as a serious offence/misconduct issue and that I may be removed from the Council of Governors.

I understand that it is a requirement of the Constitution to sign the Code of Conduct and that failure to do so will preclude me from continuing in office as a Governor.

Signature ……

Date ……

3. RECOMMENDATIONS

The Board is asked to consider the proposed amendment to the constitution as outlined above and to approve. These amendments which will be entered to create v3.9

We are WHH & We are PROUD to make a difference

NHS
Warrington and Halton Teaching Hospitals
NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/21/01/15**			
SUBJECT:	**Infection Prevention and Control**			
DATE OF MEETING:	27 January2020			
AUTHOR(S):	Lesley McKay, Associate Chief Nurse, Infection Prevention & Control			
EXECUTIVE DIRECTOR SPONSOR:	Kimberley Salmon-Jamieson, Chief Nurse & Deputy Chief Executive			
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	SO1 We will.. Always put our patients first through high quality, safe care and an excellent patient experience.			
	SO2 We will.. Be the best place to work with a diverse, engaged workforce that is fit for the future.			
	SO3 We will..Work in partnership to design and provide high quality, financially sustainable services.			
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): **(*Please DELETE as appropriate)***	#1124 Failure to provide adequate PPE caused by failures within the national supply chain and distribution routes resulting in lack of PPE for staff. #1134 Failure to provide adequate staffing caused by absence relating to COVID-19 resulting in resource challenges and an increase within the temporary staffing domain. #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 provides a summary of infection prevention and control activity for Quarter 2 (Q2) of the 2020/21 financial year and highlights the Trust's progress against infection prevention and control key performance indicators. In Q2 the Trust reported:- • 15 Clostridium difficile cases • 1 MRSA bacteraemia cases • 8 MSSA bacteraemia cases. There is no national reduction target • 9 E. coli bacteraemia cases Healthcare associated infection reduction targets have not been set for 2020/21. A decrease in the local incidence of Covid-19 was observed in July and August with cases rising in September. Five outbreaks affecting patients and staff were reported in September. Outbreak Control Groups were established to manage the incidents. Learning from the incidents has been shared trust-wide.			
PURPOSE: (please select as appropriate)	Information	Approval	To note √	Decision
RECOMMENDATION:	The Trust Board is asked to note the contents of the report.			
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			

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NHS
Warrington and Halton Teaching Hospitals
NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS

SUBJECT	Infection Prevention and Control	AGENDA REF:	BM/21/01/15

1. BACKGROUND/CONTEXT

This report provides an overview of infection prevention and control activity for Quarter 2 (Q2) of the 2020/21 financial year (FY). The report highlights the Trust's progress against Healthcare Associated Infection (HCAI) reduction targets and the response to the Covid-19 Pandemic.

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

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

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

In June NHSE/I published case definitions as follows:

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

A cluster of cases is defined as 2 cases arising within the same ward/department over a 14 day period. Further investigation assess if the cases are likely linked.

2. KEY ELEMENTS

HCAI data

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

Table 1: HCAI data by month

Indicator	Target	Position	A	M	J	J	A	S	Total
C. difficile	Local <44	Over trajectory	5	4	2	6	5	4	26
MRSA bacteraemia	Zero tolerance	Over trajectory	0	0	0	0	0	1	1
MSSA bacteraemia	No target	No target	1	2	0	5	1	2	11
E. coli bacteraemia	TBC	On trajectory	2	2	5	0	6	3	18
Klebsiella spp. bacteraemia	TBC	On trajectory	0	1	0	2	2	1	6
P. aeruginosa bacteraemia	TBC	On trajectory	0	0	1	0	0	0	1

Clostridium difficile

- 15 cases reported (10 hospital onset/ healthcare associated: 5 community onset/ healthcare associated)
- All hospital apportioned cases undergo post infection review. During the Covid-19 pandemic support was obtained from staff who are shielding to commence the investigations
- Internal review panel meetings were suspended to focus activity on Covid-19. A plan is in place to re-establish review meetings as soon as capacity allows
- The CCG also suspended review panel meetings. The outstanding cases from the 2019/20 FY will be submitted for review when meetings reconvene – date to be confirmed
- Ribotyping of all hospital onset/healthcare associated and community onset/ healthcare associated cases has not identified any links between the toxin positive cases

Bacteraemia Cases

Gram positive bacteraemia

Meticillin resistant Staphylococcus aureus (MRSA) bacteraemia

- 1 case reported in September

Review of this case highlighted an elderly female patient, living with dementia and negative MRSA admission screen. During the admission the patient developed a unilateral facial swelling and received an ENT review. Antibiotic treatment was given and an ultrasound scan revealed no sign of abscess. The post infection review identified dehydration and areas for improvement with peripheral cannula monitoring. The infection was considered avoidable.

Meticillin sensitive Staphylococcus aureus MSSA bacteraemia

- 8 hospital onset cases
- An increased association with peripheral cannula care. Supportive training has been provided to wards where this was observed and wider sharing of learning taken to Trust-wide safety brief
- No national reduction target/threshold

Gram negative bacteraemia (GNBSI)

E coli bacteraemia

- 9 hospital onset cases

Klebsiella Spp.

- 5 hospital onset cases

Pseudomonas aeruginosa

- Nil hospital onset case

Due to Covid demand across the Trust, there is a reduced focus on activity for GNBSI reduction. Work is taking place in the background to refocus the reduction action plan and meetings with Quality Academy support will recommence as soon as possible.

Comparative data on HCAI cases and rates from July 2019 – September 2020 across the Northwest is included in appendix 2. Appropriate comparison with similar organisations shows a slightly higher number

(1) of MRSA bacteraemia cases and lower numbers of MSSA cases than one of our than Local Delivery System partners. The Trust has a higher number of C. difficile cases than Local Delivery System partners over the twelve moth rolling period. A significantly lower numbers of E. coli, Klebsiella spp. and Pseudomonas aeruginosa bacteraemia are noted.

Outbreaks/Incidents

Viral Gastroenteritis

There were no reports of viral gastroenteritis outbreaks in Q2.

Table 2: Viral Gastroenteritis incidents by month

	A	M	J	J	A	S
Outbreaks	0	0	0	0	0	0

Covid-19

A decrease in the local incidence of Covid-19 was observed in July and August with cases rising in September (appendix 3). The Infection Control team continued to support all CBUs with advice on restoration of elective services, appropriate precautions and risk assessments. The pandemic escalation plan was revised with the Emergency Planning Officer in preparation for wave 2. The Infection Prevention and Control Nurses continue to provide a 7 day and on call service and text message alerting of confirmed Covid-19 results ensures timely management of cases.

During September 5 Covid-19 outbreaks were reported:

- 3 outbreaks affecting staff
- 1 outbreak affecting patient
- 1 outbreak affecting both staff and patient

Learning form the outbreaks has been shared Trust-wide and includes:

- Car sharing - without face masks
- Social distancing in break room - less than 2 metres apart whilst eating /drinking
- Accuracy of office/ break room risk assessments - sitting less than 2 metres apart
- Missed Covid admission screening /Missed Covid day 5 screening
- Patients in neighbouring bed / wander some patients
- Incorrect /missed equipment decontamination

In response to the outbreaks reported, NHSE/I visited the Trust on 30 September 2020. The inspection team advised the visit was to intended to be supportive and not for performance management. A small number of suggestions were made which included purchase of additional hydrogen peroxide vapour machines for environmental decontamination. A business case has been developed and 4 additional machines purchased.

The following documents have been developed and updated by the Infection Prevention and Control Team to provide guidance to staff on Covid-19:

- Patient placement SOP
- Quantitative Fit testing Sop

The Infection Prevention and Control Team members continued to provide education and road shows where staff raised concerns about PPE guidance. The programme of Fit Testing of FFP3 respirators has continued during Q2.

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

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

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

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

Infection Prevention and Control Training

Overall compliance with Mandatory training was 84% in May 2020.

Table 3 Infection Control Training compliance

Infection Control Training	A	M	J	J	A	S
Overall % of staff trained	-	84%	-	-	85%	

Overall compliance with mandatory training is 85%. Level 2 (clinical training) is 76%. Face to Face mandatory infection control training was halted due to the coronavirus pandemic and will recommence as part of the recovery schedule. All Clinical Business Units have been requested to set an improvement trajectory.

Infection Prevention and Control Audits

The IPCN audits were halted due to the coronavirus pandemic and will recommence as part of the recovery schedule.

Environmental Hygiene

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

Infection Control Sub-Committee

The Sub-Committee meetings met monthly during Q2.

Antimicrobial Stewardship

Antibiotic ward rounds were fully established in Q2. A concern has been noticed with an increase in use of piperacillin/tazobactam (Tazocin) for treatment of community acquired pneumonia. The Consultant Microbiologists are in discussion with the respiratory consultants to reduce use of this broad spectrum antibiotic.

Awareness raising events

The Infection Prevention and Control Team have focussed awareness raising activity throughout Q2 on coronavirus.

3. ACTIONS REQUIRED/RESPONSIBLE OFFICER

- Develop the Infection Prevention and Control Service recovery plan
- Publish the Infection Prevention and Control Strategy
- Continue to provide expert advice throughout the pandemic

4. IMPACT ON QPS

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

5. MEASUREMENTS/EVALUATIONS

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

6. TRAJECTORIES/OBJECTIVES AGREED

- The Clostridium difficile threshold for 2020/2021 has been set locally at ≤ 44 cases
- There is a national target for a 25% reduction by 2021/2022 and the full 50% reduction by 2024. A 5% GNBSI reduction target has been set as a priority within the Quality Strategy
- The zero tolerance to avoidable MRSA bacteraemia cases remains in place

Work streams will continue to:-

- Progress GNBSI reduction
- Launch the revised Urinary Catheter Passport
- Reduce the incidence of Clostridium difficile infection and implement learning from incidents

- Promote Antimicrobial Stewardship and challenge inappropriate prescribing
- Partnership working with Urgent and Emergency Care CBU to support timely blood culture sampling
- Implement Covid-19 screening competency assessments
- Monitor invasive device management/bacteraemia reduction
- Recommence ANTT competency assessor training
- Implement an infection control surveillance systems including Catheter Associated UTI
- Support staff training in Infection Prevention and Control where CBU compliance is lower than 85%
- Promote excellent standards in uniform/workwear and the Bare Below the Elbows campaign
- Promote excellence in adherence to Covid-19 PPE guidance
- Support assessment of decontamination standards
- Enhance the surgical site infection surveillance programme
- Implement a recovery plan to review overdue policies

7. MONITORING/REPORTING ROUTES

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

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

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

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

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

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

8. TIMELINES

2020/21 Financial Year

9. ASSURANCE COMMITTEE

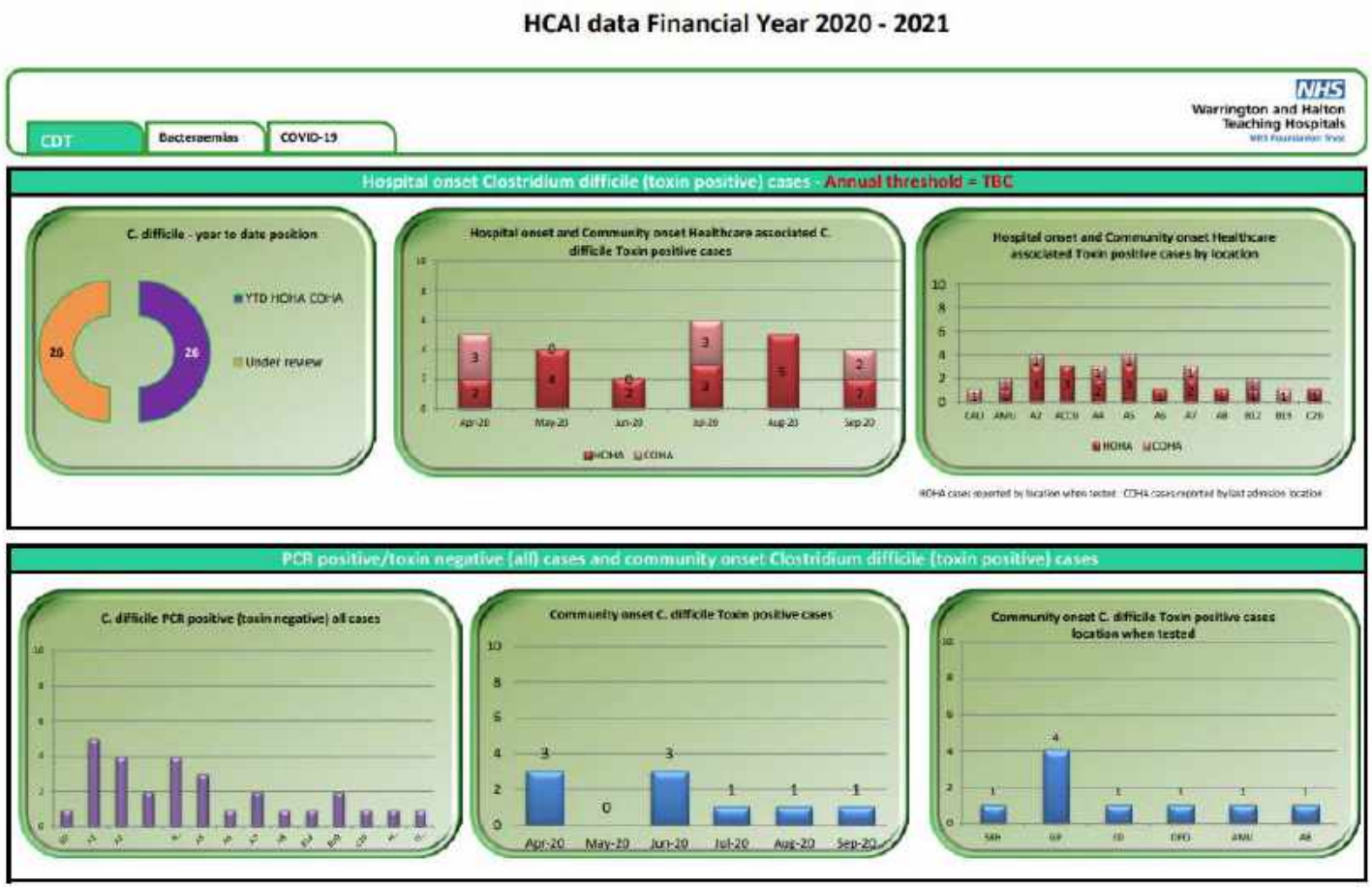
- Infection Control Sub-Committee

10. RECOMMENDATIONS

The Trust Board is asked to: note the content of the report; the exceptions reported and the progress made.

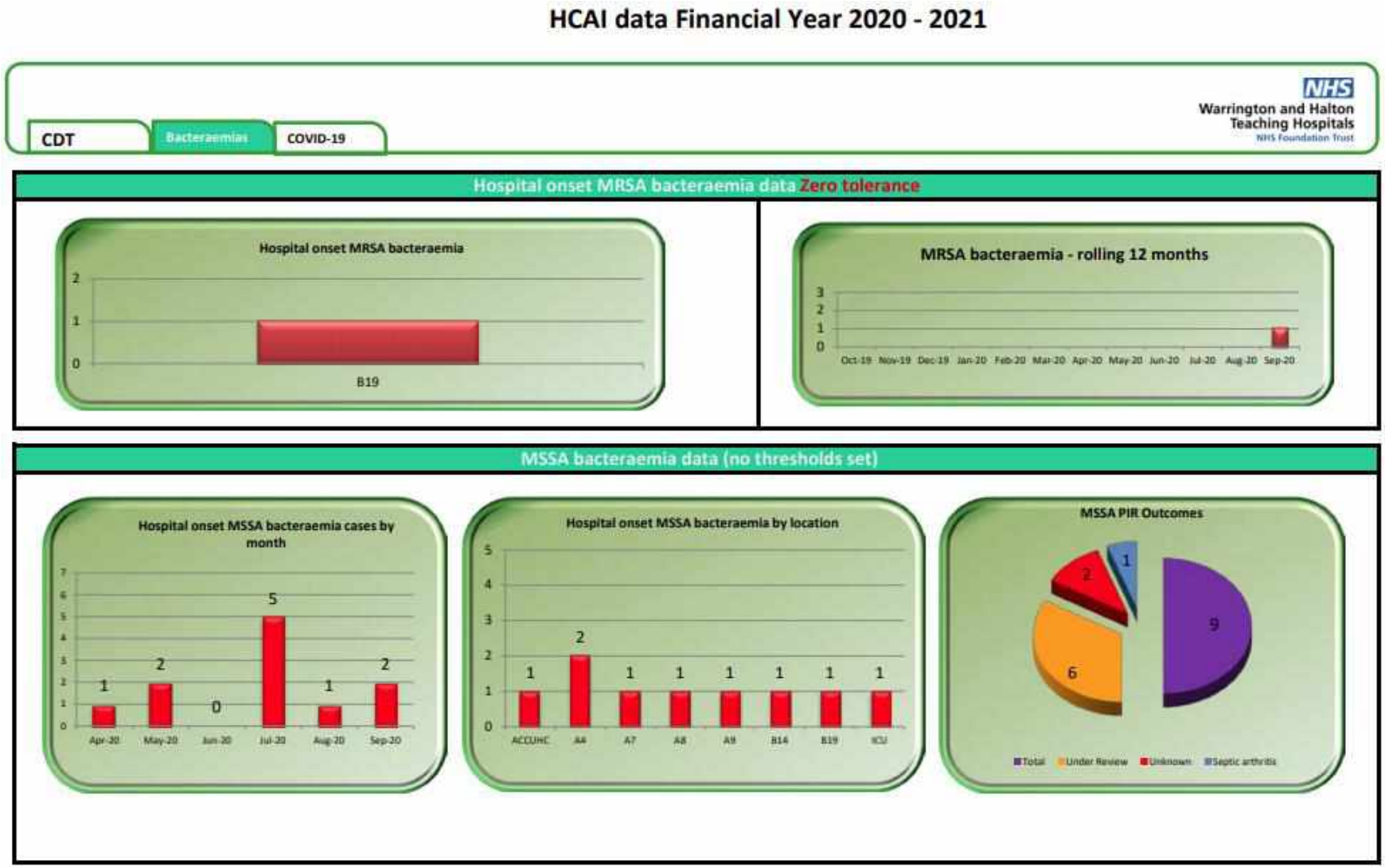
APPENDIX 1 Healthcare Associated Infection Data April – September 2020

Clostridium difficile Cases

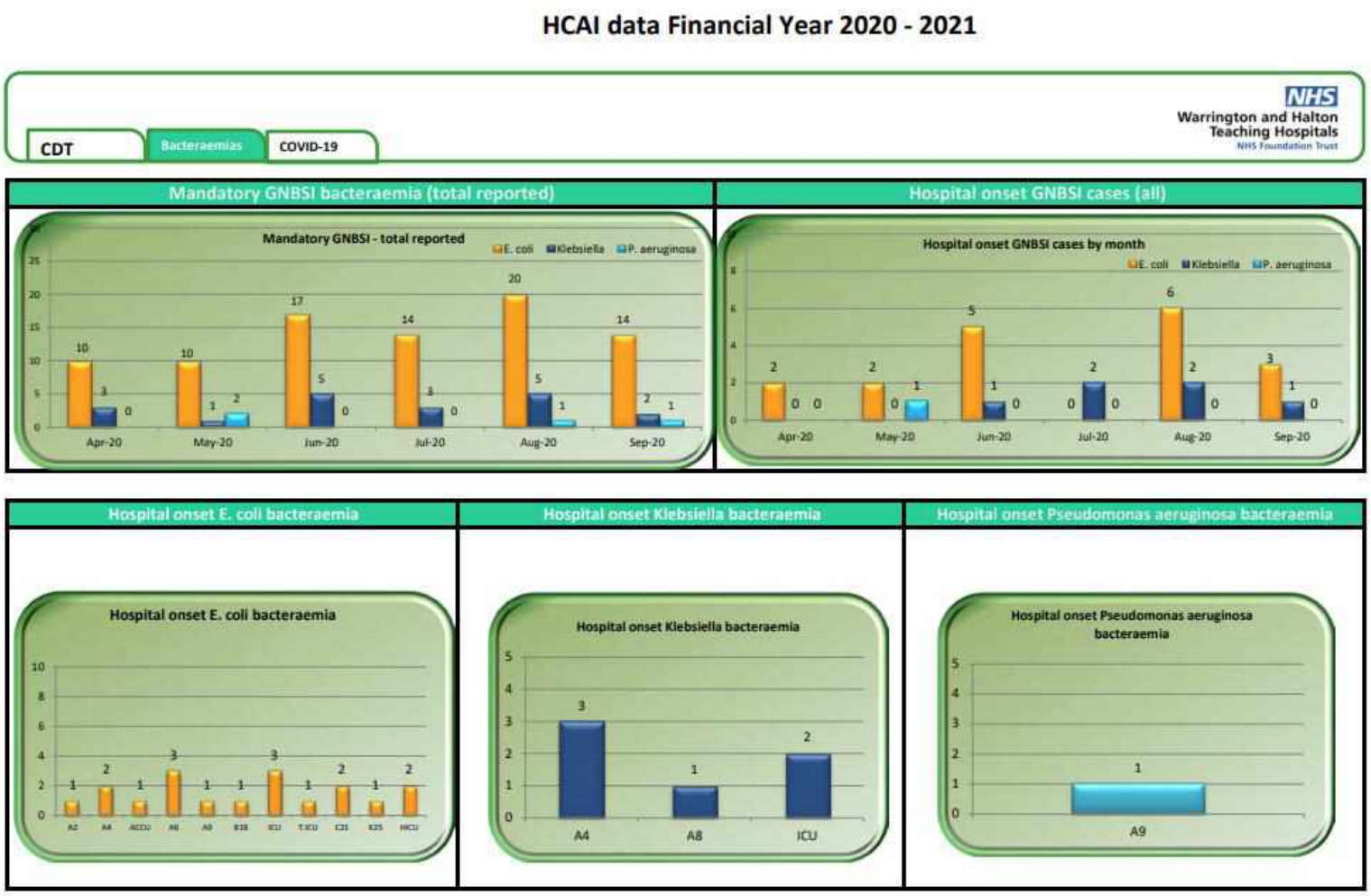


Hospital onset/Healthcare associated = HOHA
Community onset/Healthcare associated = COHA
Community onset/Healthcare associated cases are linked to the ward the patient was most recently discharged from

Gram Positive Bacteraemia Cases



Gram Negative Bacteraemia Cases



APPENDIX 2 COMPARISION OF HEALTHCARE ASSOCIATED INFECTION DATA ACROSS THE NORTHWEST

Clostridium difficile (October 2019 – September 2020)

Public Health England

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

Organisation Name	October 2019 to September 2020	Rate per 100,000 bed days	Significance
ALDER HEY CHILDREN'S NHS FOUNDATION TRUST	7	10.7	Low (0.025)
BLACKPOOL TEACHING HOSPITALS NHS FOUNDATION TRUST	119	49.1	High (0.001)
BOLTON NHS FOUNDATION TRUST	42	16.6	Low (0.025)
COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST	37	18.4	
EAST CHESHIRE NHS TRUST	12	9.9	Low (0.001)
EAST LANCASHIRE HOSPITALS NHS TRUST	74	22.0	
LANCASHIRE TEACHING HOSPITALS NHS FOUNDATION TRUST	116	37.9	High (0.001)
LIVERPOOL HEART AND CHEST HOSPITAL NHS FOUNDATION TRUST	5	11.6	
LIVERPOOL WOMEN'S NHS FOUNDATION TRUST	0	0.0	
LIVERPOOL UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	134	23.2	
MANCHESTER UNIVERSITY NHS FOUNDATION TRUST	160	22.4	
MID CHESHIRE HOSPITALS NHS FOUNDATION TRUST	22	10.8	Low (0.001)
NORTH CUMBRIA INTEGRATED CARE NHS FOUNDATION TRUST	71	32.8	High (0.025)
PENNINE ACUTE HOSPITALS NHS TRUST	89	20.5	
SALFORD ROYAL NHS FOUNDATION TRUST	47	16.5	Low (0.025)
SOUTHPORT AND ORMSKIRK HOSPITAL NHS TRUST	34	22.9	
ST HELENS AND KNOWSLEY TEACHING HOSPITALS NHS TRUST	46	16.6	Low (0.025)
STOCKPORT NHS FOUNDATION TRUST	40	17.7	
TAMESIDE AND GLOSSOP INTEGRATED CARE NHS FOUNDATION TRUST	34	22.7	
THE CHRISTIE NHS FOUNDATION TRUST	35	57.5	High (0.001)
THE CLATTERBRIDGE CANCER CENTRE NHS FOUNDATION TRUST	6	24.4	
THE WALTON CENTRE NHS FOUNDATION TRUST	3	6.0	Low (0.001)
UNIVERSITY HOSPITALS OF MORECAMBE BAY NHS FOUNDATION TRUST	63	25.5	
WARRINGTON AND HALTON TEACHING HOSPITALS NHS FOUNDATION TRUST	56	27.8	
WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FOUNDATION TRUST	54	20.2	
WRIGHTINGTON, WIGAN AND LEIGH NHS FOUNDATION TRUST	50	29.4	
North West	1356	23.7	

MRSA – Annual rolling rate (July 2019 – September 2020)

Public Health England

MRSA quarterly tables: Trust cases & rates

Organisation Name	July to September 2020	Rate per 100,000 bed days	Significance
ALDER HEY CHILDREN'S NHS FOUNDATION TRUST	0	0.0	
BLACKPOOL TEACHING HOSPITALS NHS FOUNDATION TRUST	1	2.5	
BOLTON NHS FOUNDATION TRUST	1	2.0	
COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST	0	0.0	
EAST CHESHIRE NHS TRUST	1	5.3	
EAST LANCASHIRE HOSPITALS NHS TRUST	0	0.0	
LANCASHIRE TEACHING HOSPITALS NHS FOUNDATION TRUST	0	0.0	
LIVERPOOL HEART AND CHEST HOSPITAL NHS FOUNDATION TRUST	0	0.0	
LIVERPOOL WOMEN'S NHS FOUNDATION TRUST	0	0.0	
LIVERPOOL UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	2	2.2	
MANCHESTER UNIVERSITY NHS FOUNDATION TRUST	2	2.0	
MID CHESHIRE HOSPITALS NHS FOUNDATION TRUST	0	0.0	
NORTH CUMBRIA UNIVERSITY HOSPITALS NHS TRUST	0	0.0	
PENNINE ACUTE HOSPITALS NHS TRUST	2	3.1	
SALFORD ROYAL NHS FOUNDATION TRUST	0	0.0	
SOUTHPORT AND ORMSKIRK HOSPITAL NHS TRUST	0	0.0	
ST HELENS AND KNOWSLEY HOSPITAL SERVICES NHS TRUST	0	0.0	
STOCKPORT NHS FOUNDATION TRUST	1	3.0	
TAMESIDE AND GLOSSOP INTEGRATED CARE NHS FOUNDATION TRUST	0	0.0	
THE CHRISTIE NHS FOUNDATION TRUST	1	10.2	
THE CLATTERBRIDGE CANCER CENTRE NHS FOUNDATION TRUST	0	0.0	
THE WALTON CENTRE NHS FOUNDATION TRUST	0	0.0	
UNIVERSITY HOSPITALS OF MORECAMBE BAY NHS FOUNDATION TRUST	0	0.0	
WARRINGTON AND HALTON TEACHING HOSPITALS NHS FOUNDATION TRUST	1	3.0	
WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FOUNDATION TRUST	0	0.0	
WRIGHTINGTON, WIGAN AND LEIGH NHS FOUNDATION TRUST	0	0.0	
North West	12	1.3	

MSSA – Annual rolling rate (July 2019 – September 2020)

Public Health England

MSSA quarterly tables: Trust cases & rates

Organisation Name	July to September 2020	Rate per 100,000 bed days	Significance
ALDER HEY CHILDREN'S NHS FOUNDATION TRUST	7	68.7	
BLACKPOOL TEACHING HOSPITALS NHS FOUNDATION TRUST	12	29.8	
BOLTON NHS FOUNDATION TRUST	8	15.9	
COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST	6	17.4	
EAST CHESHIRE NHS TRUST	6	32.0	
EAST LANCASHIRE HOSPITALS NHS TRUST	11	21.3	
LANCASHIRE TEACHING HOSPITALS NHS FOUNDATION TRUST	10	23.8	
LIVERPOOL HEART AND CHEST HOSPITAL NHS FOUNDATION TRUST	2	34.9	
LIVERPOOL WOMEN'S NHS FOUNDATION TRUST	1	19.6	
LIVERPOOL UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	11	12.3	
MANCHESTER UNIVERSITY NHS FOUNDATION TRUST	23	22.9	
MID CHESHIRE HOSPITALS NHS FOUNDATION TRUST	5	15.2	
NORTH CUMBRIA INTEGRATED CARE NHS FOUNDATION TRUST	6	17.6	
PENNINE ACUTE HOSPITALS NHS TRUST	10	15.3	
SALFORD ROYAL NHS FOUNDATION TRUST	11	27.0	
SOUTHPORT AND ORMSKIRK HOSPITAL NHS TRUST	6	24.5	
ST HELENS AND KNOWSLEY TEACHING HOSPITALS NHS TRUST	12	26.4	
STOCKPORT NHS FOUNDATION TRUST	2	5.9	Low (0.025)
TAMESIDE AND GLOSSOP INTEGRATED CARE NHS FOUNDATION TRUST	1	4.6	Low (0.025)
THE CHRISTIE NHS FOUNDATION TRUST	4	40.7	
THE CLATTERBRIDGE CANCER CENTRE NHS FOUNDATION TRUST	0	0.0	
THE WALTON CENTRE NHS FOUNDATION TRUST	6	82.4	
UNIVERSITY HOSPITALS OF MORECAMBE BAY NHS FOUNDATION TRUST	7	18.3	
WARRINGTON AND HALTON TEACHING HOSPITALS NHS FOUNDATION TRUST	9	27.2	
WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FOUNDATION TRUST	3	8.0	Low (0.025)
WRIGHTINGTON, WIGAN AND LEIGH NHS FOUNDATION TRUST	3	10.5	
North West	182	20.1	

E. coli bacteraemia – Annual rolling rate (July 2019 – September 2020)

Public Health England

E. coli quarterly tables: Trust cases & rates

Organisation Name	July to September 2020	Rate per 100,000 bed days	Significance
ALDER HEY CHILDREN'S NHS FOUNDATION TRUST	4	39.2	
BLACKPOOL TEACHING HOSPITALS NHS FOUNDATION TRUST	20	49.7	
BOLTON NHS FOUNDATION TRUST	12	23.9	Low (0.025)
COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST	10	28.9	
EAST CHESHIRE NHS TRUST	10	53.3	
EAST LANCASHIRE HOSPITALS NHS TRUST	28	54.2	
LANCASHIRE TEACHING HOSPITALS NHS FOUNDATION TRUST	13	30.9	
LIVERPOOL HEART AND CHEST HOSPITAL NHS FOUNDATION TRUST	1	17.4	
LIVERPOOL WOMEN'S NHS FOUNDATION TRUST	5	98.1	
LIVERPOOL UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	43	48.2	
MANCHESTER UNIVERSITY NHS FOUNDATION TRUST	57	56.8	
MID CHESHIRE HOSPITALS NHS FOUNDATION TRUST	3	9.1	Low (0.001)
NORTH CUMBRIA INTEGRATED CARE NHS FOUNDATION TRUST	24	70.5	
PENNINE ACUTE HOSPITALS NHS TRUST	28	42.8	
SALFORD ROYAL NHS FOUNDATION TRUST	17	41.7	
SOUTHPORT AND ORMSKIRK HOSPITAL NHS TRUST	18	73.5	
ST HELENS AND KNOWSLEY TEACHING HOSPITALS NHS TRUST	24	52.9	
STOCKPORT NHS FOUNDATION TRUST	18	53.2	
TAMESIDE AND GLOSSOP INTEGRATED CARE NHS FOUNDATION TRUST	3	13.7	Low (0.025)
THE CHRISTIE NHS FOUNDATION TRUST	6	61.1	
THE CLATTERBRIDGE CANCER CENTRE NHS FOUNDATION TRUST	0	0.0	
THE WALTON CENTRE NHS FOUNDATION TRUST	1	13.7	
UNIVERSITY HOSPITALS OF MORECAMBE BAY NHS FOUNDATION TRUST	22	57.4	
WARRINGTON AND HALTON TEACHING HOSPITALS NHS FOUNDATION TRUST	14	42.4	
WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FOUNDATION TRUST	12	32.2	
WRIGHTINGTON, WIGAN AND LEIGH NHS FOUNDATION TRUST	11	38.4	
North West	404	44.7	

Klebsiella bacteraemia - Annual rolling rate (July 2019 – September 2020)

Public Health England

Klebsiella quarterly tables: Trust cases & rates

Organisation Name	July to September 2020	Rate per 100,000 bed days	Significance
ALDER HEY CHILDREN'S NHS FOUNDATION TRUST	4	39.2	
BLACKPOOL TEACHING HOSPITALS NHS FOUNDATION TRUST	9	22.4	
BOLTON NHS FOUNDATION TRUST	5	10.0	
COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST	0	0.0	
EAST CHESHIRE NHS TRUST	0	0.0	
EAST LANCASHIRE HOSPITALS NHS TRUST	5	9.7	
LANCASHIRE TEACHING HOSPITALS NHS FOUNDATION TRUST	4	9.5	
LIVERPOOL HEART AND CHEST HOSPITAL NHS FOUNDATION TRUST	0	0.0	
LIVERPOOL WOMEN'S NHS FOUNDATION TRUST	0	0.0	
LIVERPOOL UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	26	29.1	
MANCHESTER UNIVERSITY NHS FOUNDATION TRUST	29	28.9	High (0.025)
MID CHESHIRE HOSPITALS NHS FOUNDATION TRUST	2	6.1	
NORTH CUMBRIA INTEGRATED CARE NHS FOUNDATION TRUST	6	17.6	
PENNINE ACUTE HOSPITALS NHS TRUST	9	13.8	
SALFORD ROYAL NHS FOUNDATION TRUST	9	22.1	
SOUTHPORT AND ORMSKIRK HOSPITAL NHS TRUST	7	28.6	
ST HELENS AND KNOWSLEY TEACHING HOSPITALS NHS TRUST	3	6.6	Low (0.025)
STOCKPORT NHS FOUNDATION TRUST	8	23.6	
TAMESIDE AND GLOSSOP INTEGRATED CARE NHS FOUNDATION TRUST	5	22.8	
THE CHRISTIE NHS FOUNDATION TRUST	1	10.2	
THE CLATTERBRIDGE CANCER CENTRE NHS FOUNDATION TRUST	0	0.0	
THE WALTON CENTRE NHS FOUNDATION TRUST	2	27.5	
UNIVERSITY HOSPITALS OF MORECAMBE BAY NHS FOUNDATION TRUST	5	13.1	
WARRINGTON AND HALTON TEACHING HOSPITALS NHS FOUNDATION TRUST	5	15.1	
WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FOUNDATION TRUST	3	8.0	
WRIGHTINGTON, WIGAN AND LEIGH NHS FOUNDATION TRUST	4	14.0	
North West	151	16.7	

Pseudomonas aeruginosa - Annual rolling rate (July 2019 – September 2020)

Public Health England

Pseudomonas aeruginosa quarterly tables: Trust cases & rates

Organisation Name	July to September 2020	Rate per 100,000 bed days	Significance
ALDER HEY CHILDREN'S NHS FOUNDATION TRUST	0	0.0	
BLACKPOOL TEACHING HOSPITALS NHS FOUNDATION TRUST	2	5.0	
BOLTON NHS FOUNDATION TRUST	1	2.0	
COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST	3	8.7	
EAST CHESHIRE NHS TRUST	0	0.0	
EAST LANCASHIRE HOSPITALS NHS TRUST	3	5.8	
LANCASHIRE TEACHING HOSPITALS NHS FOUNDATION TRUST	7	16.7	
LIVERPOOL HEART AND CHEST HOSPITAL NHS FOUNDATION TRUST	0	0.0	
LIVERPOOL WOMEN'S NHS FOUNDATION TRUST	0	0.0	
LIVERPOOL UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	5	5.6	
MANCHESTER UNIVERSITY NHS FOUNDATION TRUST	8	8.0	
MID CHESHIRE HOSPITALS NHS FOUNDATION TRUST	0	0.0	
NORTH CUMBRIA INTEGRATED CARE NHS FOUNDATION TRUST	2	5.9	
PENNINE ACUTE HOSPITALS NHS TRUST	2	3.1	
SALFORD ROYAL NHS FOUNDATION TRUST	4	9.8	
SOUTHPORT AND ORMSKIRK HOSPITAL NHS TRUST	2	8.2	
ST HELENS AND KNOWSLEY TEACHING HOSPITALS NHS TRUST	3	6.6	
STOCKPORT NHS FOUNDATION TRUST	0	0.0	
TAMESIDE AND GLOSSOP INTEGRATED CARE NHS FOUNDATION TRUST	2	9.1	
THE CHRISTIE NHS FOUNDATION TRUST	0	0.0	
THE CLATTERBRIDGE CANCER CENTRE NHS FOUNDATION TRUST	0	0.0	
THE WALTON CENTRE NHS FOUNDATION TRUST	2	27.5	
UNIVERSITY HOSPITALS OF MORECAMBE BAY NHS FOUNDATION TRUST	2	5.2	
WARRINGTON AND HALTON TEACHING HOSPITALS NHS FOUNDATION TRUST	0	0.0	
WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FOUNDATION TRUST	4	10.7	
WRIGHTINGTON, WIGAN AND LEIGH NHS FOUNDATION TRUST	4	14.0	
North West	56	6.2	

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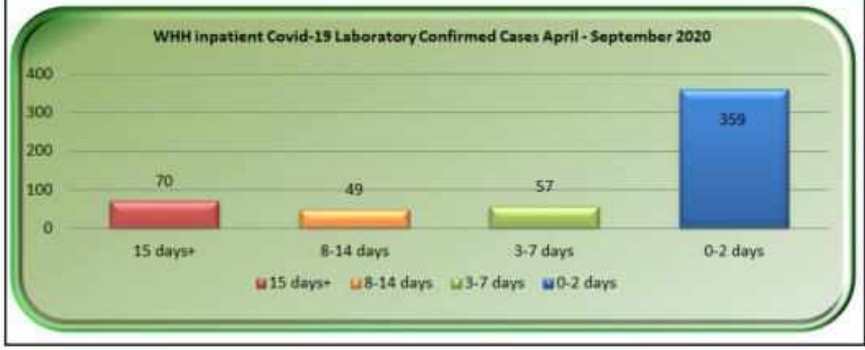
APPENDIX 3 COVID-19 Cases

HCAI data Financial Year 2020 - 2021

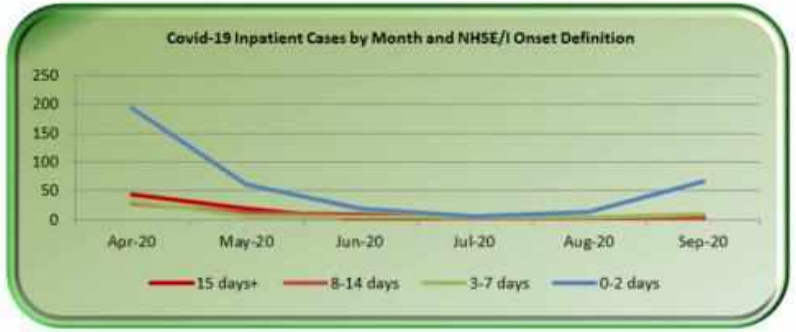
CDT | Bacteraemias | COVID-19

NHS Warrington and Halton Teaching Hospitals NHS Foundation Trust

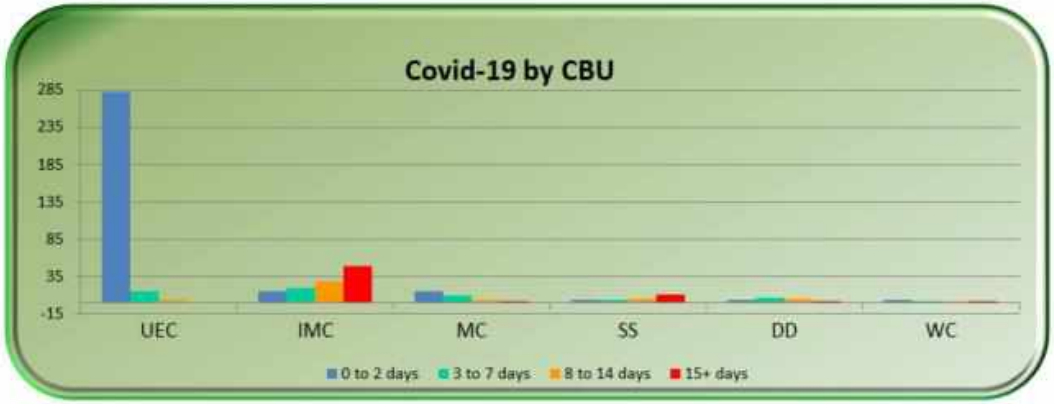
COVID-19 - Total inpatient cases from April - September



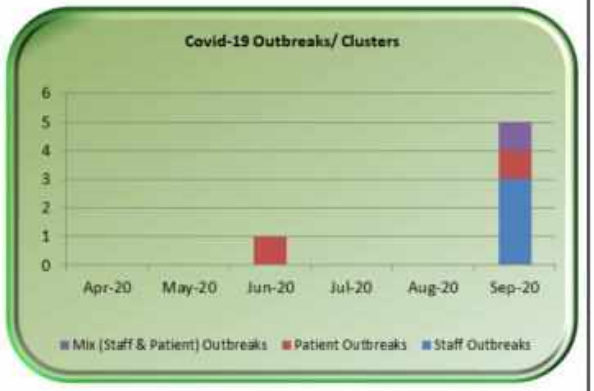
Covid-19 Cases by Month



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



Outbreaks



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REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/21/01/16**			
SUBJECT:	Learning from Experience Report - Q2 2020/21			
DATE OF MEETING:	27 January 2021			
AUTHOR(S):	Layla Alani, Deputy Director Governance			
EXECUTIVE DIRECTOR SPONSOR:	Kimberley Salmon-Jamieson, Chief Nurse & Deputy Chief Executive			
LINK TO STRATEGIC OBJECTIVE: (*Please select as appropriate*)	SO1 We will.. Always put our patients first through high quality, safe care and an excellent patient experience. 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*)				
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 2, 2020/21.			
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/20/12/144**		
	Date of meeting	**1 December 2020**		
	Summary of Outcome	**Noted**		
FREEDOM OF INFORMATION STATUS (FOIA):	**Choose an item.**			
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	**Choose an item.**			

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NHS Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS

SUBJECT	Learning from Experience Report 2020/21 Q2	AGENDA REF:	BM/21/01/16

1. BACKGROUND/CONTEXT

This report relates to the period 1st July – 30th September 2020 (2020/21 Q2). It contains a quantitative and qualitative analysis (using information obtained from the Datix risk system) including Incidents, Complaints, Claims, Health & Safety, Mortality and Clinical Audit. The report includes a summary of the key findings identified in Quarter 2 with specific recommendations.

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

2.0 KEY ELEMENTS - ITEMS FOR ASSURANCE FROM Q2

2.1. Incident Reporting

There was an increase in incident reporting in Q2 when compared to Q1 (1891 in 2020/21 Q1 vs 2447 in Q2). The notable reduction in reporting between April and May 2020 is considered a likely consequence of the Covid-19 pandemic. The 'Report to Improve' campaign will continue to be delivered for the remainder of the year.

2.2. Learning and Actions from Incidents

- Medication - An inpatient was prescribed and administered 480mg of gentamicin, when the correct dose should have been 330mg in accordance with the patient's age, ideal body weight and renal function. The day after this was administered the patient was diagnosed with acute kidney injury (AKI). A Rapid Incident Review was held to identify contributory factors, learning and actions from the incident:
    - A gentamicin calculator has been launched across the Trust. This calculator will allow support staff to undertake levels when appropriate.
    - Learning from the incident was shared at the Trust Safety Huddle and Medical/Surgical Handover.

- Medication - A patient was treated on the Intensive Care Unit (ICU) for diabetic ketoacidosis (DKA). When they were stepped down from ICU, their insulin was not prescribed on EPMA. The patient had a low threshold to ketosis and developed a further episode of DKA, which delayed their discharge. A Rapid Incident Review took place and identified the following learning actions:
    - Incident shared at ICU safety brief. The importance of prescribing all medicines on EPMA from the ICU prescription chart and other charts (E.g. Diabetes chart, Anticoagulation chart etc.) when patients are stepped down from ICU.
    - A concise root cause analysis is now being completed for the incident to identify further learning and actions.

Pressure Ulcer incidents, actions from learning:

- Following trial of Parafricta underwear (to reduce friction damage) on Ward B12 (FMN Unit) this is now available to order from supplies.
- Trial of oxygen therapy checklist on Ward A8 (following PU from oxygen tubing).
- All dressings and bandages to be removed on admission to check for pressure damage. Any pressure damage on admission is reported on Datix for the Tissue Viability Team to review.

- Information Governance

A member of staff accessed a patient's electronic record in order to document notes. This activated the automated NHS Spine trace which produced a suggested match and the wrong patient was selected. This resulted in a standard GP discharge summary being created for the incorrect patient. The discharge summary was then dispatched electronically to the GP for the incorrect patient. The following actions were taken:

- The error has been discussed for Trust wide learning at our Trust wide Safety Brief and via the Trust Communications bulletin
- Future training programmes for Lorenzo will include the NHS spine tracing and matching process for all Lorenzo users. It will also include guidance for the data correction procedure.
- A Safety Alert SOP/Poster has been circulated Trust wide providing screen shots of the NHS Spine Trace process – reiterating the correct action to take.

- A 91 year old patient with a medical history of Type 2 diabetes and Cerebrovascular accident (CVA) had a fall at home, attended ED and was admitted to the acute medical ward for an x-ray which did not identify any concerns. The patient was optimized for discharge. There was a catheter in situ and a community DNAR in place. A diabetic foot ulcer was also noted which required a district nurse referral. The referral was not made and the incorrect medications were provided on discharge. Learning points:
    - EPMA was reviewed with the EPMA pharmacist to make the dose information for certain medications clearer for prescribers.
    - Guidance for intermediate care placements for three facilities to be reviewed by the discharge team.
    - Reflective learning was completed by pharmacy staff involved in the clinical checking, dispensing and accuracy checking of medications.

Patients from 3 clinics had no follow up. E outcomes were completed in the clinic but the appointments remained in a 'booked in' status causing a delay of 3 months. The 'e-outcome' is a separate system to Lorenzo that records the outcome of attendance and instructs the booking staff of the future management generally managed in real-time. If patients fail to attend reception to 'book-out' of a clinic or as in this case it is a telephone clinic there is a safety net in place to capture any outcomes that are 'missing'. An information report highlights all missing outcomes and the reception area is identified during the clinic build. In this incident they were incorrectly attributed to a team in the background and fell into a category of 'other' rather than OPD. As a consequence this clinic was 'not in the sight' of the appointments team.

This issue was caused by an IT issue and the way in which the 'Other' clinic has been built but the proposed safety net of inserting a start date should prevent a reoccurrence. Actions following the no harm incident:

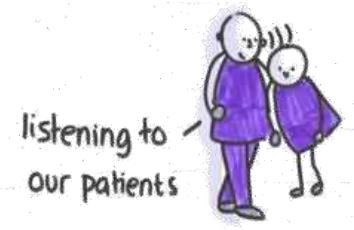
- The EPMA dose sentences were reviewed with the EPMA pharmacist to make the dose sentences for certain medications clearer for prescribers.

- Guidance for intermediate care placements for three facilities to be reviewed by the discharge team.
- Reflective learning was completed by pharmacy staff involved in the clinical checking, dispensing and accuracy checking of medications.

Covid-19 outbreak with 4 definitive hospital acquired Covid positive patients. Learning points:

- The EPMA dose sentences were reviewed with the EPMA pharmacist to make the dose information for certain medications clearer for prescribers.
- Guidance for intermediate care placements for three facilities to be reviewed by the discharge team.
- Reflective learning was completed by pharmacy staff involved in the clinical checking, dispensing and accuracy checking of medications.

2.3. Complaints and PALS



- Over the 2019/20 financial year, all Clinical Business Units made significant improvement in responding to complaints on time. A number of complaints breached during Q2 (n=5%), however at the time of reporting all complaints are being responded to within timeframe. This has been improved with the support of additional paralegal staff temporarily funded through existing nursing and governance vacancies.
- The Trust had a target to respond to 90% of complaint on time and in Q2 the Trust achieved 95%.
- There was a 113% increase in complaints opened Trustwide in Q2 (115 in Q2 versus 54 in Q1).
- 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 action reports are also made available Trustwide on a weekly basis.

- The Trust currently has 2 open PHSO cases. The PHSO closed one investigation in Q2.

2.4. Mortality

- As part of the mortality review process, 50 SJRs were conducted during Quarter 2. Most of these cases were rated 'Good' with some 'Adequate' also being discussed. 5 SJRs reported the overall care grading as Excellent'.
- 'DoLS/LD patient' was the highest trigger for an SJR in Q2.
- The Summary Hospital Mortality Indicator (SHMI) and Hospital Standardised Mortality Ratios (HSMR) remained within expected range.
- The Mortality Review Group has become a virtual meeting during the period of Covid-19 ensuring that appropriate assurance and oversight has been maintained. Deaths are being reviewed and discussed at the group which continues to have external representation from our Commissioning bodies.

- The MRG have prepared terms of reference for a Focused Review into COVID-19 deaths. This review commenced in Q2 with the aim to complete the review by Q3.
- MRG 'Case of the Month' has been launched, providing lessons learned from MRG.

2.5. Clinical Audit

- There are a number of audits ongoing across the Trust. For Q2 this briefing makes reference to the National Lung Cancer Audit. The audit findings are favourable indicating significant assurance.
- Major Haemorrhage Protocol has been audited locally in Quarter 2 to provide prompt feedback to clinicians and laboratory staff; problems that occur are addressed immediately. The audit highlighted no significant issues with major haemorrhage within the Trust, thus providing a high level of assurance.

2. KEY LEARNING FROM SI INVESTIGATIONS CONCLUDED IN Q2

- **Lorenzo Discharge Issue - Lessons Learned**
    - The LOR190 PAN response tested the PAN process and processes with the Lorenzo EPR. A number of recommendations have emerged from this investigation. The importance was highlighted for the Trust to undertake a review of the discharge summary content and format in partnership with its primary care stakeholders given a simplified form of discharge summary is currently provided.

- **JJ Stent Insertion Never Event - Lessons Learned**
    - A clear line of communication between the surgeon and the radiographer is required, and the radiographer must advise if the image intensifier is not accurately focused.

- **Baby born with Hypoxic Ischaemic Encephalopathy (HIE) - Lessons Learned**
    - Pre-eclampsia can have many presenting symptoms. In the case of mild hypertension and proteinuria, adequate follow-up arrangements should be made for monitoring of potential pre-eclampsia.
    - Humoral hypercalcaemia of pregnancy is a rare disease but needs to be considered in cases of persistent tachycardia.
    - The number of handovers in a unit increases the potential for error.
    - Handovers should be facilitated by a written or electronic process that is clear to all members of the team.
    - Consistency of senior team members is important in delivering good patient care over an admission period.
    - When referrals are made by the Obstetric Team to other specialties, it should be very clear from the start what is expected by the referral: i.e. when telephone advice only is being sought, and when face to face assessment is required.
    - Women in the third trimester calling the Obstetric Unit for advice relating to their pregnancy should normally be assessed and triaged by the Obstetric Team in the Obstetric Unit. If staff require support they should speak to the senior obstetric doctor to agree where the most appropriate place of care is for the patient.
    - If patients attend ED with a pregnancy-related problem without having contacted the Obstetric Unit, and require further care, then

transfer should not be delayed, and communication between the two teams should be effective and prompt.

- For the very small number of patients who are sent to ED from the Obstetric Unit, there should be effective and prompt communication between the two teams regarding what is required from the ED team, specifying how Obstetric Team oversight will be maintained whilst the patient is in ED. The Obstetric team may need to attend the ED to see the patient if the woman is very unwell. This should be a Consultant to Consultant request.
- Information should be shared with all clinical and nursing ED Staff that the MEWS rather than NEWS score should be used in the assessment of pregnant women.
- Ultrasound scanning in ED by ED clinicians should not be used as a way of providing reassurance about fetal wellbeing.

3. ITEMS FOR ESCALATION FROM Q2

4.1. Clinical Incidents

- There was an increase of 16 incidents causing Moderate to Catastrophic harm in Q2 (16 in Q1 vs 32 in Q2), recognising the reduced incident reporting noted in Q1 as a result of the Covid-19 pandemic. However the number of harm incidents (32) reported Q2 is within normal variation.
- The Trust reported 281 incidents open in CBUs in the Q1 LFE. This increased to 440 in Q2 as a consequence of operational pressures across the Trust in Q2. The Patient Safety Manager now provides a weekly assurance report to the Associate Director of Governance regarding the closure of actions. Further escalation is actioned to the Deputy Director of Governance as necessary. Providing feedback and closing incidents in a timely manner remains an important focus and work will continue to ensure that performance improves and CBUs are supported during the Covid-19 pandemic.

4.2. Non-Clinical Incidents

- From 1st July to 30th September 2020, there were 328 non-clinical incidents reported. The top 2 categories were Security Incidents and Health & Safety Incidents.
- Injury to staff was the top reported sub-category for Health & Safety Incidents, followed by needlestick injuries. This is being monitored by the Health & Safety team for themes and trends.

4.3. Complaints

- Staff attitude and behaviour complaints increased by 117% in Q2. It is recognised that in Q2 there was a significant increase in the number of complaints received.
- There was a 5% decrease in the number of complaints meeting timescales during Q2 compared to Q1. The Trust achieved 95% in quarter 2 when compared to 100% in Q1. This is as a result of the Covid-19 pandemic.

4.4. Claims

- Payments for clinical claims settled with damages totalled: £4,133,182 excluding costs;
- Payments for non-clinical claims settled with damages totalled £10,670. Learning from individual claims continues to be disseminated and a thematic deep dive of claims is being undertaken.

5.0 RECOMMENDATIONS

The Board of Directors is asked to note the report.

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QUALITY PEOPLE SUSTAINABILITY

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Learning From Experience Q2 Report

Layla Alani

Deputy Director of Governance

November 2020

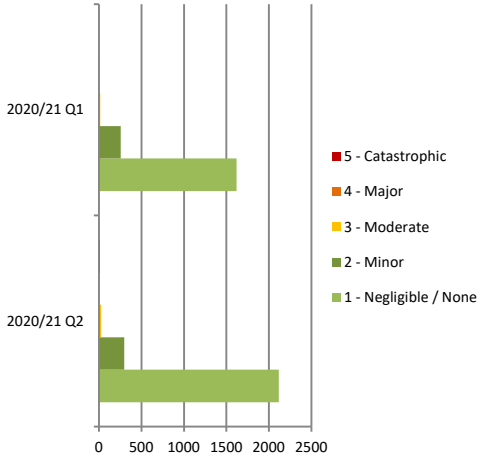
Overview

The following slides provide an overview of the information extracted from the Datix system and other clinical governance reports for Incidents, Complaints, Claims, Health & Safety, Mortality and Clinical Audit related to Quarter 2, 2020/21. They should be viewed in conjunction with the High Level Briefing Report.

Incident Headlines Q1 vs Q2

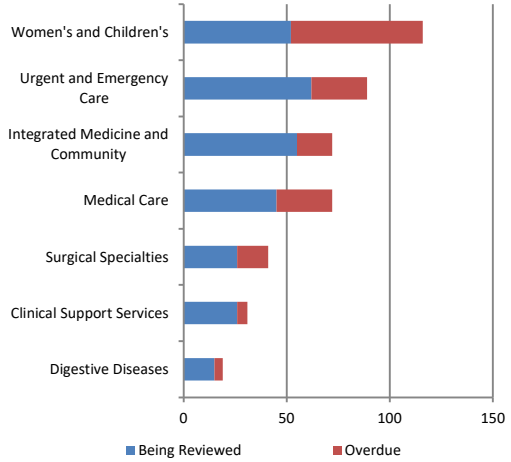
How many staff are raising incidents Q1 vs Q2?

- There was a 29% increase in incident reporting within the Trust in 2020/21 Q2 (1891 in 2020/21 Q1 vs 2447 in Q2).
- There was an **increase** in incidents causing Moderate to Catastrophic harm in Q2 (16 in Q1 vs 32 in Q2)
- The number of no harm incidents reported increased by 31% in Q2 following notable reductions in reporting in April and May 2020 – partly attributed to the Covid-19 pandemic. In response to this, the 'Report to Improve' campaign was relaunched.



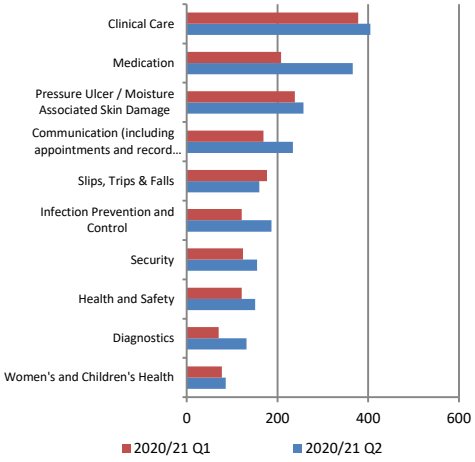
How many incidents are open Q1 vs Q2?

- The Trust reported 281 incidents open in CBUs in the Q1 LFE. To date that has increased to 440. The graph below shows the 7 CBUs with open incidents and the number of which are overdue.
- Providing feedback and closing incidents in a timely manner remains an important focus and work will continue to ensure that performance improves and CBUs are supported during the Covid-19 pandemic.



What type of incidents are we reporting Q1 vs Q2?

- As stated, there was an increase in the amount of incidents reported. Incidents relating to clinical care, medication, communication, infection prevention and diagnostics increased in Q2 following the overall increase in incident reporting.
- Incidents relating to slips, trips and falls decreased in Q2.



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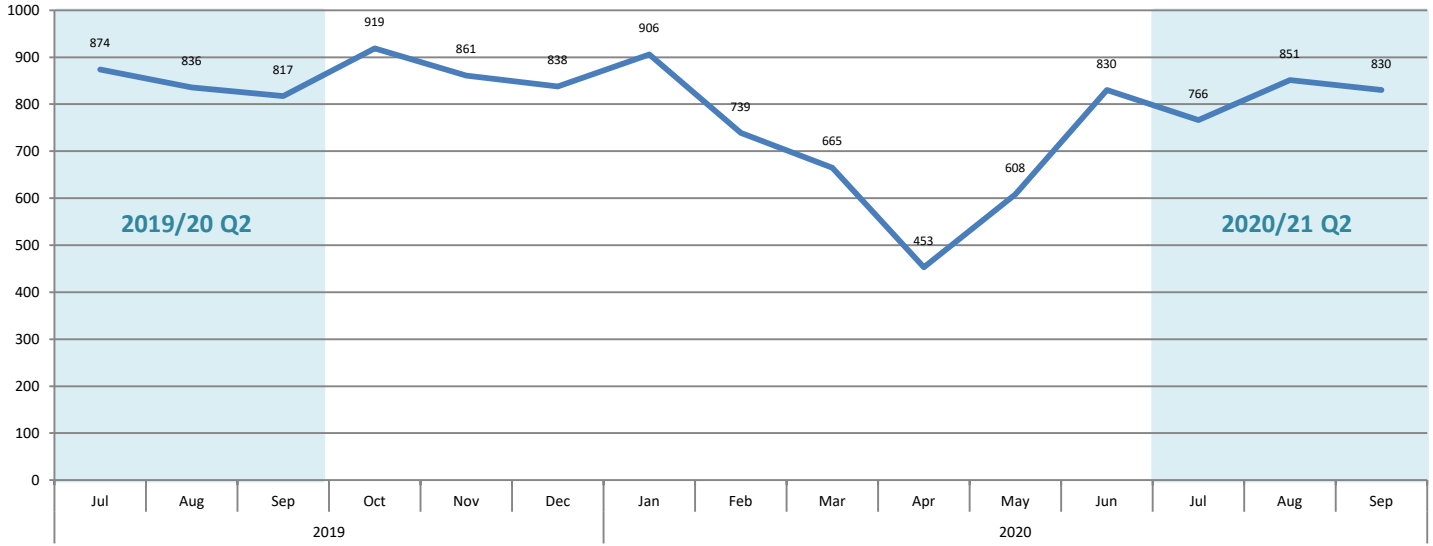
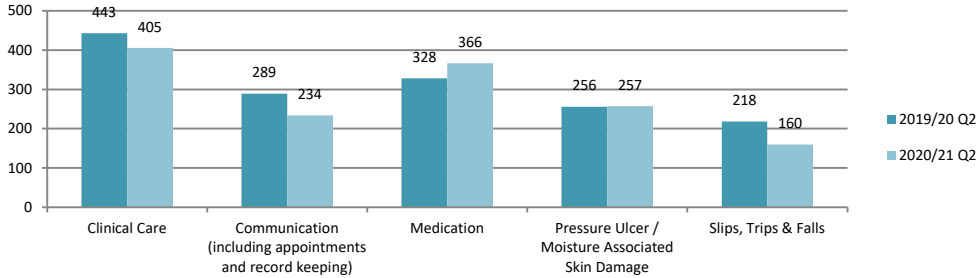
Incident Reporting 2020/21 Q2 vs 2019/20 Q2



In 2020/21 Q2 there was a 3% reduction in incident reporting when compared to 2019/20 Q2. However, in August and September 2020 incident reporting increased.

Comparison of Top 5 Incidents Reported



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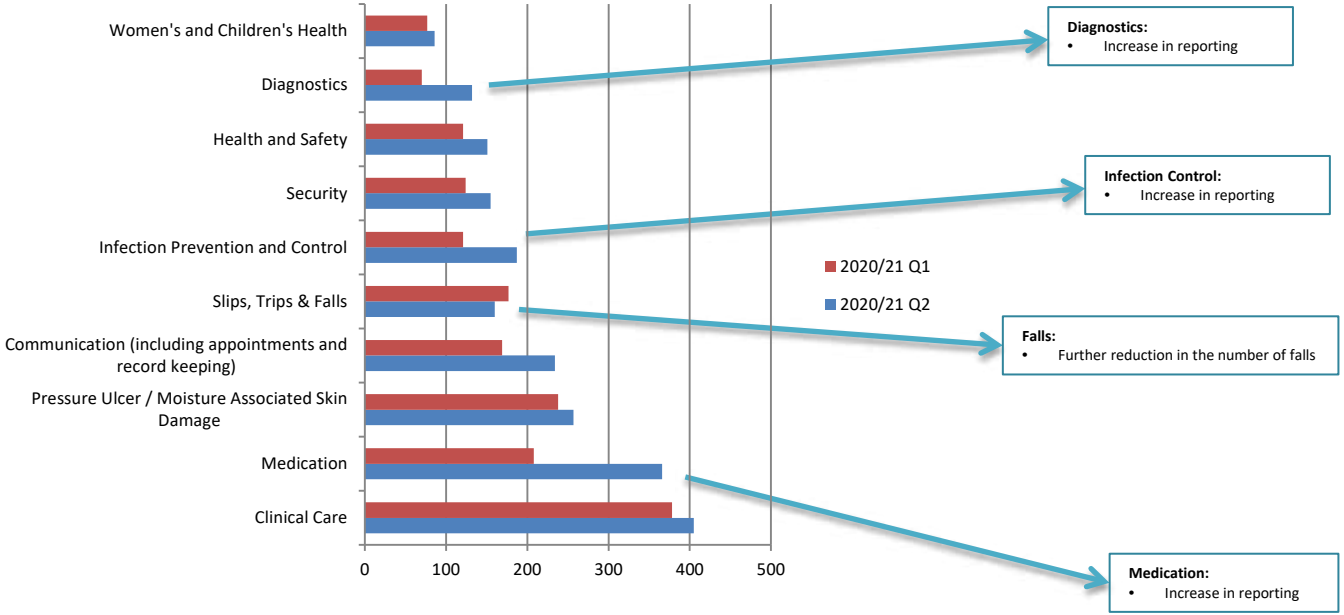
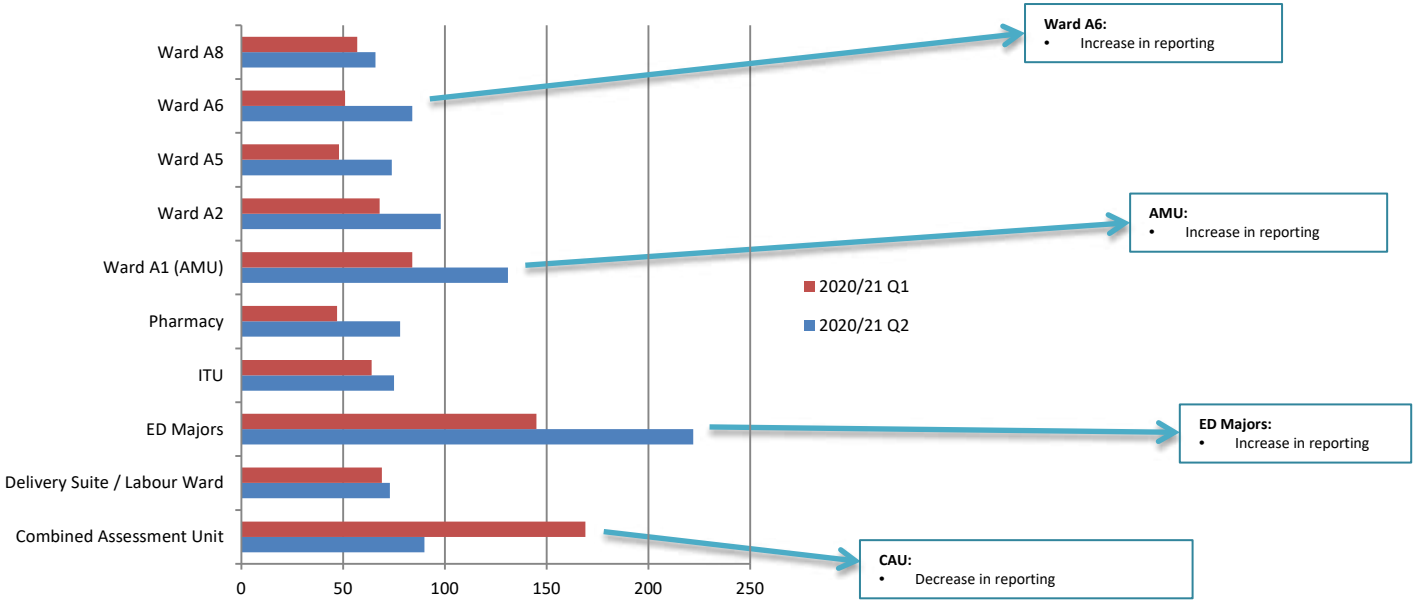
Incident Category Analysis Q1 vs Q2

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



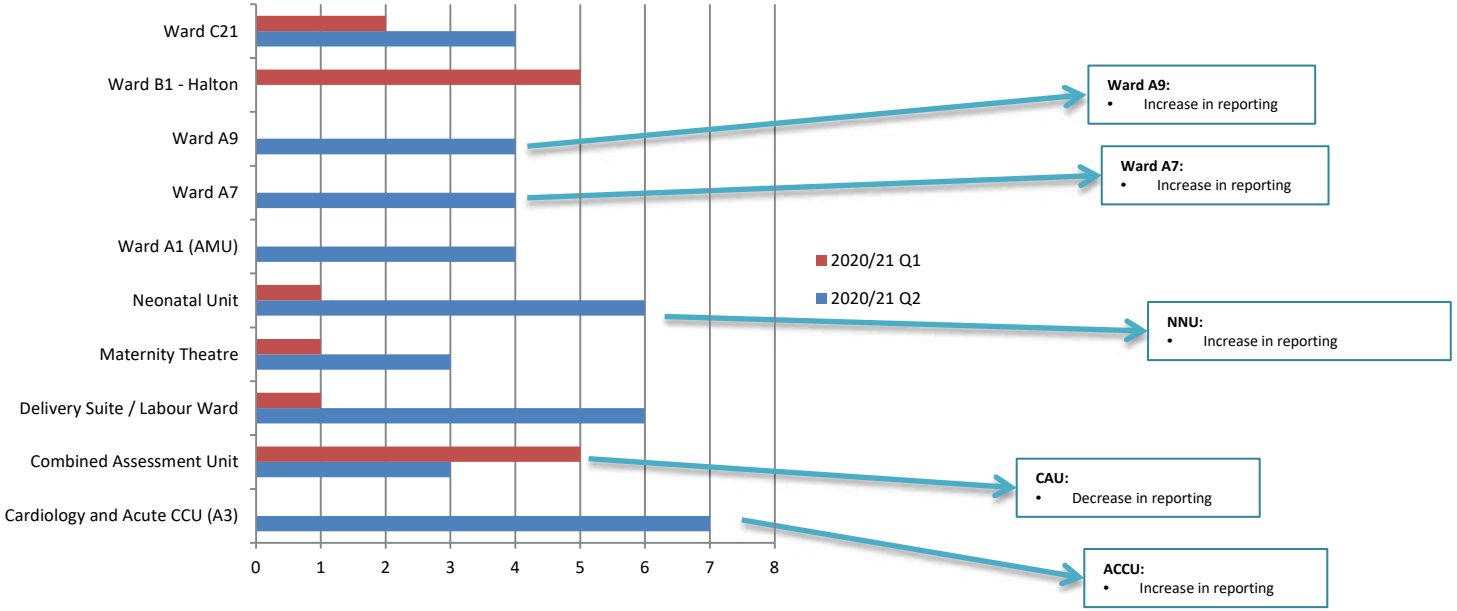
Incident Location Analysis Q1 vs Q2

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



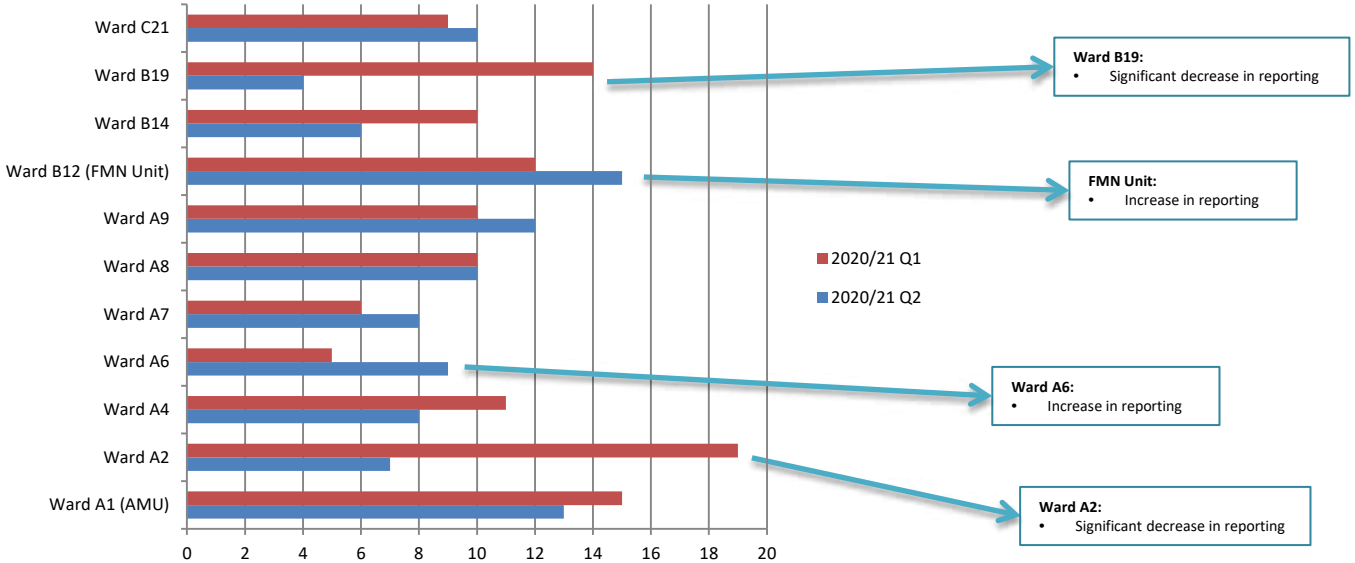
Staffing Incidents Location Analysis Q1 vs Q2

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



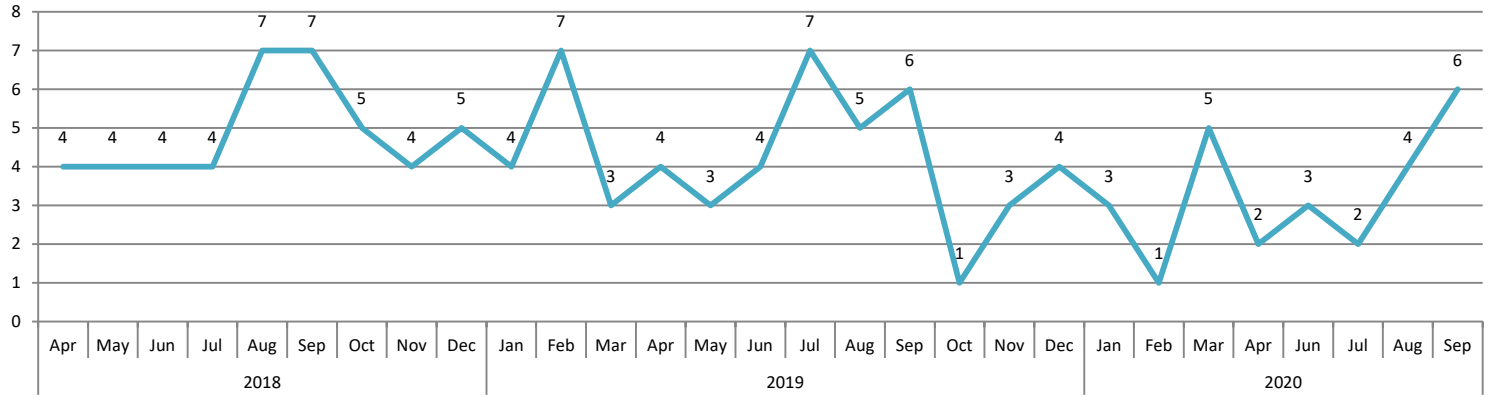
Patient Falls Location Analysis Q1 vs Q2

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

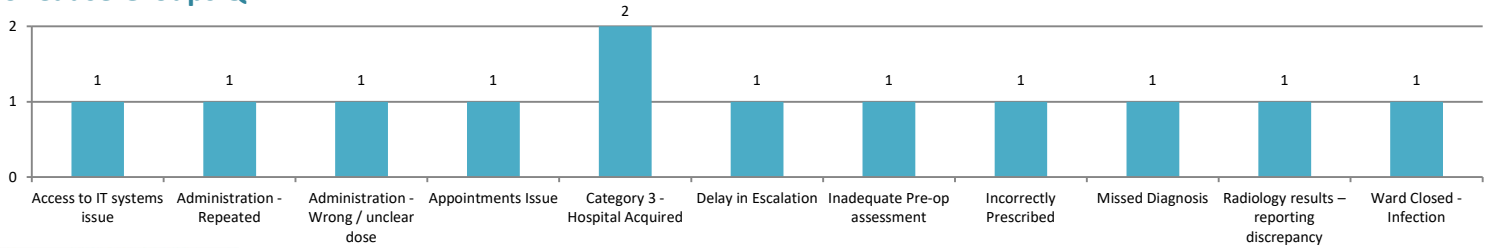


Serious Incident (SI) Reporting

SIs reported by Month



SI Cause Groups Q2



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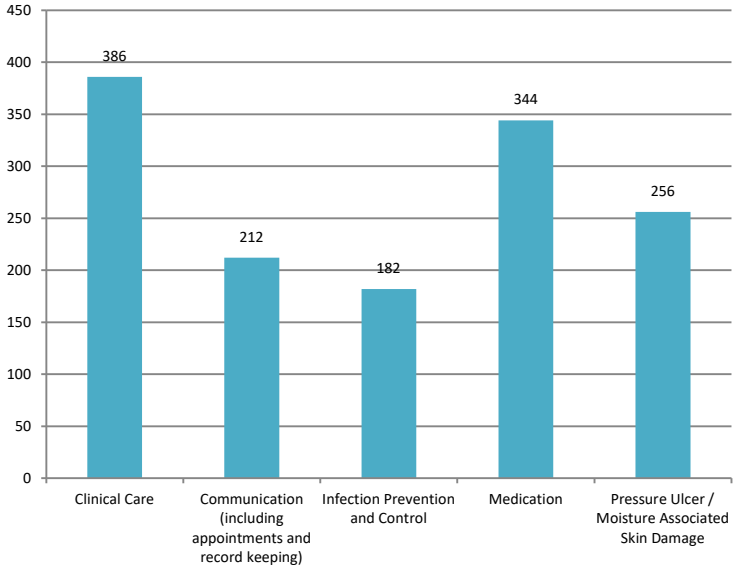
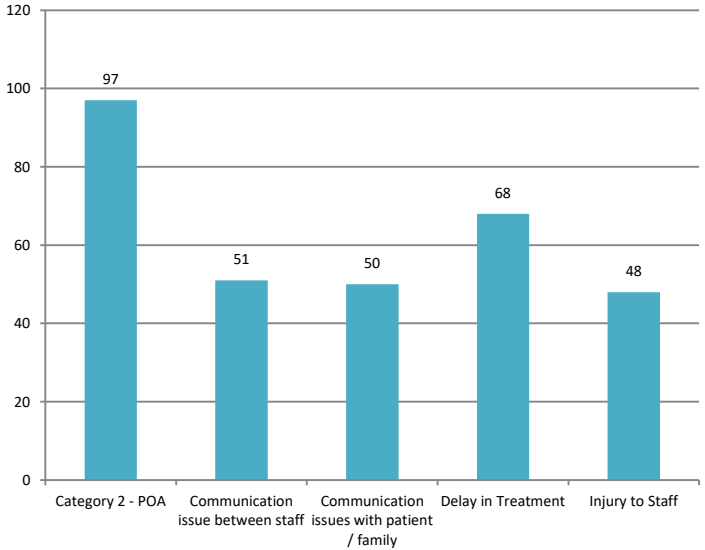
Across the 7 CBUs in Q2

A total of 2264 incidents were reported across the 7 CBUs in Q2, this has increased from 1759 from Q1.

The top 5 categories and subcategories in Q2 were reported as follows:





Learning from Incidents – Medical Care

1. We found….

A 76 year old admitted with reduced air entry and a NEWS2 score of 6. IV antibiotics were commenced and the patient was transferred to the Respiratory ward.
During the stay there were 2 episodes of elevated NEWS2 which should have prompted a MET call but did not. The increased oxygen requirement (60%) was not highlighted to the night staff. There were amendments on the NEWS2 chart which were not signed and had been scribbled out instead of a line marked through. There was a delay in requesting a medical review when the NEWS2 score was again elevated in the morning. Once the review was completed the patient was admitted to the ITU.

We Acted….

- The need to follow guidelines on appropriate action required for a high NEWS2 score were reinforced
- A process was implemented that any NEWS2 score requiring action must be documented on Lorenzo including actions.
- Staff were reminded that any alterations to the NEWS2 chart must be signed - countersigned if made by a student.
- A process was implemented that Ward Handover will include a review of the NEWS2 chart.
- Staff were reminded to countersign all student's documentation and record any advice given.
- Staff working at the time of the incident performed personal reflections.
- Feedback provided to the university regarding the incident / omission by the student to sign the alterations on the NEWS2 chart.
- A review the possibility of incorporating an electronic NEWS2 chart to be completed.
- A Skills passport was created for student nurses rotating through A7 to ensure a high level of practical skills

2. We found….

A 91 year old patient with a medical history of Type 2 diabetes and Cerebrovascular accident (CVA) had a fall at home, attended ED and was admitted to the acute medical ward for an x-ray which did not identify any concerns. The patient was optimized for discharge. There was a catheter was in situ and a community DNAR in place. A diabetic foot ulcer was also noted which required a district nurse referral. The referral was not made and the incorrect medications were provided on discharge.

We Acted….

- EPMA was reviewed with the EPMA pharmacist to make the dose information for certain medications clearer for prescribers.
- Guidance for intermediate care placements for three facilities to be reviewed by the discharge team.
- Reflective learning was completed by pharmacy staff involved in the clinical checking, dispensing and accuracy checking of medications.

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Learning from Incidents – Integrated Medicine and Community

1. We found….

A 59 year old patient with Down's Syndrome, Depression, Hypothyroidism and a recognised learning disability, had numerous admissions with D&V over a period of months since first diagnosed with C Diff. During admissions and in the community there was input from a variety of specialities including the SALT team as the patient was known to have a poor appetite and intake. However there was limited documentation to highlight an awareness of staff to be aware that patients with learning difficulties will be less likely to report a reduced intake. There was also a lack of fluid balance sheets during the admission though overall the documentation was of a very high standard. There was also an ibleep for bloods to be repeated but the bleep was not responded to and the failure to respond was not followed up by the nursing staff.

We Acted….

- Feedback was provided to the nursing team regarding the lack of fluid balance sheets.
- Awareness was raised via a staff safety bulletin of the need to be aware that patients with learning difficulties will be less likely to report a reduced intake and therefore it is vital ask direct questions and document the answers.
- Staff were reminded to follow up any unanswered ibleep's.
- There was feedback to the nursing team of the positive findings regarding the observations charts and clearly documented actions throughout the admission.

2. We found….

A 76 years old patient with a severe T12 compression fracture who lacked capacity and had a DOLs in place was fitted with a TLSO brace for comfort and to assist with mobility was being discharged home following a full home assessment and plans were made to support the family.
2 weeks post discharge the patient was discovered to be taking medication belonging to 2 other patients who were inpatients at the time of discharge.
All discharge medications were supplied from pharmacy and as the patient did not have a blister pack It is thought that when the tote box of discharge medications were unpacked on the ward the boxes had fallen out of the bag containing all three patients discharge medications and they were all put into the same bag and provided to the patient on discharge.

We Acted….

- There was an immediate telephone consultation with the GP who discussed the medications and the plan regarding continuing / discontinuing the medications with the hospital chief pharmacist who advised to reduce the dose of one medication in half and monitor for any withdrawal effects then for the GP to further review.
- Arrangements were made by the pharmacy to collect the medications and provide some information regarding withdrawal symptoms
- The lead Consultant for the patient's care also reviewed the medications provided and any possible side effects
- There was a full apology to the patient and the family
- The Nurse who performed the discharge completed a reflective practice regarding the incident
- Staff were reminded that discharge medication must be checked by two nurses with the discharge prescription and discharge summary

Learning from Incidents – Radiology

We Found….

A 26 year old lady expecting her 3rd baby was booked for an anomaly scan at 22 weeks which is outside of the Fetal Anomaly Screening Programme guidelines for the first attempt at an anomaly scan. The appointment was booked incorrectly by a member of the Radiology administration team.

We Acted….

- The scan was completed and no evidence of structural defect was detected on the scan.
- The patient was informed of the error and an apology given.
- Public Health England (PHE) was informed and a Screening Incident Assessment Form (SIAF) completed.
- PHE responded to the SIAF to say they are happy for the incident to be managed internally.
- The incident has been included in the staff safety huddle to ensure staff are aware to use the digital calculator.
- A reflective discussion will take place regarding a review of the booking procedure for the follow up ultrasound scan, using the digital calculator with the individual member of staff who made the booking.
- All members of the booking team to be reminded to use the digital calculator when booking the anomaly scan.

We Found….

A patient attended ED following a fall from a bike - working diagnosis of a dislocated shoulder. An x-ray was reported on the same day as no abnormality. A second x-ray was not reported for 3 days. When it was reported as a missed Bankart fracture.

The second image was added to the queries folder on CRIS where Advanced Practice Radiographers place complex images for Radiologist review. A member of the clerical team will allocate the exams to a Consultant Radiologist for reporting. The person who normally does this is not currently working and less experienced members of staff, managing the reporting overlooked this particular task.

We Acted….

- Feedback was provided to the reporting radiologist trainee. a missed fracture but a very subtle one and as such easy to miss.
- Feedback was provided to the clerical staff regarding the delay in requesting review.
- The acute management would still be the same, whether a Bankart fracture fragment is there or not but an apology was provided to the patient for the missed fracture.
- The case was presented at the REALM meeting for review and learning.
- There was a review of the process for getting a senior review of x-rays: Advanced practice Radiographers to request a Radiologist review of the image at the time of reporting for complex images.

Learning from Incidents – Clinical Support Services

We Found…

Three boxes (30 ampoules) of a Controlled Drug (fentanyl) were ordered from pharmacy for Endoscopy. When the drugs were delivered to endoscopy they were being checked into the CD book by staff nurses when it was noted that there was one rather than the 2 seals expected on one box. As the affected box appeared to have been in use previously the staff opened the seal of the 3 boxes to undertake a count and found the following. 30 ampoules had been ordered but only 26 were received.
A contributing factor for the incident appears to be the rapid/unplanned decommissioning of wards during the COVID pandemic which has resulted in the return of part boxes of medication.

We Acted….

- Endoscopy staff to open and check all boxes of CD medications from this point on when signing them into the CD log book regardless of the seal.
- Pharmacy staff members involved in the incident to complete reflective practice to be shared with the line manager.
- The feedback and learning from this incident to be provided to pharmacy staff and the correct process for reporting such incidents to the senior pharmacist to be highlighted.
- The decommissioning process to be reviewed and a single point lesson regarding the process to be produced

We Found…

Patients from 3 clinics had no follow up. E outcomes were completed in the clinic but the appointments remained in a booked in status causing a delay of 3 months. The ‘e-outcome’ is a separate system to Lorenzo that records the outcome of attendance and instructs the booking staff of the future management generally managed in real-time. If patients fail to attend reception to book-out of a clinic or as in this case it is a telephone clinic there is a safety net in place to capture any outcomes that are ‘missing’. An information report highlights all missing outcomes and the reception area is identified during the clinic build. In this incident they were incorrectly attributed to a team in the background and fell into a category of ‘other’ rather than OPD. As a consequence this clinic was ‘not in the sight’ of the appointments team.
This issue was caused by an IT issue and the way in which the ‘Other’ clinic has been built but the proposed safety net of inserting a start date should prevent a reoccurrence.

We Acted….

- An immediate check was completed to ensure all attendees at the three clinics were seen and followed up appropriately
- IT to insert a start date in the report to enable the appointments team to see if any new clinics have appeared on the report to provide the opportunity to check they are assigned correctly and reassign if necessary.
- All members of the appointments team advised of the need to run a report to detect this cohort of patients

Learning from Incidents – Urgent & Emergency Care

What happened…	Learning action points
Delay in Escalation The patient arrived in ED via ambulance (not standby). The ambulance crew booked the patient into ED reception at 23:30. There was no documentation of anyone taking over the care of the patient. There were HUB patients who were very unwell and the ambulance crew stayed with the patient until someone could take over. The normal process is that a nurse would take over and complete the navigation form to determine where to allocate the patient in ED. At 00:35 the triage nurse observed that the patient appeared unwell and took him to the high care area where his observations were completed and the clinician reviewed him. The staff advised that ED had high acuity at the time and there is an expectation for the ambulance to complete observation if they remain with the patient. However, as no documented handover it is unclear who took responsibility for the patient from 23:30 to 00:35. The nurse coordinator did escalate the ED acuity to the site manager on call. A serious incident investigation is taking place due to the severity of the incident.	A review of the patients care detected that although the normal process is that triage takes place within 15 minutes of attendance to ED, in this case this did not occur. The navigation form is usually completed when a patient is accepted by the ambulance team. There is no completed navigation form to evidence a handover. There is usually intentional rounding where the coordinators have oversight of the activity in ED and there is no documentation that this occurred.

Learning from Incidents – Urgent & Emergency Care

What happened…	Learning action points
Failure to monitor patient Patient BIBA following 15ft fall resulting in dislocated shoulder. The patient received 12.5mg of morphine and 1g paracetamol via the paramedics prior to attendance. Upon arrival the patient expressed considerable pain and a further 10mg of morphine were prescribed as a stat dose. Following titrated administration of 10mg a further 10 mg of morphine were prescribed as a stat dose. 5 mg are recorded as being administered and the patients pain levels were brought under control to perform a reduction of their shoulder. Following the reduction the patient reported no concerns of pain and was left for around 15 minutes. Upon returning to patient bedside, patient was found cyanosed. Naloxone was prescribed with little effect and patient was intubated and transferred to ITU. 48 hours later it was reported that the patient had suffered a hypoxic brain injury and a Serious Incident Investigation was declared.	Findings for the initial rapid incident review found that there was no documentation on ED paperwork of the medication received prior to attendance. An immediate action shared with the team included documentation of any medication in the triage notes. There was also a lack of cumulative sight of the dose given to the patient due to the prescription of two stat doses. An immediate action shared with the team was that titrated doses should be prescribed as PRN to allow overview of total dose given.
Delay in prescribing time critical medication A patient with a significant history of liver disease acutely suffered an exasperation of a query GI bleed. The sudden onset of GI bleed is likely to have had a significant impact blood sugar as the levels had remained stable and not requiring fixed dose sliding scale. Two drugs which were known to be likely causes of agitating the GI bleed were stopped. The review noted numerous accounts that it had been difficult to cannulise the patient and a number of successful attempts had been removed by the patient. It was noted a cannula was in place when the BM increased but a second cannula was required to deliver the fixed dose sliding scale insulin.	The review concluded the patient had recovered and although it was not acceptable for such delays to take place, the patient recovered from this incident and was discharged within a few days following treatment for their original presenting complaint. Missed opportunity was upon detection of unstable blood sugar there was a delay in this patient being reviewed and therefore prescribed appropriate medication by the medic.

Learning from Incidents - Surgical Specialities

What Happened?	Learning action points
Covid-19 outbreak with 4 definitive hospital acquired Covid positive patients	• Recognition of limitations of test accuracy and higher suspicion of false negative results in presence of other symptoms. • Ensure screening of symptomatic patients at time of symptom onset • Improved communication from community setting regarding confirmed Covid-19 incidence in Care Homes from which patients admitted to hospital • When an x-ray has been reported as 'patchy air space opacities' this has been confirmed as similar to 'ground glass changes' therefore the parent team should consider the patient may be COVID 19 positive.
A patient with delirium was found with his call bell wrapped around his neck twice. Staff members removed the call bell and gave the patient reassurance. Observations were monitored throughout and enhanced care temporarily put in place.	• When a patient has shown signs of self-harm or suicidal ideation a ligature risk assessment must be completed immediately. • When a patient is showing signs of confusion or agitation staff members can consider inviting the next of kin to be in attendance. This can provide reassurance and grounding for the patient.

Learning from Incidents - Digestive Diseases

What happened…	Learning action points
A patient with learning disabilities was admitted with Gastroenteritis. The patient was usually on OD Phenytoin suspension 30mg/ 5ml 55ml through her PEG tube but through her admission was prescribed BD Phenytoin 55ml. The patient started to show signs of nystagmus and lowered levels of alertness which resolved.	• When completing clerking, the doctor must ensure that the information provided on SCR is used appropriately. • When the patient is receiving medicines reconciliation stage 1 and 2 the pharmacy technician and pharmacist must ensure that all information is used before verifying. • When a patient with learning disabilities and non- verbal autism attends the Trust all opportunities must be taken to confirm the patient's baseline and document appropriately. • Phenytoin toxicity is predominantly neurological including nystagmus, ataxia, reduced conscious level and convulsions.
Patient attended clinic on 28.2.20 for review of two cutaneous lesions which were metastases. SHO was asked to do a punch biopsy under supervision and book a staging CT scan. SHO inadvertently booked the CT scan for the wrong patient. Although the CT performed on the wrong patient confirmed a pathology which required urgent management this was still classed as a radiation incident and reported externally.	• For clinicians to check carefully that they have identified the correct patient before filing any details on the system.

Learning from Incidents – Children's Health

What happened…	Learning action points
5 week old baby diagnosed with epilepsy was discharged home with a new bottle of Keppra which was contained in a sealed box. The box contained a 10ml oral medicine syringe and a 1ml syringe had been supplied separately. The baby's dose was 0.9ml. In error the father used the 10ml syringe that came in the medicine box to draw up 9mls. The baby had too much Keppra and was brought to hospital for urgent review.	Observations and blood tests were normal and the baby did not display any clinical signs of side effects from the drug. It was a minor harm incident as the baby had to have blood tests taken. Learning to pharmacy and ward staff to thoroughly check TTOs that only the correct size oral medicine syringes are supplied with the medication.
Potential tissue injury from cord clamp 5 day old baby in neonatal unit had suspected tissue injury. Referred to tissue viability nurse for review. Injury was caused by rubbing from cord clamp when baby positioned prone.	Staff advised caution when positioning babies prone and cord clamp still attached.
Learning from a recent Rapid Incident Review when a 4 year old boy died of cardiac arrest in the Emergency Department. The child was known to have congenital heart disease and nephrotic syndrome. A child death is a stressful and distressing event for all involved and the care that this child and his parents received is commended. They were kept informed and involved in decision making.	The learning is that the Pan-Cheshire Guidelines for The Management of Sudden Unexpected Death in Infants and Children (SUDIC) is to be completed in all cases when a child was not expected to die 24 hours before the death occurred.

Learning from Incidents – Women's Health

What happened…	Learning action points
Delay in postnatal blood transfusion	• On reviewing a recent incident where a woman had a 12 hour delay before receiving a blood transfusion, there was an opportunity to complete this on labour ward before the woman was transferred to the postnatal ward. When a plan is made for a woman to receive a blood transfusion, this should be prescribed and completed as soon as possible and not handed over to the postnatal ward if it is possible to complete on labour ward.
Incidental findings and learning shared from perinatal mortality review	• A woman booked late at 18+4 weeks. The reason for this was not documented in the maternity notes. Learning: Explore more when completing the booking about why women book late for maternity care and document this. • Women who are being induced in labour are classified as high risk and should have a formal risk assessment completed. • A partogram should be used for women experiencing pregnancy loss as it is required to monitor the progress of labour and maternal clinical condition.
Concerns were raised regarding a woman with complex risk factors who was booked for induction on a Friday	• Response and reassurance from the senior obstetric and midwifery team: It was appropriate to look at all planned induction admissions in view of safe staffing; when there are no issues with staffing, there is no reason to postpone planned care. It is appropriate to continue caring for all women 24/7 irrespective of clinical factors such as obesity, scarred uterus. • Women with raised BMI only as a risk factor receive their anaesthetic reviews on admission to induction bay/labour ward during the Covid-19 pandemic.

Learning from Medication Incidents

We found…..	We acted…..
An inpatient was prescribed and administered 480mg of gentamicin, when the correct dose should have been 330mg for the patient's age, ideal body weight and renal function. The day after the patient was diagnosed with acute kidney injury (AKI).	• A Rapid Incident Review was held to identify contributory factors, learning and actions from the incident. • Learning from the incident was shared at the Trust Safety Huddle and Medical/Surgical Handover. • A gentamicin calculator has now been launched across the Trust to help prescribe the most appropriate dose of gentamicin for the patient and when levels need to be taken.
A patient was treated on ICU for diabetic ketoacidosis (DKA). When they were stepped down from ICU, their insulin was not prescribed on EPMA. The patient had a low threshold to ketosis and developed a further episode of DKA, which delayed their discharge.	• A Rapid Incident Review was held to identify contributory factors, learning and actions from the incident. • Incident shared at ICU safety brief and the importance of prescribing all the patient's medicines on EPMA from the ICU prescription chart and other charts they may have in use (E.g. Diabetes chart, Anticoagulation chart etc.) when patients are stepped down from ICU. • A concise root cause analysis is now being completed for the incident to identify further learning and actions.

Learning from Incidents – Pressure Ulcers

- The Pressure Ulcer Collaborative programme recommenced in September.
- New Cheshire and Merseyside Pressure Ulcer Patient Information leaflet is now available to order and should be available on every ward.
- Accurate documentation on care and comfort charts to be reinforced including prescribed care. Spot checks by Ward Managers/Matrons.
- Following trial of Parafricta underwear (to reduce friction damage) on Ward B12 (FMN Unit) this is now available to order from supplies.
- Focus on pressure ulcer prevention e-learning to improve compliance.
- Trial of oxygen therapy checklist on Ward A8 (following PU from oxygen tubing).
- Admissions checklist and 'at a glance' board implemented on Ward B19.
- All dressings and bandages to be removed on admission to check for pressure damage.

Learning from Incidents – Information Governance

We Found	We Acted….
A member of staff accessed a patient's electronic record in order to document notes. This activated the automated NHS Spine trace which produced a suggested match and the wrong patient was selected. This resulted in a standard GP discharge summary being created for the incorrect patient. The discharge summary was then dispatched electronically to the GP for the incorrect patient.	• The error has been discussed for Trust wide learning at our Trust wide Safety Brief and via the Trust Communications bulletin • Future training programmes for Lorenzo will include the NHS spine tracing and matching process for all Lorenzo users. It will also include guidance for the data correction procedure. • A Safety Alert SOP/Poster has been circulated Trust wide providing screen shots of the NHS Spine Trace process – showing the correct action to take.
Confidential information sent to a third party's address due to an error within the Radiology Secretaries' team. This happened due to the CRIS Radiology system not interfacing with other systems and lack of updates to patients details when GP referrals are received by Radiology directly.	• Incident reported to ICO (Information Commissioner's Office) who took no further action against WHH • Radiology standard procedure for checking every patient's address for every referral has been reiterated to Radiology staff

Complaints Headlines Q1 vs Q2

How many people are raising complaints Q1 vs Q2?

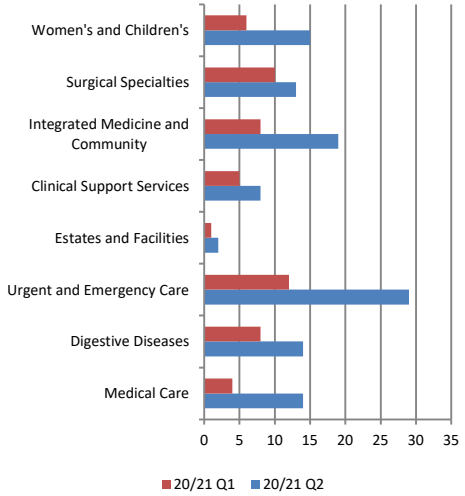
- There was a 113% increase in complaints opened Trustwide in Q2 (115 in Q2 versus 54 in Q1).
- Each CBU saw an increase in the number of complaint received during Q2.

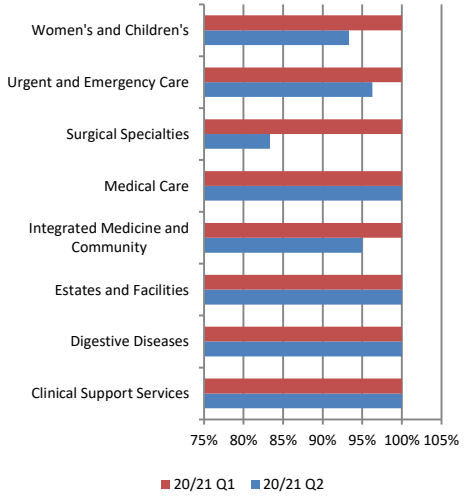
Are we Responsive Q1 vs Q2?

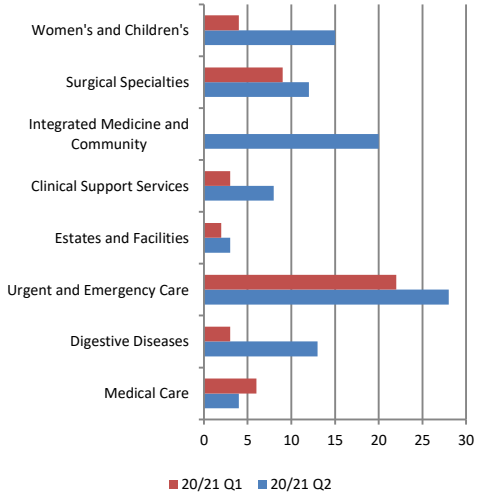
- There was a decrease in the number of complaints meeting timescales during Q2.
- Surgical Specialties, Integrated Medicine and Community, Women's and Children's and Urgent and Emergency Care have decreased in the number of complaints closed on time
- The Trust had a target to respond to 90% of complaint on time and in Q2 the Trust achieved 95%.
- The Trust currently has 0 breached complaints
- There is one complaint over 6 months old

How many complaints has the Trust closed Q1 vs Q2?

- There was an increase in the number of complaints closed in the Trust in Q2 (102 in Q2 versus 45 in Q1).
- Integrated Medicine an d Community, Urgent and Emergency Care, Surgical Specialties, Women's and Children's , Digestive Diseases, Clinical Support Services and Estates and Facilities have increased in the number of complaints closed in Q2. Integrated Medicine and Community have seen the highest decrease.
- Medical Care have decreased the amount of complaints they have closed.

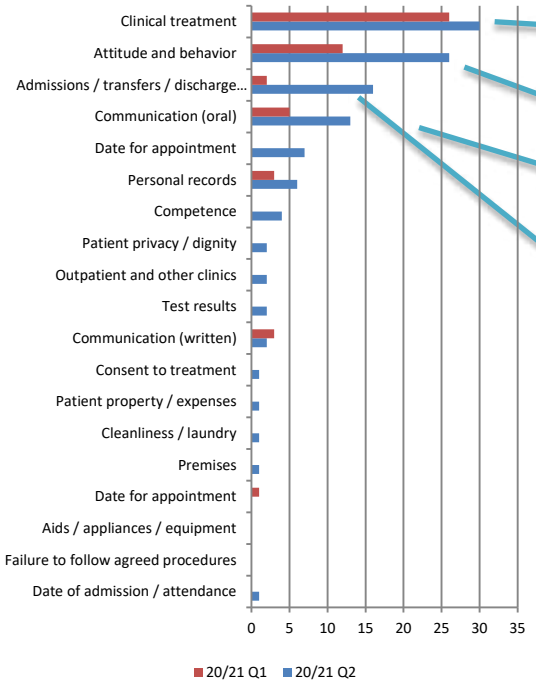






Complaints Analysis Q1 vs Q2

The information shows the top subjects in complaints in Q1 vs Q2.
Note: Complaints can have more than one subject.



Clinical treatment:
- There was an increase in the number of complaints received in Q2 compared to Q1 regarding clinical treatment (30 in Q2 verses 26 in Q1). Concerns include coordination of medical treatment, wrong diagnosis and problems with medication.
- Insensitive to patients needs and communication issues can also be linked to when the Trust is on full capacity.

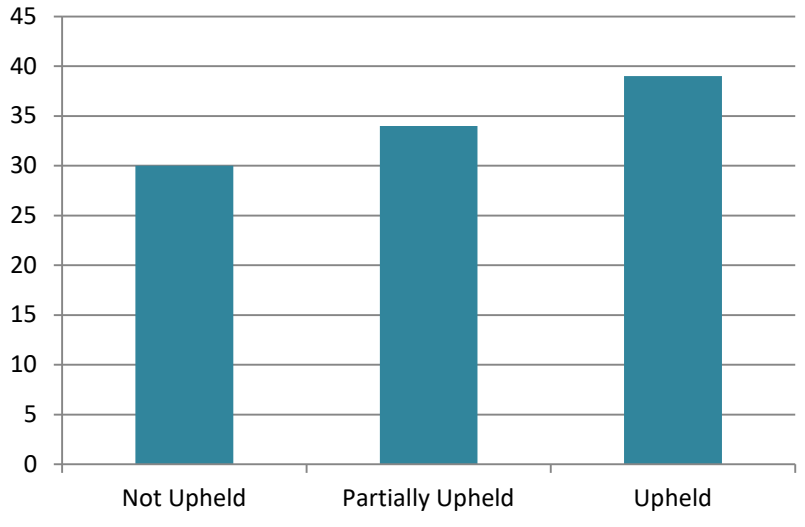
Communication and Attitude and Behaviour:
- Staff attitude and behaviour has increased by 14 in Q2 compared to Q1.

Admissions, transfers or discharge procedures:
- In Q2 there has been an increase in complaints relating to inappropriate discharges.

Complaints Outcomes Q2

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.

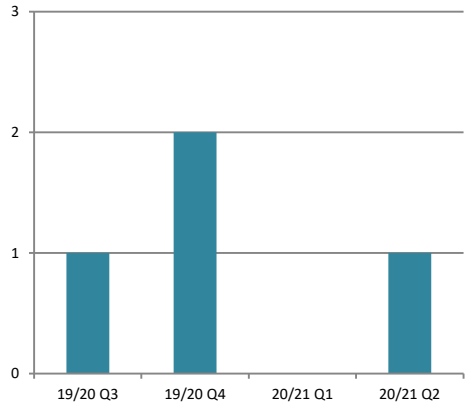
A complaint will be “upheld”, “upheld in part” or “not upheld”.



PHSO Q2

So how many complaints do they investigate?

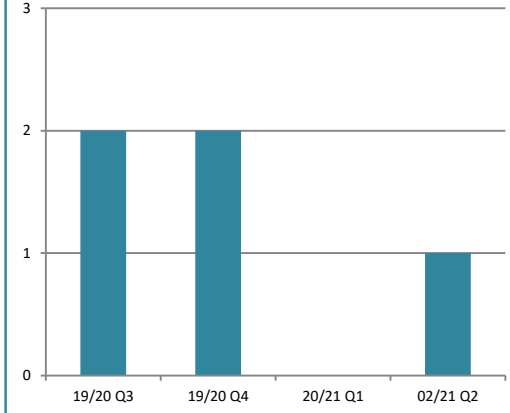
The PHSO has commenced 1 investigation into the Trust in Q2. The PHSO closed 2 investigations during Q2.



Complainants dissatisfied with the Trust's response have the right to ask the Parliamentary Health Service Ombudsman (PHSO) to consider their complaint. 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.

And what are the outcomes?

The Trust currently has 2 open PHSO cases. The PHSO closed 1 investigation in Q2.



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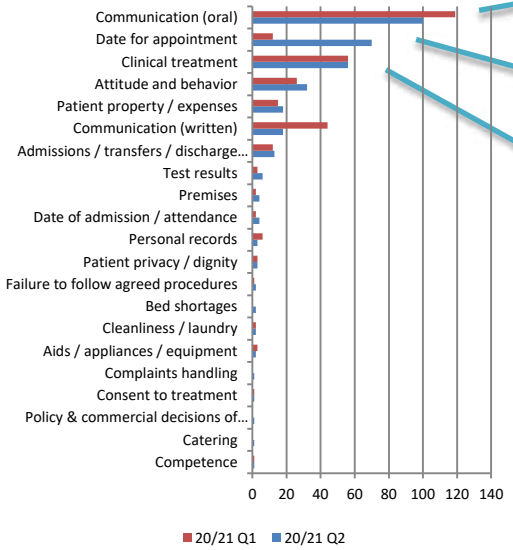
PALS Analysis Q1 vs Q2

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



Communication:
- Difficulties with telephone communication
- Lack of clear explanation
- Misunderstandings
- Patient not verbally being told things

Date for an appointment:
During the Covid-19 pandemic there has been an increase in the number of PALS concerns relating to Appointments including : -
- Unacceptable time to wait for an appointment
- Appointment date continues to be rescheduled
- Cancellation of appointment

Clinical Treatment:
- Co-ordination of medical treatment
- Delay in treatment
- Poor aftercare
- This is also mirrored in the complaints analysis.

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

Q1	Q2
7 days	6 days

PALS to Complaints:

Q1	Q2
0	2

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Learning from Complaints

You Said….	We Did….
A patient raised concerns regarding the management of early pregnancy loss whereby the ward staff she spoke to over the telephone were not as responsive as they should have been.	The Women's and Children's CBU have produced guidance for relating to pregnancy complications for ward attenders and inpatients. The guidance sets out the escalation process and advises for staff to follow to ensure that the patient is fully supported.
A relative raised concerns that the discharge paperwork was not of a high quality and lacked information	The Integrated Medicine and Community CBU have implemented a 'ward round proforma'. This document details standard practice with respect to diagnosis during admission, medication changes made with clinical reasoning and, follow up plans. The proforma will help to ensure safe patient discharges. In addition, when new doctors join the Trust, they will be appraised at induction and the start of their placement about how the proforma can be used to provide accurate discharge summaries.
A patient raised concerns that they were given conflicting information about being admitted to hospital and an associated scan.	The Digestive Diseases CBU have reviewed the process for surgical patients who are assessed as fit to go home and return for planned investigations or review. A Standing Operating Procedure has been developed to ensure a smooth process for patients.

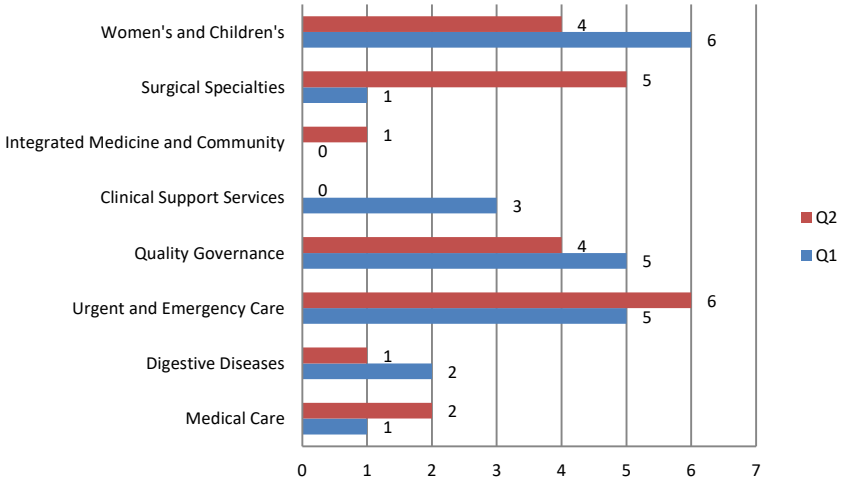
Complaints Headlines

- 115 complaints were opened during Q2 2020/21, which is an increase of 113% compared to Q1 (54). The increase is a result of the Covid-19 pandemic and the national pause placed on the complaints process during Q1.
- In Q2, the number of complaints relating to admissions, transfers or discharge procedures have increased compared to Q1.
- There has also been an increase in the number of attitude and behaviour, communication, date for an appointment and clinical treatment complaints in Q2 compared to Q1.
- 338 PALS concerns were received during Q2 2020/21, which is a 10% increase compared to Q1
- There has been an increase in the number of PALS concerns received regarding a date for an appointment where unacceptable time to wait for an appointment, an appointment date continues to be rescheduled and cancellation of appointments has been raised.
- The Trust received 17 dissatisfied complaints in Q2 2020/21; which is an increase of 113% compared to Q1 where there was 8.
- In Q2, 3 complaints were closed and deemed to require an SI investigation.

Analysis of Claims Received Q2

Clinical Claims Received 2021/20 Q1 v Q2

Q1: 23 Received
Q2: 23 Received



23 Claims received via:
- 2 Incident (ERS)
- 1 Letter of Claim
- 20 Requests for notes

There has been 444 request for notes via Medico-Legal Services
(314 previously in Q1)

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Analysis of Claims Closed Q2

Clinical Claims Closed Q2 2020/2021

10 Claims closed with damages (totalling £4,133,182.85* (excluding costs))

Clinical Business Unit	Repudiated	Settled with damages	Withdrawn	Total
Clinical Support Services	0	1	2	3
Digestive Diseases	1	3	1	5
Medical Care	0	0	1	1
Surgical Specialties	2	5	3	10
Urgent and Emergency Care	1	0	3	4
Women's and Children's	1	1	2	4
Total	**5**	**10**	**12**	**27**

* 1 claims settled with periodic payments with additional annual payments for life

Non-Clinical Claims Closed Q2 2020/21

3 Employer Liability Claims closed with damages (totalling £10,670.82 (excluding costs))

Specialty	Details
T&O	Assaulted by patient
Ophthalmology	Slipped on wet floor
Theatres	Hit by falling object

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Action taken on Clinical Claims

Radiology

Failure to diagnose	• Discussed at Radiology learning meeting. • Although rare, the case was included in the ED missed x-rays teaching presentation which is shared with the ENPs and doctors as an interesting and unusual case

General Surgery

Negligent management of pressure sores	• Discussed at bed management – Trauma Nurse/Matron to liaise with ward to ensure patients are place appropriately
Poor technique to remove dressing	• All staff reminded via safety brief to use the "stretch and release" technique to remove cannula dressing • All staff reminded via safety brief to complete incident reports in any injury occurs

Trauma and Orthopaedic

Failure to diagnose jaundice in new born infant resulting in brain damage	• Since this case we have implemented a much more detailed guideline on the identification and treatment of jaundice in the newborn based on the NICE guideline. • All junior (SHO level) doctors receive training regarding neonatal jaundice within a few weeks of commencing their post. • The neonatal nurses have a high awareness of the importance of checking bilirubin levels. • The gestation specific bilirubin charts are easily available on the neonatal unit and are filed securely within the nursing folder along with the observation charts. • All this documentation is subsequently filed in the case notes. • One of the issues in monitoring bilirubin is the need for repeated invasive blood tests. - We now have non-invasive bilirubinometers available for babies over 35 weeks, a new model has just become available which allows testing of lower gestation babies and direct linking to the Éclair software which I am going to assess in the near future - this would extend the ability for routine testing on the neonatal unit without an increase in blood testing. Ideally these machines should also be available for community midwives, although the risk in well babies is much lower, kernicterus has been seen in the UK in that group.

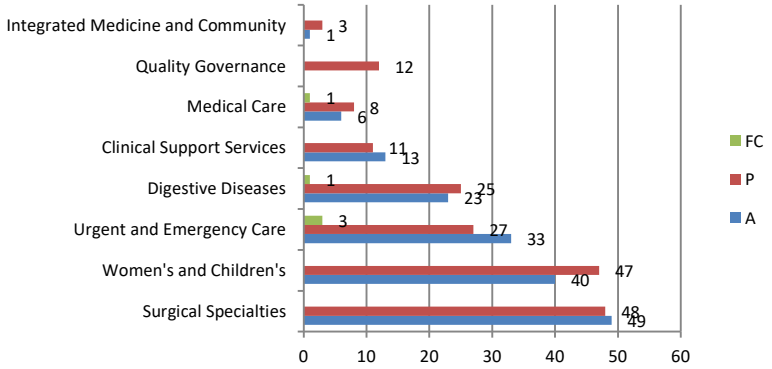
Action taken on Clinical Claims

Trauma and Orthopaedic

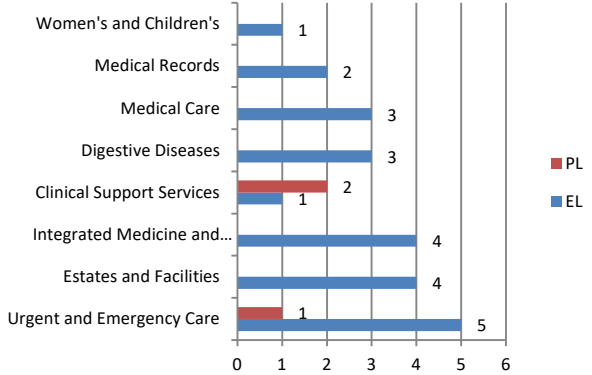
Failure to diagnose tumour	• The clinicians involved in the management of patient should reflect on the findings of this investigation. • The orthopaedic department to review the organisation of the trauma week which allows sufficient time for reviewing ward patients as well as operating time. This would also include making any specialty referrals • The Walton centre is in the process of reviewing their regional referral system (ORION) and should update WHH when this is complete. • WHH to adopt a standard communication note within electronic patient records (Lorenzo) which documents advice provided from other hospitals. This should include the person who is giving the advice, documented management plan and who the information has been handed over to. • This case should be presented at all CBU Morbidity and Mortality meeting to illustrate the lessons learned below.
Displacement of screw during hip surgery	• Clinician involved should complete a formal written reflection and meet with the educational supervision to review and discuss the incident for learning. The formal written reflection was completed and the educational supervisor met with ST6 and is satisfied that learning has taken place. The discussion is recorded in ST6 official mid-term review on the inter-collegiate surgical curriculum program (ISCP). • Report the incident to the deanery as part of the inter-collegiate surgical curriculum program. This is reviewed by the training programme director. • Share the report at the orthopaedic specialty meeting

Claims Position – End of Q2

352 **Clinical Claims** open
165 Actual (Formal Claim) | 181 Potential (Request for notes) | 5 Coroners Funding



26 **Non-Clinical Claims** open
23 Employer Liability |3 Public Liability



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

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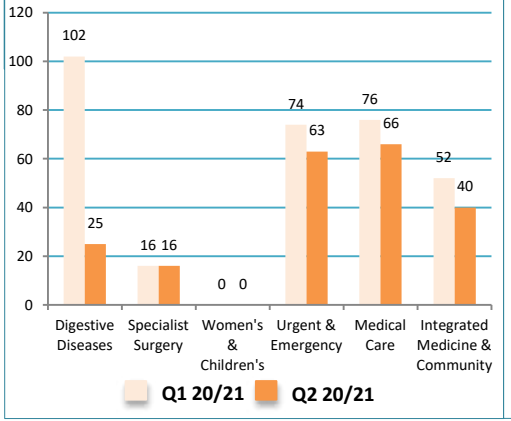
Mortality Headlines

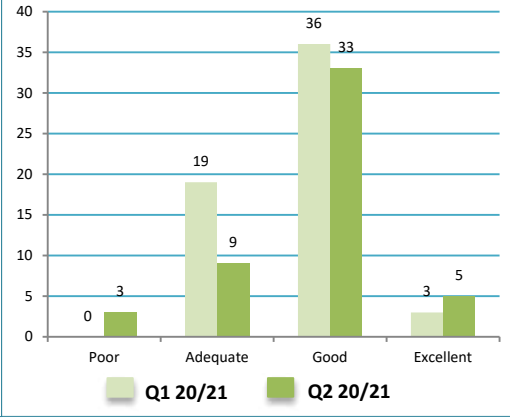
Q2 CBU Mortalities

As expected, the three CBUs with the most mortalities in Q2 are the ones with the greatest throughput and largest number of patients with multiple comorbidities: Medical Care, Integrated Medicine & Community and Urgent & Emergency Care.



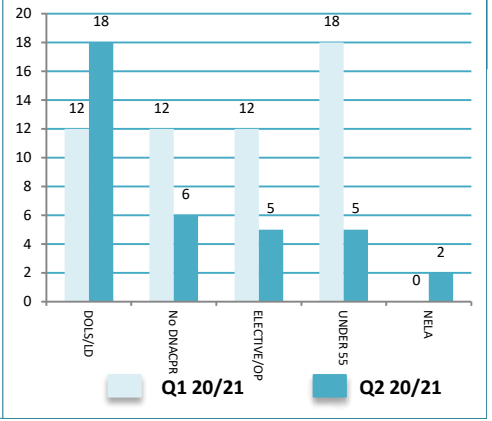
Q2 SJRs – Overall Care Grading

The majority of SJRs conducted have found that our overall standard of care is rated as “Good” followed by “Adequate”, although “Excellent” care was also evident within the reviews.



Q2 Triggers for SJRs

Comparing to Quarter 1, ‘DoLS/LD patient’ has become the highest trigger for an SJR in Q2.



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Headlines of Learning from Deaths

- The Mortality Review Group has become a virtual meeting. Deaths are being reviewed and discussed at the group which continues to have external representation from our Commissioning bodies.
- SHMI and HSMR, are within the expected range at present.
- The MRG have prepared terms of reference for a Focused Review into COVID-19 deaths. This review commenced in Q2 with the aim to complete the review in Q3.
- MRG 'Case of the Month' has been launched, providing lessons learned from MRG.

Learning from National Audits

Royal College of Physicians | National Lung Cancer Audit

NHS Warrington and Halton Teaching Hospitals NHS Foundation Trust

Summary:

The audit covers patients with a diagnosis of lung cancer who have been classified with code C34 (ICD-10), and where the diagnosis was made between 1 January and 31 December 2018. NHS hospitals in England submit the details for all lung cancer patients, including patients undergoing lung cancer surgery, to the NLCA, via the National Cancer Registration and Analysis Service (NCRAS) as part of the Cancer Outcomes and Services Dataset (COSD).

Summary of results for WHH: Firstly, as of now, the trust has not received a specific outlier status notification from NLCA for any of the below key metrics for this audit period.
Below are results for WHH (comparing with 2017 figures, national mean & national audit standards) including red, amber and green rating of individual measures on whether they are statistically significantly different to national mean.

Action Required
Improve pathological confirmation rate
Expansion of Lung CNS hours
Further improvement in surgical resection rates and oncology treatment rates

Assurance Rating:

Significant

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

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1. **Data completeness Metrics –**

Metric (%)	2018 cohort	2017 cohort	National Mean	Audit standard
Performance status recorded	94.9 ↑	93	85.3	95
Cancer stage recorded	96.9 ↑	95	95.8	95

2. **Process Metrics –**

Metric (%)	2018 cohort	2017 cohort	National mean	Audit standard
Overall PCR	63.1 ↑	60	69.4	NA
PCR in stage I/II PS 0-1	77.2 ↔	77.8	85	93
Assessed by CNS	75.9 ↑	71.5	74	90

PCR – Pathological confirmation rate; **CNS** – Cancer nurse specialist

3. **Treatment Outcome Metrics –**

Metric (%)	2018 cohort	2017 cohort	National mean	Audit standard
Curative treatment in NSCLC	73.3 ↑	64.8	80.5	80
Surgical resection in NSCLC	16 ↔	14.3**	18.3	17
Chemotherapy in SCLC	63.2 ↑	44	69	70
SACT in PS 0-1 advanced NSCLC	57.1 ↑	51	66	65
1 year survival	38.6 ↔	40	38.9	NA

NSCLC – Non small cell lung cancer; **SCLC** – small cell lung cancer; **SACT** – systemic anti-cancer therapy
** See 2017 exec summary for explanation of lower than expected *adjusted* surgical resection rate (unadjusted rate – 17.7%).

Learning from Local Audits

Major Haemorrhage Protocol activations during 2019

Background:

Major haemorrhage activations are audited prospectively to provide prompt feedback to the clinicians and laboratory staff; problems that occur are addressed immediately. The information is collated on a yearly basis and reviewed by the Hospital Transfusion Committee. Doing so gives an insight to where they occur, the type of patients involved, problems encountered, trends happening etc.

Key Findings:

Major haemorrhage activations have more than doubled in 2019, some of this is due to the introduction of 'Code Red' activations in AE. Unstable trauma patient's en-route to one of the major trauma centres are now being diverted to local hospitals. These patients are often hard to cannulate, hence samples for blood transfusion are difficult to obtain. The one downside of 'Code Red' activations can be seen in the increase of group AB FFP wastage; a price we have to pay for having the blood and FFP on-site in AE prior to the patient presenting

The audit shows prompt action from the laboratory; blood whether emergency, group specific or cross-match was available for the patient within the set timeframe set by the region.
It took greater than 15 minutes following activation for 68% of pre-transfusion samples to be sent to the laboratory; possibly contributing to the increased need for emergency blood on a ward setting. In 2018 this was 34%.

Learning from Local Audits - continued

Major Haemorrhage Protocol activations during 2019

Conclusion:

The audit highlighted no significant issues with major haemorrhage within the Trust. The number of activations had doubled yet the wastage of blood components was less than in 2018. The introduction of 'Code Red' for trauma patients was working well and there was no inappropriate use of O RhD Negative blood. There is a need however, to send the pre-transfusion sample sooner; the key performance indicator is that the sample should be sent in less than 15 minutes from activation. This is to prevent the need for emergency blood by using group specific or cross-matched units.

Recommendations:

Include activation process in doctors induction for 2020 – FY Induction 28/07/2020, ST Induction 05/08/2020, included in presentations

Assurance:

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

Non-Clinical Incidents Q2

From 1st July to 30th September 2020, there were 328 non-clinical incidents reported. The top 2 categories were:

Security incidents = 63

The top sub-categories were:

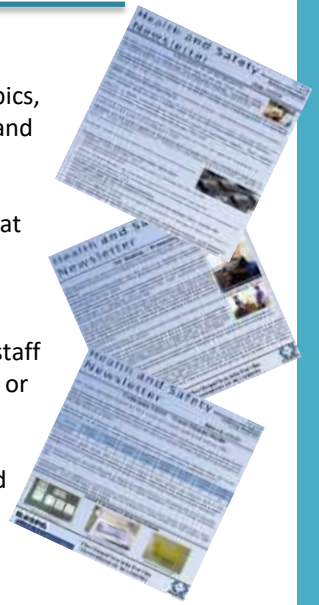
- Aggressive behaviour by patients/relatives
- Loss
- Abuse - verbal

Health and Safety incidents = 113

The top sub-categories were:

- Injury to staff
- Needlestick Injury
- Other Sharps issue

Health and Safety Newsletters



The Health and Safety Newsletter is produced on a bi-monthly basis. It covers a wide range of health and safety topics, information, advice and support. Recent editions have supported staff through the COVID pandemic by covering hand hygiene, cleanliness of keyboards, fit testing and specific risk assessments.

There have been articles on staff welfare and wellbeing which included the recent purchase of 24 picnic benches that have been erected on both the Warrington and Halton Hospital sites. Already these have been welcomed by staff especially on sunny days.

Publicising the Trust No Smoking Policy and identifying illicit smoking areas and cigarette littering is a reminder for staff to adhere to the smoke-free site and to encourage smokers to liaise with the Warrington Livewire Smokefree Team or Halton Health Improvement Team for stop smoking support and advice. Contact details provided.

There is a regular article too on Lessons Learnt which clearly demonstrates the joint work undertaken by Health and Safety and the Estates Department to ensure the Trust is maintaining a safe environment

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Stay Alert – Don't get hurt

Learning from Non-Clinical Incidents

We found….	We Acted….
Due to a dip surrounding a manhole cover, a wheelchair has stopped suddenly and the patient has fell out of the Wheelchair 	Estates arranged to have the surrounding area of the manhole to be lifted and re-cemented to ensure this area is now level. This has been made good to prevent anyone from tripping 

Sharps Incidents

During Q2, there were a total of 24 sharps incidents

- Inappropriate disposal = 1
- Needlestick injury = 17
- Other Sharps issues = 6

These occurred within 19 separate areas, therefore no trends or hot spot areas. ED had 6 incidents spread over several sub-areas, Theatres had 5 shared across both the Warrington and Halton sites and 2 in Radiology. All other areas only had one incident each within this 3 month period. These took place when suturing, taking bloods, during biopsy, lumbar puncture and central line procedures, using k-wire, diabetic needles, knives etc. Other incidents happened with patients scratching staff, the poor disposal of equipment and setting up procedures.

In July 2020, a CT2 Anaesthetist received a sharps injury. The member of staff was holding the central line in place with one hand and suturing the skin with their right hand. The patient's skin was tough. The trainee jerked causing the needle to catch her middle finger on their left hand. Patient was Hepatitis C positive (RIDDOR reportable).

In September 2020, a member of staff received a sharps injury from a needle that had been disposed of in an orange clinical waste bag. As she was taking the bags to the large wheelie bins on the landing, the sharp penetrated through the bag and went into her knee. A full investigation was carried out but the exact bin could not be found and it was unknown who actually disposed of the needle in the orange bag.

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The Health and Safety Department continually remind staff to complete the NSI1 form following a sharps incidents. Receipt of these are monitored as the Trust policy states these forms are to be completed and returned to Health and Safety within 48 hours of the incident occurring. Once received, the completed form is then uploaded onto Datix as additional evidence.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/20/01/17**	
SUBJECT:	**Maternity Serious Incident Report**	
DATE OF MEETING:	27th January 2021	
AUTHOR(S):	Layla Alani, Deputy Director Governance	
EXECUTIVE DIRECTOR SPONSOR:	Kimberley Salmon-Jamieson, Chief Nurse & Deputy Chief Executive	
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	SO1 We will.. Always put our patients first through high quality, safe care and an excellent patient experience. 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):*	In 2017, following a letter from bereaved families raising concerns regarding the delivery of maternity services at Shrewsbury and Telford Hospital NHS Trust a review was commissioned by the former Secretary of State for Health and Social Care. In December 2020 this review was shared with all Trusts with clear recommendations identified, one of which was the sharing of Serious Incident (SI) information for assurance of learning from ward to board. This information must also be shared with the Local Maternity System (LMS) and the Trust await further guidance upon this process. This report will provide detail on the number of SIs reported at WHH in the last 12 months with learning identified.	

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

RECOMMENDATION:		
PREVIOUSLY CONSIDERED BY:	**Committee**	Choose an item.
	Agenda Ref.	
	Date of meeting	
	Summary of Outcome	
FREEDOM OF INFORMATION STATUS (FOIA):	Choose an item.	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	Choose an item.	

REPORT TO BOARD OF DIRECTORS

SUBJECT	Maternity Serious Incident Report	AGENDA REF:	BM/20/01/17

1. Background

In 2017, following a letter from bereaved families raising concerns regarding the delivery of maternity services at Shrewsbury and Telford Hospital NHS Trust a review was commissioned by the former Secretary of State for Health and Social Care. In December 2020, this review was shared with all Trusts with clear recommendations identified, one of which was the sharing of Serious Incident (SI) information for assurance of learning from ward to board. This information must also be shared with the the Local Maternity System (LMS) and the Trust await further guidance upon this process.

This report will provide detail on the number of SIs reported at WHH in the last 12 months with learning identified.

2. Key Elements and Lessons Learned

2.1 Over the past 12 months maternity services at WHH have reported 4 SI's. Two of these investigations are not yet concluded and relate to:

- A retained vaginal pack which was reported and reviewed on 24 December 2020. No harm was identified to the patient.

- The closure of the maternity unit on 8th January 2021 between the hours of midnight and 5am. Whilst no harm occurred to the 5 patients diverted the closure falls within the criteria of an SI.

2.2 Two Serious Incident investigations have been completed and the full reports have been shared with the LMS.

- A case where the baby was born with Hypoxic Ischaemic Encephalopathy (HIE) as a result of pregnancy induced hypercalcaemia.
- Caesarean Section: Possible Inadequate Pre-Operative Assessment reported on 16th March 2020.

2.3 Following a comprehensive investigation in accordance with the Serious Incident Framework the following learning points were identified and action plans are in place. This is monitored by the Governance Manager and Clinical Business Unit.

2.3.1 Lessons Learnt: Baby was born with Hypoxic Ischaemic Encephalopathy (HIE) as a result of pregnancy induced hypercalcaemia.

1 Pre-eclampsia can have many presenting symptoms. In the case of mild hypertension and proteinuria, adequate follow-up arrangements should be made for monitoring of potential pre-eclampsia.

2 Humoral hypercalcaemia of pregnancy is a rare disease but needs to be considered in cases of persistent tachycardia.

3 The number of handovers in a unit increases the potential for error.

4 Handovers should be facilitated by a written or electronic process that is clear to all members of the team.

5 Consistency of senior team members is important in delivering good patient care over an admission period.

6 When referrals are made by the Obstetric Team to other specialties, it should be very clear from the start what is expected by the referral: i.e. when telephone advice only is being sought, and when face to face assessment is required.

7 Women in the third trimester calling the Obstetric Unit for advice relating to their pregnancy should normally be assessed and triaged by the Obstetric Team in the Obstetric Unit. There should be no default option of ‘send to A&E’ without such assessment. If staff are unsure they

should speak to the senior obstetric doctor available at the time where the most appropriate place of care is.

8 If patients attend ED with a pregnancy-related problem without having contacted the Obstetric Unit, and require further care, then transfer should not be delayed, and communication between the two teams should be effective and prompt.

9 For the very small number of patients who are sent to ED from the Obstetric Unit, there should be effective and prompt communication between the two teams regarding what is required from the ED team and specifying clearly how Obstetric Team oversight will be maintained whilst the patient is in ED. The Obstetric team may need to attend the ED to see the patient if the woman is very unwell. This should be a Consultant to Consultant request.

10 Information should be shared with all clinical and nursing ED Staff that the MEWS rather than NEWS score should be used in the assessment of pregnant women.

11 Ultrasound scanning in ED by ED clinicians should not be used as a way of providing reassurance about fetal wellbeing.

2.3.2 Caesarean Section: Possible Inadequate Pre-Operative Assessment reported on 16th March 2020.

1. Make sure a patient is consulted and is able to give informed consent for their given circumstances for any procedure. Importance of good clear communication and the recording of information/conversations held with the patient are extremely important.

2. Documentation of communication with patient: side effects to procedures or delivery of duty of candour.
3. There is no clear consensus around exactly how long before a Caesarean section a scan should be done but this should be on the day of the planned Caesarean section.
4. When carrying out a category 3 caesarean section, the registrar should discuss this with the consultant on-call in case there are elements of the care plan that are to be clarified

3.0 MONITORING/REPORTING ROUTES

The SI action plans are monitored within the Clinical Business Unit with the support of the Governance Manager. All concise and SI's are discussed at the weekly meeting of harm when the investigation is complete. All maternity SIs are reported via the Quality Assurance Committee monthly and updates are provided weekly to the Strategic Oversight Group (this includes maternity).

4.0 RECOMMENDATIONS

The Board of Directors is asked to receive the report.

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NHS
Warrington and Halton Teaching Hospitals
NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/21/01/18**	
SUBJECT:	**COVID-19 Mortality Review Report**	
DATE OF MEETING:	27 January 2021	
AUTHOR(S):	Alex Crowe, Executive Medical Director	
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.	
EXECUTIVE SUMMARY (KEY ISSUES):	This paper reviewed the management of those patients who died with COVID-19 at Warrington Hospital. The Mortality Review Group (MRG) suggested a randomised review of deaths which occurred. 30 patients from 1st wave were reviewed; in total, fifty percent of these had been actively managed and admitted to ITU and the other fifty percent had been triaged for ward based care. These cases were selected randomly from the total number of patients who died of COVID-19 from the period 1st March 2020 until 24th	

PURPOSE: (please select as appropriate)	Information	Approval	**To note √**	Decision
RECOMMENDATION:	The Board to note the report			

PREVIOUSLY CONSIDERED BY:	**Committee**	Quality Assurance Committee
	Agenda Ref.	QAC/21/01/04
	Date of meeting	12 January 2021
	Summary of Outcome	Noted
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED: (if relevant)	Choose an item.	

Covid-19 Mortality Review

Contents

1.0 Introduction

Coronavirus disease (COVID 19) caused by the Sars-Cov-2 virus, first emerged in Wuhan in China in December 2019. It is a highly infectious acute respiratory infection, which was declared a pandemic on March 11th 2020 by the World Health Organisation (WHO).

The first UK case of COVID 19 was January 31st 2020 and the first UK death was announced as March 5th. In Warrington and Halton Teaching Hospitals NHS Foundation Trust admissions with COVID 19 started in March 2020. The first recorded in-patient with COVID 19 was on 12th March 2020 and the first recorded COVID 19 related death was on 19th March 2020.

It was clear from data from Wuhan and Italy that patients presenting to hospital had a fever, cough and shortness of breath, it later emerged that a loss in smell and taste was also common. Patients with underlying medical conditions were much more likely to die of the disease.

The patients with severe disease progressed from dyspnea to acute respiratory distress syndrome usually occurring from 8-12 days of onset of illness.

The Medical Director at WHH was keen to review the management of those patients who died at Warrington and the Mortality Review Group (MRG) suggested a randomised review of some of the deaths which occurred here. We reviewed 30 patients in total, fifty percent of these had been actively managed and admitted to ITU and the other fifty percent had been triaged for ward based care. These cases were selected randomly from

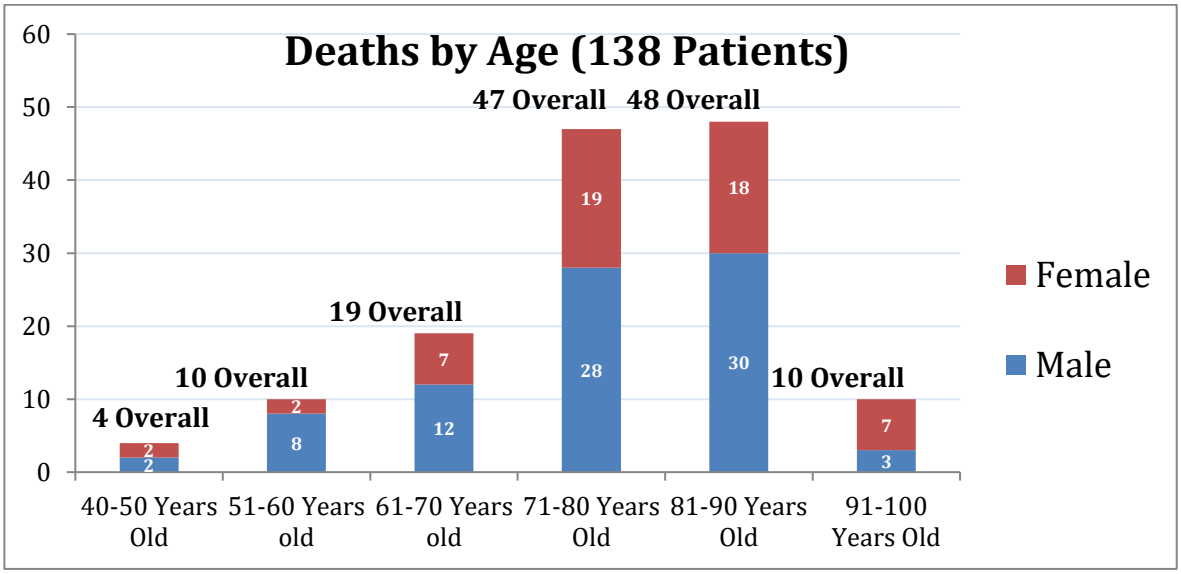
the total number of patients who died of COVID-19 from the period 1st March 2020 until 24th August 2020. In this period there were a total of 138 deaths

2.0 Demographics of COVID-19 patients in WHH

Below is a breakdown of significant statistics of all of the 138 deaths between the period of 1st March 2020 to 24th August 2020.

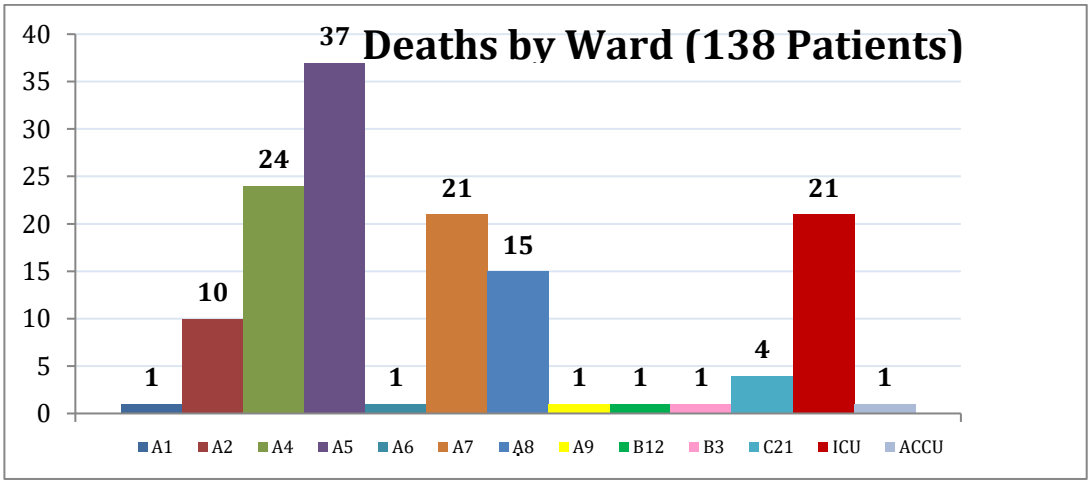
2.1 Age and Sex

The average age of death was **77** years old (ranging from 40- 97 years old). 60% of the deaths were male.



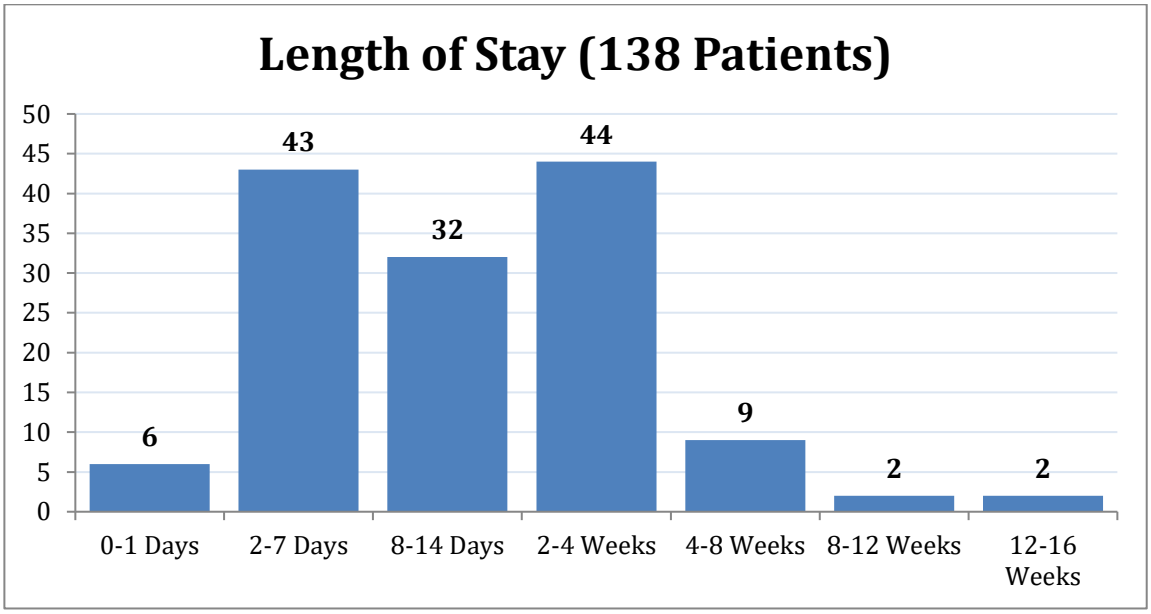
2.2 Ward Based Care

In total there were 14 wards in which one or more COVID 19 related deaths occurred. Of these deaths 25 patients received care on Intensive Care Unit (ICU). 4 of these patients were discharged from ICU to wards A7, A6 and A8 (x2) Following appropriate assessments and discussions with patients and their family, patients were transferred to ward A4 and A5 for palliative and supportive care. Patients requiring further respiratory escalation were transferred to ward A7.

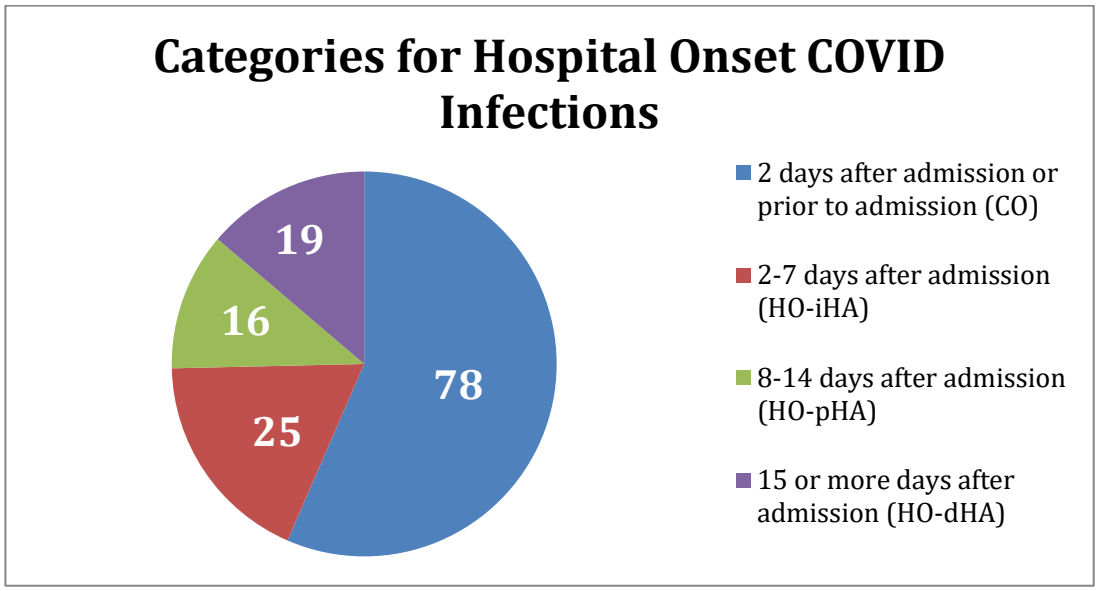


2.3 Length of Stay

Following review of the cases identified the average length of stay was 16 days, this ranged from 0 to 107 days in Hospital.



2.4 Nosocomial versus Community Acquired Pneumonia



NHSE/I Definitions:

Day of admission is day 1 – swab on day 1 or 2 or prior to admission is community onset (CO)

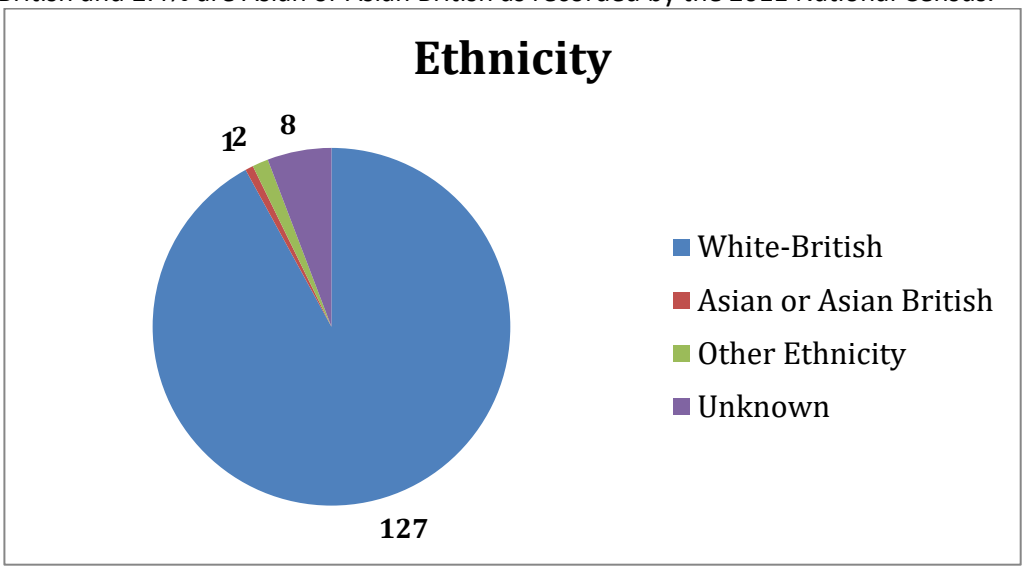
Hospital-Onset Indeterminate Healthcare-Associated (HO-iHA) – First positive specimen date 3-7 days after admission to trust

Hospital-Onset Probable Healthcare-Associated (HO-pHA) – First positive specimen date 8-14 days after admission to trust

Hospital-Onset Definite Healthcare-Associated (HO-dHA) – First positive specimen date 15 or more days after admission to trust.

Ethnicity

Of the 138 deaths, the majority (92%) were of White-British ethnicity. 92% of the Warrington population are White British and 2.4% are Asian or Asian British as recorded by the 2011 National Census.



3.0 Method

This review adopted a methodology of randomization identifying 30 cases of patients with COVID-19 noted as the cause of death on the death certificate (1a on death certificate) for the period of 1st March 2020 to 24th August 2020. As of 9th January 2021, there have been 331 deaths of patients who have been identified by swab as COVID-19 positive. The Mortality Review Group have continued to review patient deaths following 24th August 2020 and a further review of nosocomial patient deaths in second wave (from 31st August 2020) is in progress.

Four Mortality Review Group (MRG) members from different clinical specialty backgrounds including: Critical Care, General Medicine, Urgent and Emergency care and Elderly Care undertook reviews of the 30 cases identified (see Appendix 2). The Royal College of Physicians Structured Judgement Review tool (SJR) was applied to all of the cases reviewed and the following phases of care for each patient were considered;

- Admission and initial management
- On-going care
- Care during a procedure
- Perioperative care
- End of Life care
- Assessment of problems in healthcare
- Quality of records

Prior to commencing the reviews the Mortality Review Group members were asked to read the Standard Operating Procedure for the Management of Novel Coronavirus (COVID-19), in Adults and Children and consider if this was followed correctly for each case. (See Appendix 1).

The reviewers were also given a set of parameters to address which were pertinent to COVID-19 management and outcomes, these are listed below:

- Age
- Ethnicity (if possible)
- Indicate if patient come in from a care home or their own home

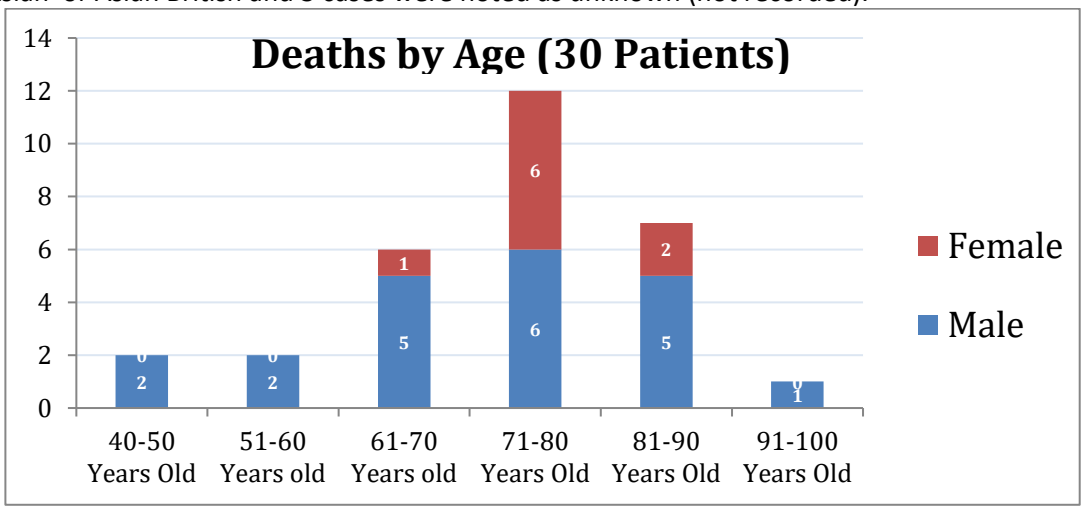
- Indicate if the patient was admitted with a positive diagnosis of COVID soon after admission or if the patient develop COVID during their admission and if so at what stage?
- Comorbidities
- Date of admission and date of death
- Ward – in line with the cohort requirements were they on the correct ward in accordance with their cohort group?
- Indicate if there was significant delay in specialty review. Please detail timeframes
- Indicate if the combined Clinical Frailty Score and WHO Performance score used to make an assessment for escalation
- Indicate if there was a discussion with the patient or their family/carer re their expectations and the decisions re escalation and was this clearly documented?
- Indicate any subsequent review of any prior decisions to escalate to Level 2 or Level 3 care?
- Indicate clear decisions made to stop active treatment
- Indicate if a DNACPR put in place appropriately and following discussion with the patient/LPA/relatives. Was this documented?
- Indicate if consultants were involved in all these decisions
- Indicate if there was a clear plan for Ceilings of Care
- Indicate if the Palliative care Team were involved
- Indicate if you feel things should have been done differently

4.0 Findings of the Structured Judgement Review

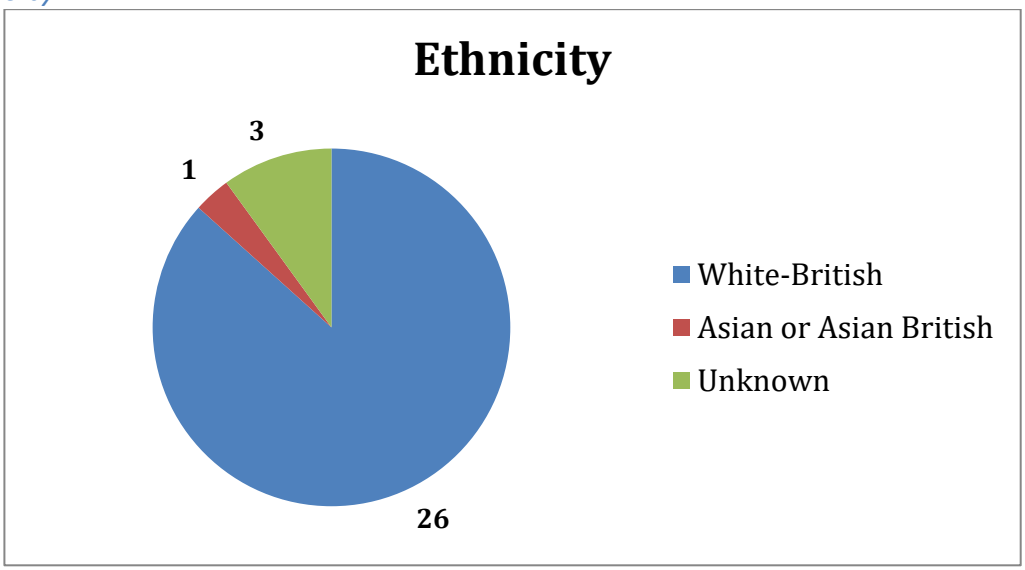
The findings of the 30 Structured Judgement Reviews for the period specified is detailed below:

3.1 Age and Sex

The average age of death was **73** years old. 21 Males and 9 females, of which 26 patients were white British, one of Asian or Asian British and 3 cases were noted as unknown (not recorded).



3.2 Ethnicity



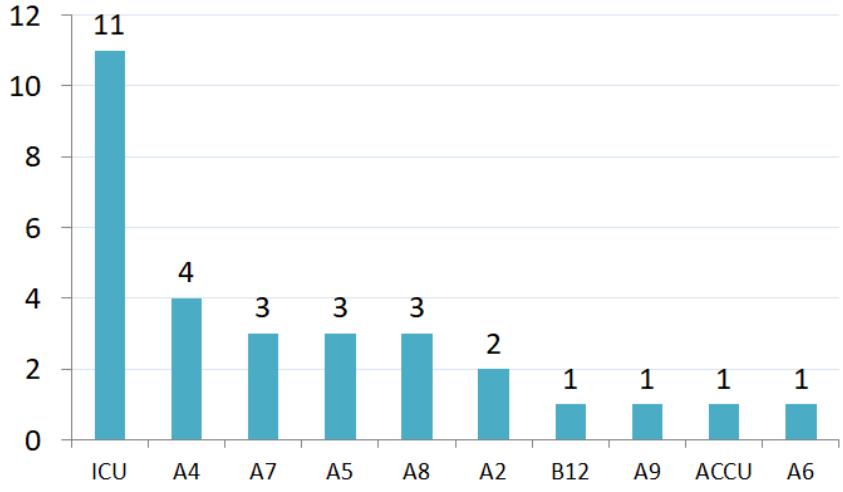
3.3 Community Settings

The review considered how many patients were admitted to Warrington and Halton Teaching Hospital NHS Foundation Trust (WHH) from community placements of which 6 were identified equating to 20% of the 30 cases reviewed. 6 of the 30 cases within the focused review were admitted to hospital from a care home or a resident other than their own homes. This included:

- Hollins Park
- St Mary's Continuing Care
- Heathercroft Care Home x2
- Beechcroft Nursing Home
- Callands Care Home

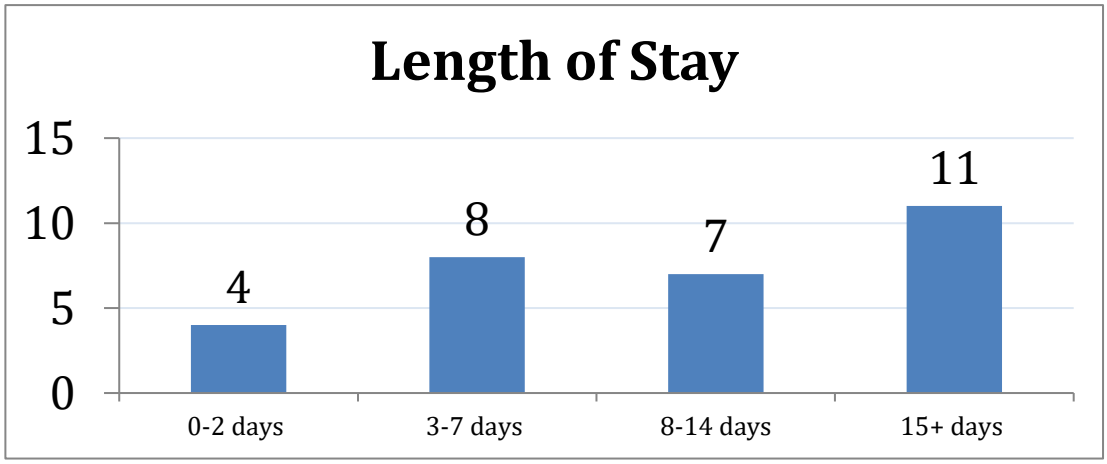
3.4 Wards

Below is a breakdown of the wards in which the 30 patients reviewed died with the highest number 37% being seen on ICU. This is an expected finding.



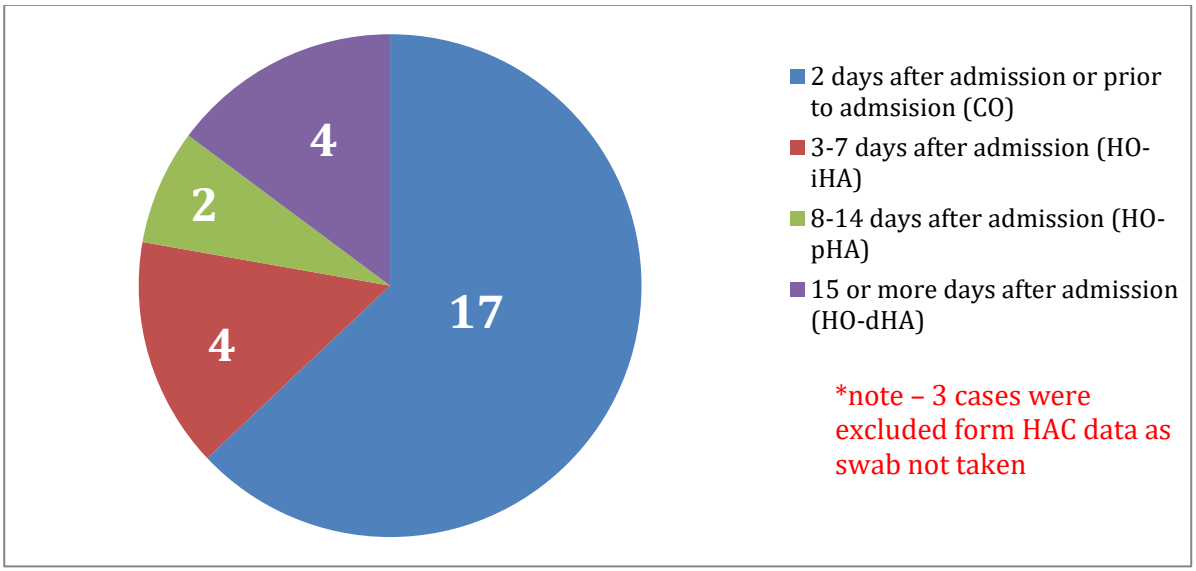
3.5 Length of stay and Hospital Acquired COVID-19.

The average length of stay in this cohort of 30 patients was 15 days. This ranges from 0-56 days in hospital. This is in keeping with previous average length of stay figures.



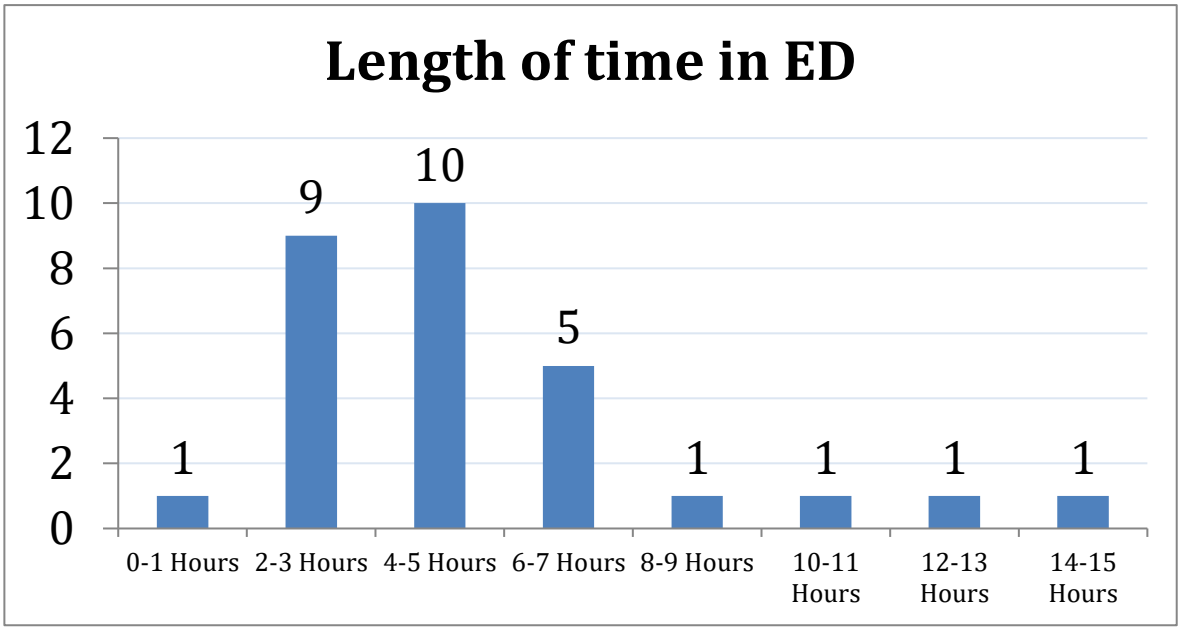
3.6 Nosocomial Versus Community Acquired Pneumonia

Following review of the randomly selected 30 cases the majority were community acquired. 57% were positive within 2 days of admission and a further 13% within 7 days of admission, thus confirming that the covid-19 was community acquired as per NHSE/I definitions. The reviewers where unable to determine whether or not 3 patients in the cohort had acquired COVID-19 in the hospital or the community as a swab was not done, although COVID-19 appeared as a cause of death on the death certificate. It is important to acknowledge that all emergency patient admission screening was not in place until 24 April 2020 as per national guidance. The sensitivity of a mRNA viral swab is 70% (Interpreting a covid-19 test result (bmj.com)



3.7 Time spent in ED

The average time that the 30 patients in the cohort spent on the Emergency Department (ED) was 4 hours. This is evidenced with the graph below which shows that the majority of the patients spent between 2-5 hours in ED. It is important that patients are triaged and transferred safely and timely to appropriate wards.

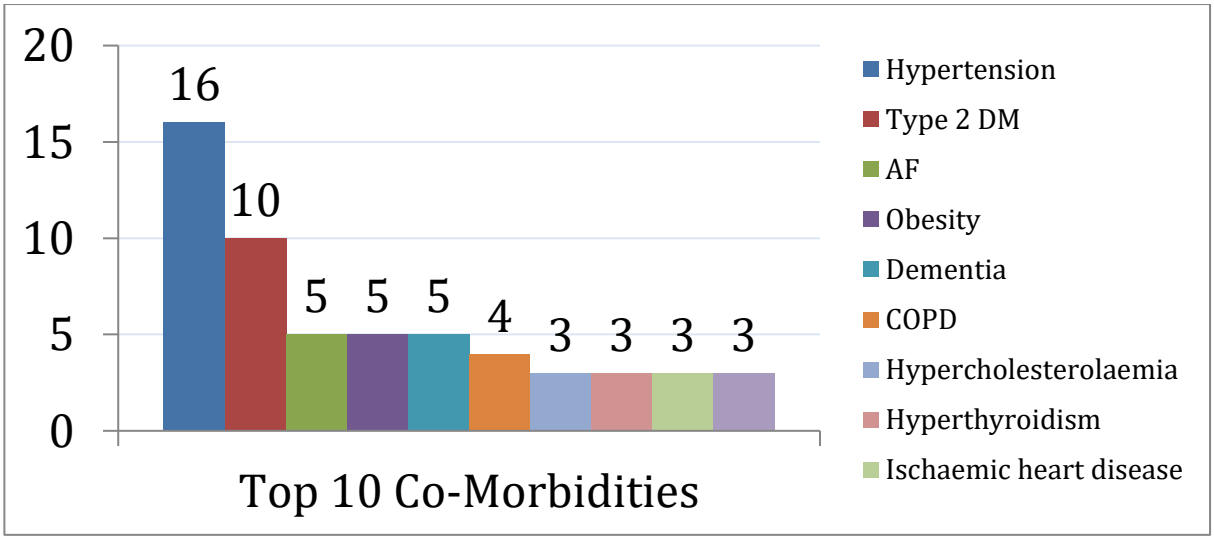


3.7 Family Liaison Officer (FLO) Involvement

When COVID-19 was declared a pandemic, it was instructed by NHSE/I that relatives should not attend the hospital in order to protect patients, staff and the wider public from further transmission. WHH have been compliant with this instruction throughout the pandemic with the exception of individual cases, following assessment of risk in circumstances including patients who are dying. This understandably created much anxiety for both patients and their families for which a Family Liaison Officers (FLO) service was established to support the clinical area in ensuring that families were updated regarding the care of their loved one.

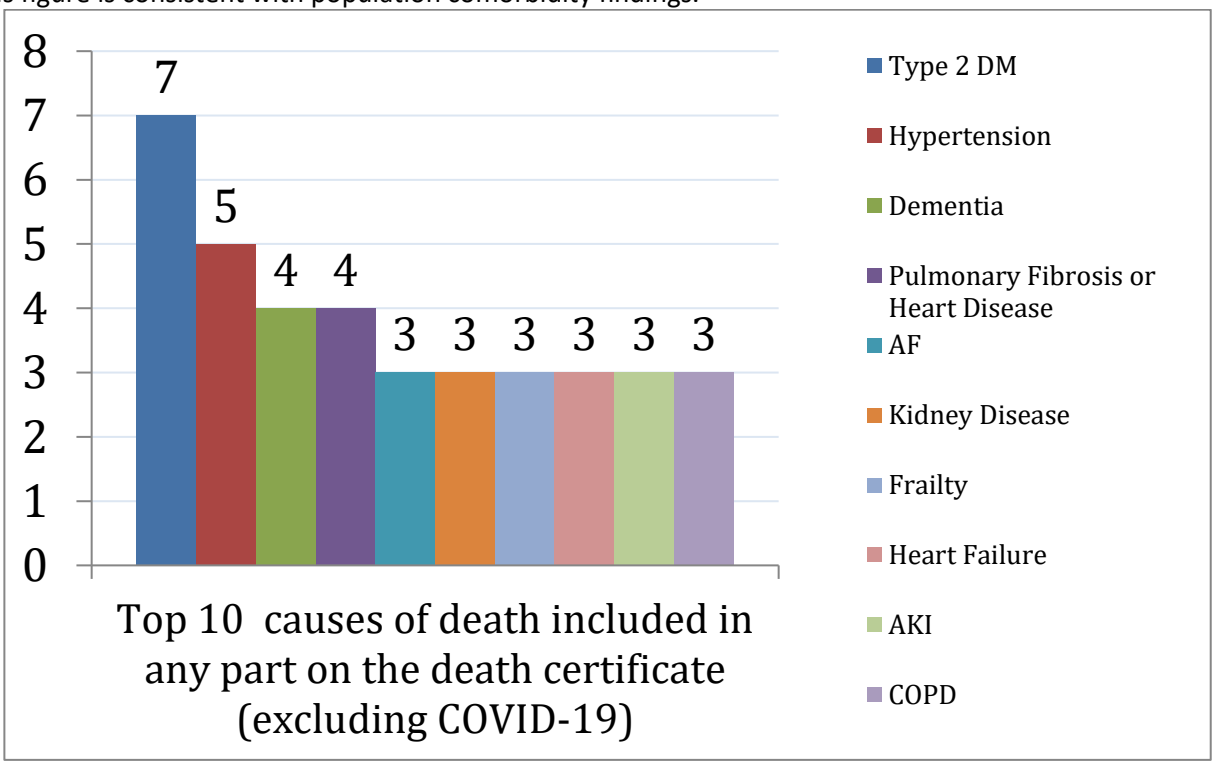
3.8 Co-morbidities

Below are the top 10 comorbidities of all 30 patients reviewed. This figure is consistent with population comorbidity findings. It is noted that many of the patients had multiple comorbidities.



3.10 Other causes of death and conditions contributing to death that appear on the death certificate.

Below are the top 10 other causes and conditions contributing to the death of the 30 cases reviewed appearing on the death certificate : (COVID-19 appeared on all death certificates although not always as 1a.). This figure is consistent with population comorbidity findings.



4.0 Results of the Specific COVID-19 Parameters Observed by Reviewers

Below is a breakdown of the specific questions the reviewers were asked to observe as part of their review criteria:

Was there a discussion with the patient or their family/carer re their expectations and the decisions re escalation and was this clearly documented?			
Yes	No	N/A	Died on admission
24/30	3/30	2/30	1/30

There were a number of cases where deterioration of clinical condition was very rapid. There were 3 patients who had impaired Mental capacity according to documentation. Mental Capacity assessment took place later during inpatient stay.

1) An admission from Hollins Park. No recorded history of discussion with wife until day 9.
2) Patient was admitted from own home where he was living alone with carers 4 times a day. The patient had been found on the floor and he was confused. The patient had a fractured NOF with no capacity to consent for operation. The patient's brother-in-law was contacted on day 2. On day 9 staff apologized to the patients brother in law for the lack of updates provided. On day 23 the patient died. The ward rang the patient's brother-in-law about contacting the bereavement office and the

brother-in-law was unaware of the patient's death. Overall the patient's clinical management was good however the communication was very poor.

3) Patient admitted from nursing home; the patient had a brain injury from previous alcohol excess. The family had not been contacted until day 4. Decision on 'not for MET call' was made on day 1 but there was no documented discussion with the family regarding this (DNCPR already in place in the nursing home).

Overall the decisions made for healthcare escalation planning were deemed to be appropriate as was the care of these 3 patients.

Learning:

- Early discussions with family are critical to that patients and their families understand in full the plan of care for each patient and where a patient lacks capacity there must be clear documentation regarding the provision of care in the best interest of the patient. All discussions of this nature must be documented within patient records
- Where a patient lacks mental capacity, it is important that all clinicians complete Mental Capacity Assessment and appropriate discussions surrounding care are undertaken with next of kin early. Clinicians must ensure that Best Interest meetings take place when appropriate.

Ward – in line with the cohort requirements were they on the correct ward in accordance with their cohort group	
Correct	Incorrect
22/30	8/30

Of the cases reviewed 8/30(27%) were considered to be in the incorrect cohort ward. as per the Standard Operating Procedure for the Management of Novel Coronavirus (COVID-19), Appendix 1.

Of the cases reviewed 4/8 (13%) of these patients had significant other medical problems; and were best managed on the appropriate specialist ward.

- 2 fractured NOF patients were managed on orthopaedic wards.
- 1 patient with brain injury was managed on B12.
- 1 patient who had bone marrow failure from metastatic prostate cancer

It is important to ensure that appropriate respiratory review and regular palliative care input is made across all wards.

4/8 (13%) of these patients were located on acute escalation wards although their healthcare plan indicated palliative care. This could be attributed to a possible bed shortage in escalation areas at the time. The frailty assessment/WHO scores are a guidance only and do not override clinical decision making.

Learning: Where COVID-19 patients have other pathologies e.g. fractures, they should stay on the appropriate ward where possible. However it is important to maintain the facilities of COVID-19 wards e.g. physician visits and palliative care input should be put in place for COVID-19 patients on other wards.

Was there a significant delay in specialty review?	
Yes	No
2/30	28/30

In 2 cases there was no evidence of a specialty review. These were cases where COVID-19 was not initially suspected and when confirmed, the patient was not allocated to the appropriate ward as per COVID-19 SOP. Care was appropriate, senior oversight was present in both cases from initial presentation.

Appendix 3 details a retrospective review of 112 patients with COVID-19 to assess whether the CFS/WHO score attributed to the patient was appropriate. It demonstrated that clinical decisions in relation to escalation were appropriate in all cases reviewed and showed that no patients were denied critical care inappropriately.

Was a clear decision made to stop active treatment?		
Yes	No	Patient Died too Quickly
27/30	2/30	1/30

Where no decision was made, the patients were either admitted very unwell, had Cardiopulmonary Resuscitation (CPR) but unsuccessful or died very close to time of admission or unexpectedly.

Was the Palliative Care team involved?		
Yes	No	Patient Died too Quickly
17/30	12/30	1/30

In the cases where the palliative care team was not involved, all were either patients who had full escalation to ICU or when the decision was made to withdraw active treatment the patient died quickly and palliative care involvement was not required, or were patients who died close to time of admission. One patient was managed with anticipatory medications on the ward and died quickly. Palliative care was not required and would not have offered any improvement in the care delivered.

Was a consultant involved in all decisions?			
Yes	No (or Very Late)	Not Clear if Yes or No	Died too quickly
25/30	3/30	1/30	1/30

Of the 3 'No (or very late)' cases:

- 1 patient died before post-take ward round suddenly. Do not attempt Cardiopulmonary Resuscitation (DNACPR)/ treatment escalation plan by medical trainee after a discussion with the ST trainee and implemented. The patient died on the ward without consultant review less than 24 hours from admission, the decision making was considered appropriate.
- 1 patient: The consultant made the decision "for Continuous Positive Airway Pressure (CPAP) not for intubation" on Post-Take Ward Round. When the patient was admitted to ward A8 an F2 doctor altered the patients status to "not for Non Invasive Ventilation", this was not countersigned. Although no consultant review after this review was undertaken the patient was regularly reviewed by ST7 (very experienced trainee) – decision was appropriate.
- 1 patient: 'not for MET calls' not countersigned by consultant although appropriate.

Learning: Consultants must be involved early in discussions about DNACPR and treatment escalation plan with accompanying documentation; this has already been raised at Medical Cabinet and there was an offer from one of the consultants that he could be contacted at any time for discussion. Regular communications and support at Medical Handover have been actioned. All Consultants must ensure that appropriate conversations have been held with regards to DNACPR and ceilings of care/treatment escalation plans with patient and their families. Best Interest meeting to be undertaken as appropriate where a lack of capacity with clear documentation. There is a Trust CPR decision making plan in place.

Was there a clear plan for treatment escalation planning?	
Yes	No but appropriate
27/30	3/30

Was there any subsequent review of any prior decisions to escalate to Level 2 or Level 3 care?		
Yes	No	N/A
15/30	4/30	11/30

Cardiopulmonary resuscitation (CPR) is an emergency procedure that aims to restart a persons heart if their heart stops beating or they stop breathing. It can involve chest compressions, delivery of high-voltage electric shocks across the chest, attempts to ventilate lungs and injections of drugs. CPR is an invasive and traumatic medical intervention and most CPR is unsuccessful. In most hospitals the average proportion of people who

survive is about 15-20%; out of hospital the survival rate is lower at 5-10%. Due to the nature of the treatment, in some circumstances CPR can do more harm than good. In some cases, CPR can cause injuries such as punctured lungs, broken ribs and bruising.

A DNACPR decision is an instruction not to attempt CPR, designed to protect people from unnecessary suffering by receiving CPR tat they do not want , that will not work or where harm outweighs benefits.

In cases where there was no review of CPR, this was deemed appropriate in all cases. In one case a DNACPR and treatment escalation plan was already in place form a nursing home. When the patient deteriorated on day 4, a decision to withdraw active treatment was discussed with the patient's family. As this was the first contact with the family, they were not initially in agreement. However following a family discussion there was later agreed.

Was there a DNACPR in place?	
Yes	No but appropriate
27/30	3/30

5.0 Results from the Structured Judgement Reviews

Each of the sections (outlined in section 2.0) are rated 1 to 5 (very poor – excellent) by the reviewers and reviewers will then give an overall rating assessment for the case.

Overall Care Rating				
5 Excellent	4 Good	3 Adequate	2 Poor	1 Very Poor
0/30	19/30	7/30	4/30	0/30

63% of the cases reviewed were rated as good, 24% adequate and 13% rated poor.

The 4 patients identified as receiving 'poor care' were discussed with the full Mortality Review Group. All other patients rated 3 or above have been discussed with reviewers and collators.

Note: Cases which are deemed to be poor care by the reviewer are all discussed at Mortality Review Group and a joint decision is made as to whether the group agrees with this score. If there is agreement that these cases are poor they are escalated to the governance department to be investigated as per the Trust incident process and will initially undergo a rapid incident review to determine the level of investigation required It was not felt that any of these cases required escalation to the governance team as there was clear learning identified which will be shared via CBU and Specialty Governance meetings. Details of poor care for 4 patients and subsequent response/action can be found in Appendix 4.

6.0 COVID 19 Structured Judgement review Learning and Recommendations

6.1 Summary

- Most patients were elderly and had multiple co-morbidities
- 26/30 (87%) of cases were deemed to score overall care as good or average.
- There were no cases where the reviewers/MRG felt that the outcome would have been altered, however there were a number of cases where it was agreed that care could have been improved. We have listed the themes identified for improvement below.

- Learning from SARS -COV-19 Pandemic First Wave – NW Mortality cell feedback shared with clinicians (Appendix 5).

6.2 Recommendations

1) Communication

- Early discussions should occur with families There should be ongoing and regular documented updates regarding the patient's status with family.
- Clear discussion regarding treatment escalation plans, CPR decision making and stopping active treatment with families need to be documented in patient records and agreed with consultant.
- Clear documentation of communication between wards during transfers.
- Discussed regularly at Tactical Group meetings, Weekend Handover meetings, Medical Cabinet, Medical Cabinet and Medical Cabinet noticeboard.

Best practice for communication: during the first wave of the pandemic, ward A4 gave each junior doctor a bay of patients to look after, they were tasked with communicating with the family every afternoon. A family member and their contact numbers were identified for this communication. I-Pads were used to allow patients to see their family, which was noted to be hugely beneficial and very well received by both patients and families, especially as a significant number of these patients were dying.

2) Documentation

- Ensure ALL conversations with family are documented
- Care should be taken with nursing documentation as there was evidence of significant variation in notes between different nurses for the same patient (mainly agency nurses)
- Document ALL co-morbidities
- Document all communications as noted in the previous section (1).
- Discussed regularly at Tactical Group meetings, Weekend Handover meetings, Medical Cabinet, Medical Cabinet and Medical Cabinet noticeboard. Clinical audit follow up.

3) DNACPR/treatment escalation plan countersignature

- Decisions made must be countersigned by a consultant at the first opportunity and must be discussed with the patient and their family.
- Recent guidance sent to remind consultants of the process and their responsibilities regarding these decisions has been sent to all clinicians. This should be done as soon as possible and at the latest on the patients next PTWR.

- DNACPR decisions made appropriately in discussion with patient and in line with legal requirements and best practice.
- Discussed regularly at Tactical Group meetings, Weekend Handover meetings, Medical Cabinet, Medical Cabinet and Medical Cabinet noticeboard.
- There is a Trust CPR Decision making plan in place.

4) Assessment of Mental Capacity

- This must be undertaken in all patients deemed to lack capacity – DOLS put in place and early discussions with family regarding management and treatment decisions must be undertaken. Best Interest Meetings must take place as appropriate and documented.
- Discussed at Tactical Group meetings, Weekend Handover meetings, Medical Cabinet, Medical Cabinet and Medical Cabinet noticeboard. Follow up clinical audit.

5) Hospital acquired COVID-19

- All efforts must be made to avoid transmission between patients, between staff, and between staff and patients.
- Early swab, isolate until swab result, consider COVID-19 as a diagnosis, even if the patient has been admitted with other conditions
- Management of this is high priority in the Trust.
- Patient must undergo swabbing for COVID-19 as per current screening guidance. A care bundle will be launched soon which brings together IPC elements.

6) Death certificate (MCCD) accuracy

- Not accurate in 5/30 cases, did not include co-morbidities that would have likely contributed to the patient's death
- Inclusion of surgery (e.g. #NOF)
- Discussed with Medical Examiner and Medical Workforce; opportunity for group teaching on completion of death certificates.

7) Senior review

- Senior reviews should be timely and regular with documentation.
- Discussed at Tactical Group meetings, Weekend Handover meetings, Medical Cabinet, Medical Cabinet and Medical Cabinet noticeboard.

8) Palliative Care

- The team could have been involved earlier in 2/30 cases.

Best practice: The palliative care team visited ward A4 and A5 (Supportive Care Wards) every day to review patients.

9) Allergies

- Ensure penicillin allergic patients are not prescribed antibiotics containing penicillin. Beware of antibiotics where penicillin is combined with another antibiotic as this may not be obvious in the drug name.
- Discussed through Pharmacy newsletter
- Where there are 'near misses' a Datix should be completed to allow for learning.

10) Escalation of patient care

- If oxygen requirements suddenly increase this should be escalated quickly.
- Discussed at Tactical Group meetings, Weekend Handover meetings, Medical Cabinet, Medical Cabinet and Medical Cabinet noticeboard

11) Other infections

- Consider other infections as a possible cause for patients symptoms – not all are COVID-19

12) Staff caring for these patients on COVID-19 wards

- Can be emotionally draining and debriefing the team by the consultants was found to be particularly helpful.
- The consultants were in turn de-briefed by the palliative care consultants.

Appendix 1 – SOP for the Management of Novel Coronavirus (COVID-19) in Adults and Children

For the most up-to-date Standard Operating procedure on the management of COVID-19 in adults and children please use the link below.

http://thehub/PP/Policies/COVID%20-19%20SOP%20for%20Management%20of%20%20Novel%20Coronavirus%20(COVID-19)%20in%20Adults%20and%20children%20v%2021092020.pdf

Appendix 2 – Review Team

3.1 Review Team

Dr Graham Barton	Medicine & Elderly Care Consultant – Clinical review of 12 cases
Dr Paula Chattington	Diabetes and Medical Consultant – Clinical review of 6 cases
Dr James Williamson	Emergency Medicine Consultant – Clinical review of 6 cases
Dr Jeff Little	Anaesthetics and ICU Consultant – Clinical review of 6 cases
Dr Phil Cantrell	Trust Mortality Lead and Consultant Radiologist – Co-ordination and collation of review
Camille Cortez-James	Patient Safety Manager - Co-ordination and collation of review
Jade Keenan	Quality and Effectiveness Facilitator - Co-ordination and collation of review

Appendix 3 – Retrospective Review of Ward COVID Deaths Audit

Retrospective | open attachment to view.

Appendix 4 – Details of Poor Care and Actions taken

1. Patient prescribed Tazocin on admission (contains penicillin) and the patient was penicillin allergic. It was noted that the patient was allergic to penicillin before patient received the dose and it was changed to levofloxacin. No Datix had been submitted. This was escalated to governance to discuss and disseminate learning and concerns. Care was good otherwise but as this was a near miss and was not reported on Datix, it was rated as poor.

Action:

- This was escalated to specialty governance meetings for discussion with those involved.
- Approach to assessing allergy discussed at COVID Safety Response and Pharmacy newsletter.

2. 77 year old patient with a brain injury from excess alcohol (frontal lobe damage) admitted from a Care Home. Found on floor, reduced oral intake / immobility 2-3 days prior to admission. Despite low oxygen saturations, hypertension and increased WCC, patient was not deemed likely to have COVID-19. Patient was not swabbed and admitted to B19. Patient lacked mental capacity, had a DNACPR and treatment escalation plan in place from care home and decision was made ' not for MET calls or acute care team'. Family not aware that the patient was in hospital until day 4, when it was thought the patient was likely COVID-19 positive and prognosis poor.

Issues:
No formal assessment of mental capacity
No discussion about decision of not for MET calls/ acute care with family.
No contact with family until day 4
Poor index of suspicion for COVID-19

Action:

- Discussed at MRG, Dr Raper (Palliative care consultant) assured the group that Trust-wide training in palliative care will commence weekly from October 2020 for doctors and ANPs. This case was used as MRGs 'case of the month' and was distributed to Mortality and morbidity meetings and governance leads in November 2020.
- Confirm if admission date prior to 24th April as not routine swabbing protocol in place
- Confirm role of Care Home to update family
- Discussed at Tactical Group meetings, Medical Cabinet and Medical Handover

3. Patient admitted with shortness of breath and recent falls. 3 month history of cough, immediately assumed to be COVID-19 positive. No DNACPR and treatment escalation plan put in place and triaged to Supportive Care (appropriate). The patient had been allocated to Supportive Care ward. Patient deteriorated in early hours of the morning following admission requiring 10 litres/minute oxygen, previously on 2 litres/minute oxygen. There was no escalation of care, no medical review until 5 hours later. Seen by consultant who assessed patient was dying and active treatment inappropriate.

Issues:

No escalation of care when change in oxygen requirement occurred

Action:

- Discussed at MRG and agreed that the case should be escalated to the respiratory lead clinician who explained that although an SOP had been agreed at the stage the patient was admitted, it had not been uploaded on the HUB for Trust-wide use. This would explain the patient being on the Supportive Care ward as opposed to the Respiratory Ward. The ward sister responded acknowledging that escalation should have taken place and this is now highlighted daily in the Trust Safety Brief /COVID Safety Response informing staff to escalate to acute care in these circumstances.
- Response to Deteriorating Patient discussed at Medical Handover

4. Patient admitted from nursing home with known COVID-19, DNACPR and treatment escalation plan put in place in ED by medical trainee following discussion with registrar. There was no consultant/senior review, no counter signature by consultant. No medical documentation after ED. Palliative care team came to start subcutaneous infusion but patient died before receiving less than 24 hours after admission.

   Issues:
   No senior medical review of patient, although it is noted that the patient was in hospital for less than 24 hours.No senior review of DNACPR or treatment escalation plan decisions
   Was admission necessary from nursing home?

Action:

- Discussed at MRG, there was good discussion with family throughout and while processes were not followed, the outcome was unlikely to be altered. Issues were raised regarding CPR decision making/treatment escalation plan discussions with consultant at medical cabinet and there was an offer from one of the consultants that he could be contacted at any time for discussion.
- Regular communications and support at Medical Handover have been actioned.

It is clear that in difficult circumstances some very good care of patients took place.

Appendix 5 – Learning from SARS-CoV-19 pandemic first wave – NW Mortality cell feedback

20201023 Mortality Cell - Learning v10 FII

Retrospective Review of Ward COVID Deaths

Evaluating the critical care triage escalation tool

Aims

- NW Critical Care Outcome Review
  - demonstrated favourable outcome for Warrington
- Established early- robust triage for critical care (level 2 & 3 support)
- Combined Clinical Frailty Score & WHO Score
- Retrospective EPR review of ward Covid deaths
  - to assess effectiveness of decision making tool

Scoring system design

- Assesses functional physiological reserve
  - chronic health effects on function
- Developed & refined - consistent with NICE Guidelines
  - ‘COVID-19 rapid guideline: critical care in adults’ (www.nice.org.uk/guidance/ng159)
- Used only as a guide
  - DNAR /escalation of care decisions individually tailored
- Not appropriate/relevant in certain circumstances
  - eg long term learning disabilities/Cerebral palsy

Scoring System – Two internationally verified scores

Clinical Frailty Score

Clinical Frailty Scale*

1 **Very Fit** – People who are robust, active, energetic and motivated. These people commonly exercise regularly. They are among the fittest for their age.

2 **Well** – People who have **no active disease symptoms** but are less fit than category 1. Often, they exercise or are very **active occasionally**, e.g. seasonally.

3 **Managing Well** – People whose **medical problems are well controlled,** but are **not regularly active** beyond routine walking.

4 **Vulnerable** – While **not dependent** on others for daily help, often **symptoms limit activities.** A common complaint is being "slowed up", and/or being tired during the day.

5 **Mildly Frail** – These people often have **more evident slowing,** and need help in **high order IADLs** (finances, transportation, heavy housework, medications). Typically, mild frailty progressively impairs shopping and walking outside alone, meal preparation and housework.

6 **Moderately Frail** – People need help with **all outside activities** and with **keeping house.** Inside, they often have problems with stairs and need **help with bathing** and might need minimal assistance (cuing, standby) with dressing.

7 **Severely Frail – Completely dependent for personal care,** from whatever cause (physical or cognitive). Even so, they seem stable and not at high risk of dying (within ~ 6 months).

8 **Very Severely Frail** – Completely dependent, approaching the end of life. Typically, they could not recover even from a minor illness.

9 **Terminally Ill** - Approaching the end of life. This category applies to people with **a life expectancy <6 months,** who are **not otherwise evidently frail.**

Scoring frailty in people with dementia

The degree of frailty corresponds to the degree of dementia. Common **symptoms in mild dementia** include forgetting the details of a recent event, though still remembering the event itself, repeating the same question/story and social withdrawal.

In **moderate dementia,** recent memory is very impaired, even though they seemingly can remember their past life events well. They can do personal care with prompting.

In **severe dementia,** they cannot do personal care without help.

* 1. Canadian Study on Health & Aging, Revised 2008.
2. K. Rockwood et al. A global clinical measure of fitness and frailty in elderly people. CMAJ 2005;173:489-495.

Always intended as guide to get team thinking about escalation decisions early

WHO Performance Score

Score	Description
0	Fully active, able to carry on all pre-disease performance without restriction
1	Restricted in physically strenuous activity, but ambulatory and able to carry out work of a light and sedentary nature(e.g. housework, office work)
2	Ambulatory and capable of all self-care, confined to a bed or a chair more than 50% of waking hours
3	Capable of only limited self-care, confined to a bed or a chair more than 50% of waking hours
4	Completely disabled. Cannot carry on any self-care. Totally confined to bed or chair
5	Dead

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To escalate or not?

Add together both scores

1 – 3	For escalation (Critical Care – Level 2/3)
4 - 5	Clinical discussion & decision (Possible level 3 but consider Respiratory High Care (Level 2)
>5	Not for escalation (uDNA-CPR and Ceiling of Care)

Method

- Coding list of patients coded - ‘COVID pneumonia’
- Divided into groups for consultant review
- 4 consultants – Drs Langton (ICU), Patel (Acute Med), Gordon (Elderly Care), Forrest (ICU) reviewed EPR
- Assessed ‘NOT to escalate’ decisions - graded as:
  - Agree with decision
  - Needs discussion
  - Disagree with decision

Results - Demographics

- 112 patients reviewed
- 63 males (56%) : 49 females (44%)
- Age:
  - <50 years – no patients
  - 50-70years – 17 patients (15%)
  - >70years – 95 patients (85%)

Decision - ‘not to escalate’

- On review – NO cases disagreed
- 1 patient needs discussion
- 111 patients we agree with decision

Needs Discussion patient

- 59 yrs, female
  - ALD (Childs C) awaiting referral for potential liver transplant, recurrent sepsis, AKI
- **CFS + WHO score = 6**
  - Parent team - decision not to escalate
  - Patient & family well known
  - Family agreement with decision
- **ICU view:** would have considered for CPAP only.
  - Not inotropes or renal replacement treatment.
  - Unlikely to have made difference to outcome

Conclusions

Patients were not denied critical care inappropriately

Robust screening tool effective and safe

Suitable for further pandemic/second wave

Learning from SARS-CoV-19 pandemic first wave – NW Mortality cell feedback

North West Region

October 2020

Dr David Levy - Regional Medical Director

Deborah Turner - Clinical Quality Director

NHS England and NHS Improvement

Introduction

- The North West was impacted significantly by COVID between March and June 2020; and continues to be so.

- The regional Mortality sub cell has reviewed deaths during this period and is now formally sharing learning, in order to improve our response to the COVID pandemic; and share the expertise that has been developed in the past seven months across the region.

- In summary, across the North West we saw an **excess number of deaths** compared to previous years from:
    - COVID in hospitals – an Intensive Care National Audit and Research Centre (ICNARC) audit has been completed and reviewed
    - COVID in care homes
    - COVID amongst the black, Asian and minority ethnic (BAME) community
    - COVID amongst those with a learning disability - a rapid LeDeR review has been completed
    - COVID in people receiving support from domiciliary care.

- In addition we have seen a rise in neuropsychiatric symptoms in the older population due to COVID infection.

- Significantly we have see a rise in Non-COVID deaths, at home.

- We have lost health care and social care staff to COVID and are learning about this through the Medical Examiners review.

- The following slide slides set out actions for systems to prepare for a winter of COVID, flu and other winter pressures by sector and populations at risk.

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Community/primary care

Main recommendations

- There needs to be a push to ensure that people experiencing serious illnesses or symptoms seek advice and treatment:
  - National and regional communications campaigns are ongoing to encourage the public to seek advice and treatment when they need it
  - Priorities for consideration should be heart attacks, asthma, diabetic ketoacidosis, cancer symptoms, stroke
  - Encourage patients to attend appointments for diagnostics and treatment if they have cancer symptoms.

- The roll out of remote consultations for primary care and hospitals has helped to ensure many people have been able to access help and advice when they need it. As part of this approach face-to-face assessments should continue to be available where needed in some cases to determine the best next steps.

- Diagnostic overshadowing - **not all that coughs is COVID**
  - Consider pneumonia, sepsis, acute asthma, flu.

- Ceilings of care for COVID and other pathologies need to reflect the wishes of patient and family.

- Work should continue to promote best practice for end of life care in patients' homes and in care homes, including monitoring the use of advanced care planning.

- Accelerate the development of Community Virtual wards to manage COVID patients.

- Note that cirrhosis excess mortality has maintained throughout 2020, but this may change, therefore targeted intervention should be consider for patients with alcohol dependency.

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Care homes

Main recommendations

- **Continue testing all residents prior to admission** to care homes and self-isolation of new residents within single room/admission suite for 14 days.
- Continuation of routine testing of staff and residents with timely results and rapid respiratory panel testing for suspected outbreaks.
- Continue with risk assessments on each new care home situation/outbreak to implement timely IPC measures and prevent further transmission (CCGS, community services, Local Authority Public Health teams, Health Protection Teams).
- Strengthen care home workforce capacity/resilience and reduce staff sharing between settings.
- Use of ‘North West COVID-19 Care Home Resource Pack’ to amalgamate and simplify relevant guidance and testing pathways.
- A neuropsychiatric presentation/deterioration could be a sign of COVID infection.
- Work should continue to improve the end of life care in patients’ homes and in care homes, including monitoring the use of advanced care planning.

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Hospitals

Main recommendations

- Good infection control and prevention measures/social distancing/contact tracing remain paramount to protecting staff and patients and reducing outbreaks.
- The Critical Care Networks should disseminate the findings from their review of Critical Care in phase one to all providers, including the outcome findings from the ICNARC Case Mix adjusted model alongside workforce recommendations (the adjustment of nurse: patient ratios should not exceed 1:2 for Intensive Care and 1:4 for High Dependency Care).
- Hospitals to enable timely ambulance handovers.
- Hospital respiratory teams require support to deal with delirium.
- Hospital respiratory teams will need to support the COVID Virtual Ward model.
- Recommendations from the Medical Examiner following review of staff deaths need to be prioritised once available.
- Implementation of new therapies into clinical practice (Remdesivir, Dexamthasone).
- Hospital providers must ensure that Learning Disability Liaison Nurse support is available when required.

Note:

- Increasing age is a strong independent risk factor for death.
- Ethnicity and IMD decile do not predict death once admitted.
- Hypertension, a frailty score>5 and cancer are significant independent risk factors for death.
- Admission CRP, admission lymphocyte count and whether lymphocytes fell during admission did not predict death, but platelets <150 were an independent risk factor for death.

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Prioritising vulnerable groups

Main recommendations

Care home residents and people having home care:

- The out of hospital cells should work with local authorities to monitor/survey access to PPE for staff through the care home portal; this should also be monitored through local resilience mechanisms.
- CCGs should prioritise monitoring the flu vaccination uptake of this group.
- Virtual wards need to be established to support these patients where possible.

Learning disability and autism:

- The in hospital/out of hospital cells, working with local authorities, should prioritise completion of the ten North West recommendations form the rapid reviews of LD deaths **(slide 9).**

BAME communities:

- BAME recommendations are detailed on **slide 8.**
- Recommendations from the regional Medical Examiner review of staff deaths should be prioritised once available.

Maternity:

- ICS/STPs should ensure the recommendations have been actioned from the 2020 review of stillbirths and babies born before arrival.

Populations living in areas of high multiple deprivation (IMD):

- Deprivation carries with it an increased likelihood of comorbidities and is therefore influencing the likelihood of severe disease/death. This should be considered in clinical decision making.

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System recommendations

- Infection prevention and control measures/social distancing and contact tracing are key to controlling and reducing transmission of the virus and reducing outbreaks in all settings.

- More prevention and chronic disease management in primary care settings:
  - reinforcing the need for flu vaccination, ongoing routine care
  - health checks to optimise long-term condition management, especially diabetes, heart and respiratory diseases - working with clinical networks.

- Develop a programme for COVID vaccination.

- Systems need to focus upon the learning from Structured Judgement Reviews.

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Black, Asian and Minority Ethnic (BAME)

Main findings

- The lack of distinction, e.g. between Black-African or Black-Caribbean and North African or West African, is limiting further analysis and learning.
- There is a regional BAME Assembly, and a BAME inequalities sub-group that works with the Lancashire Resilience Forum, reviewing research and reports to suggest what can be done to support.
- Recommendations for key workers in response to higher risk for the BAME community include:
  - Ensure adequate PPE provision
  - Continue with occupational risk assessments
  - Tackling workplace bullying and discrimination is a priority
  - Continue the increased focus on workplace wellbeing.
- Work with at risk communities to modify and reduce vulnerabilities/comorbidities, for example through primary care and clinical networks, and prioritise these group for vaccinations.
- New ways of working are needed to tackle health inequalities, for example an inequalities network across the North West.
- Roll out of the ‘Wake up call’ programme, which encourages BAME people to look after their own health, particularly around diabetes, cardiovascular disease, hypertension and underlying respiratory conditions.
- One possible action for prevention among BAME communities is to increase the recommended dosage of Vitamin D. Clinical evidence and to support this is under review and is needed to support implementation.

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LD learning from rapid reviews

Ten recommendations:

1. **Public Health:** improve prevention through annual health checks and flu vaccinations.
2. **PPE:** ensure relevant guidance is available to carers who support people who have a learning disability in any setting, and that the guidance identifies where support can be accessed and when to escalate.
3. **Testing:** consider how we can prioritise the LD population and their carers and how testing can be less intrusive.
4. **COVID specific health monitoring:** ensure relevant training material is available to enable carers to identify early warning signs, particularly a pulse oximeter.
5. **Specialist support:** ensure contracts and protocols support LD clients within hospital settings.
6. **Communication:** include hospital passports, access to grab guides, and ensuring LD nurse support is available.
7. **Diagnosis:** avoid diagnostic over shadowing when assessing patients.
8. **DNA/CPR:** ensure necessary reviews take place, to avoid blanket application. Ensure there is a clear message around resuscitation and not the limitation of medical treatment. A further key recommendation is to provide clarity on process to involve family/carers.
9. **Cause of death/death certification:** review approach to recording primary cause of death as down syndrome or learning disabilities. Meetings are taking place with medical examiner for North West to discuss further.
10. **LeDeR:** provide additional guidelines via rapid review panel members to support those completing reviews.

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Contributors to this document

Dr Faizan Ahmed - GP and Deputy Medical Director North West, NHSEI

Dr Arun Chidambara - Medical Director for Operations, Mersey Care NHS Foundation Trust

Dr Gunjit Bandesha - Healthcare Public Health Consultant, PHE North West

Dr Jane Eddleston - Joint Group Medical Director, Manchester University NHS Foundation Trust

Will Manners - Senior Analyst Right Care Programme (North) NHSEI

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We are WHHT & We are PROUD to make a difference

NHS Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/21/01/19**	
SUBJECT:	Moving to Outstanding	
DATE OF MEETING:	27 January 2021	
AUTHOR(S):	Layla Alani, Deputy Director Governance	
EXECUTIVE DIRECTOR SPONSOR:	Kimberley Salmon-Jamieson, Chief Nurse & Deputy Chief Executive	
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	SO1 We will.. Always put our patients first through high quality, safe care and an excellent patient experience.	**x**
	SO2 We will.. Be the best place to work with a diverse, engaged workforce that is fit for the future.	
	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)***		
EXECUTIVE SUMMARY *(KEY ISSUES):*	The following report provides an update on Moving to Outstanding. This will include: • Consideration of how the CQC's new regulatory approach will impact the Trust • An assessment of the current position • Identification of steps to achieve compliance with linked actions to help the trust to move towards an outstanding rating • Establishment of work streams • Monitoring arrangements • An update regarding Provider Collaboration Reviews • An overview of CQC enquiries (none received) The next engagement meeting is scheduled for 9th February 2021	

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.	
	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	Moving to Outstanding	AGENDA REF:	BM/21/01/19

1. BACKGROUND/CONTEXT

Following completion of the CQC action plan (formally signed off at the M2O meeting on 19th November 2020), next steps are being taken to further progress the M20 agenda. The CQC's draft strategy was released in September 2020. This outlines a change in the way in which the CQC will regulate Trusts. Full details of the proposed plan are outlined below. In summary it includes five key steps, with one overarching principle. The steps are:

- Consideration of how CQC's new regulatory approach will impact the Trust
- An assessment of where we are now
- Identification of steps needed to achieve compliance with linked actions to move WHH to outstanding
- Establishment of work streams
- Continued monitoring arrangements

Throughout the above five steps there needs to be an overarching principle of staff engagement in the process. Regular updates will be provided to the Moving to Outstanding meeting. Updates will also be provided the Quality Assurance Committee.

The next quarterly CQC Provider Engagement Meeting is due to be held on 9th February 2021. Meetings are likely to increase in frequency with deeper verbal assessments (like Patient FIRST), with underpinning evidence across core services. Dates for future meetings for 2021 are expected to follow the next engagement meeting.

2.0 KEY ELEMENTS

2.1 Consideration of how CQC's new regulatory approach will impact the Trust

Fundamentally CQC intends to maintain their purpose, with an active focus on encouraging services to improve. The regulations should stay the same. However, CQC plan to change the way in which they regulate. In the interim a Transitional Regulatory Approach (TRA) has been introduced and this will be in place from January 2021, for 6-8 months. The TRA will replace the Emergency Support Framework (tool used to assess the trust for IPC) and enable CQC to target regulatory activity where it is most effectively needed. The focus will move to structured conversations in relation to risk and how this is being addressed by the Trust.

Monitoring will be a key element of the CQC's role. The KLOE will be linked to monitoring frameworks. Information will be reviewed from all sources, including Provider Collaboration Reviews. CQC has a risk model to support the decision making process.

<u>Inspections</u>
Monitoring is central to the new methodology. Inspections will move away from being comprehensive. Most inspections will be focused and used to validate information the Trust has provided through engagement meetings. The change in approach will mean there will be smaller

inspections, with the aim of being less burdensome for Trusts. However, this also offers CQC greater flexibility in the inspection process of Trusts.

Ratings

Generally, focused inspections will not result in a change in rating. CQC are currently reviewing the process for how they will change ratings without an inspection taking place. The aim is to have ratings that can be changed more frequently (ideally so that they are not more than three months old). More detail will be provided early in 2021 and updates will be given through the Moving to Outstanding meetings.

Data

CQC are exploring having live access to trusts' data. This will help them make informed judgements in relation to risk and care provision. Updates will be provided through the Moving to Outstanding meetings.

2.2 An assessment of our current position and next steps

In order to identify how the Trust can effectively Move to Outstanding under the new CQC methodology the five steps outlined under section 1.0 of the report will be followed. This will be supported by a task and finish group established and being used to create assessment frameworks across all core services, additional services and for the overarching well-led assessment. These frameworks will include relevant questions from the CQC's transitional regulatory approach, their initial core service/well led frameworks to ensure that the Trust can undertake appropriate assessments for assurance of regulatory compliance.

Alongside this work we will also consider the creation of live dashboards linking quality and performance metrics and the development of internal live reports linking to CQC insight reporting metrics. Ongoing work streams include:

- Well Led
- End of Life
- Children and Young People
- Medicines Management
- Use of Resources

2.3 Use of Resources

Progress of Use of Resources has been impacted by COVID-19. Following the November 2020 update, the meeting has been temporarily paused until February 2021. The Use of Resources board paper confirms an updated position in more detail (BM21/01/21)

2.4 Provider Collaboration Review

Following the Trust's Urgent Care Provider Collaboration Review, CQC have announced that they will be completing further Provider Collaboration Reviews for cancer services, mental health and learning disabilities within systems. At this point we have not been notified that we will be asked to participate in the next Provider Collaboration Review. However, some initial preparation is in place to review our current position for Cancer, Learning Disability and Mental Health for internal assurance.

2.5 Enquiries from CQC

Since 1 January 2021 the Trust have received 0 enquiries from the CQC:

2.6 CQC Quarterly Engagement Meetings

The January 2021 engagement meeting did not go ahead. The trust made an electronic data submission as an alternative approach. The next meeting will be on 9 February 2021. Meetings are likely to increase in frequency with deeper verbal assessments (like Patient FIRST), with underpinning evidence across core services. Meetings for 2021 are likely to be agreed at this meeting along with confirmation of changes in regulatory approach.

3.0 Recommendations

The Board of Directors is asked to note the report.

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	BM/21/01/20	
SUBJECT:	**Use of Resource Assessment (UoRA) Update – Q3 2020/21**	
DATE OF MEETING:	27th January 2021	
AUTHOR(S):	Dan Birtwistle, Deputy Head of Contracts & Performance	
EXECUTIVE DIRECTOR SPONSOR:	Andrea McGee, Chief Finance Officer and 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): **(*Please DELETE as appropriate)***	#115 Failure to provide adequate staffing levels in some specialities and wards. #134 (a) Failure to sustain financial viability. #134 (b) Failure to deliver the financial position and a surplus #135 Failure to provide adequate and timely IMT system. #125 Failure to maintain an old estate. #145 (a) Failure to deliver our strategic vision. #145 (b) Failure to fund two new hospitals. #241 Failure to retain medical trainee doctors.	
EXECUTIVE SUMMARY ***(KEY ISSUES):***	The Trust continues to progress improvement in its Use of Resources both internally and in collaboration with system wide partners, however COVID-19 has impacted progress. This paper outlines the current status of the Use of Resources Dashboard, however it should be noted that many of the indicators have not been updated on the Model Hospital, which makes benchmarking difficult.	

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

RECOMMENDATION:	The Board of Directors is asked to: 1. Note the contents of this report.	
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)***	Choose an item.	

REPORT TO THE BOARD OF DIRECTORS

SUBJECT	Use of Resource Assessment (UoRA) Update – Q3 2020/21	AGENDA REF:	BM/21/01/21

1. BACKGROUND/CONTEXT

The Use of Resource Assessment (UoRA) is designed to improve understanding of how effectively and efficiently the Trust uses its resources. The UoRA is based on 5 key lines of enquiry (KLOEs) these are; clinical services, people, clinical support services, corporate services and finance. The UoRA workstream has prepared a narrative for each KLOE and has developed a dashboard. This forms the basis from which to review and improve each KLOE indicator.

UoRA data is from the Model Hospital and has been benchmarked against peer and national median groups. The RAG rating is based on the Trust's position against the national median on the model hospital. The peer median group is based on NHSI's peer finder tool.

2. KEY ELEMENTS

This paper presents the update for Quarter 3. Progress has been impacted by the COVID-19 pandemic. Performance against each UoRA KLOE is set out in **Appendix 1**, the full detail for each KLOE indicator can be found in **Appendix 2**.

The following movements in the UoRA dashboard indicators have taken place since the Quarter 2 report:

- Staff Turnover – This indicator has moved from Green to Red. The position is reflected in the Trust Integrated Performance Report. Performance has been impacted by the temporary staff that supported the Trust during COVID-19 Wave 1, who has now left their post.
- Emergency Readmissions within 30 days – This indicator has moved from Red to Green. The Trust's performance in Q2 2021/22 was better than the national median.

UoRA National Status

UoRA inspections continue to be suspended nationally in response to COVID-19. The Model Hospital is now being updated with some monthly and quarterly indicators. However annual indicators have not been updated in some time, with data from 2018/19 still being displayed. At this time, there are no timescales when the inspections will resume or the format future inspections will take given the potential impact of additional costs, resources and the reduction in activity that has been required as part of the COVID-19 response.

3. RECOMMENDATIONS

The Board of Directors is asked to:

1. Note the contents of this report.

Andrea McGee
Chief Finance Officer and Deputy Chief Executive
20th January 2021

Appendix 1 – Benchmarking Performance against the National Median

KLOE Indicator	Q1 18/19	Q2 18/19	Q3 18/19	Q4 18/19	Q1 19/20	Q2 19/20	Q3 19/20	Q4 19/20	Q1 20/21	Q2 20/21	Q3 20/21
KLOE 1 - Clinical											
Pre Procedure Elective Bed Days	Q4 2017/18	Q1 2018/19	Q2 2018/19	Q3 2018/19	Q4 2018/19	Q2 2019/20	Q2 2019/20	Q3 2019/20	Q4 2019/20	Q1 2020/21	Q2 2020/21
Pre Procedure Non Elective Bed Days	Q4 2017/18	Q1 2018/19	Q2 2018/19	Q3 2018/19	Q4 2018/19	Q2 2019/20	Q2 2019/20	Q3 2019/20	Q4 2019/20	Q1 2020/21	Q2 2020/21
Emergency Readmission (30 Days)	Q4 2017/18	Q1 2018/19	Q2 2018/19	Q3 2018/19	Q4 2018/19	Q2 2019/20	Q2 2019/20	Q3 2019/20	Q4 2019/20	Q1 2020/21	Q2 2020/21
Did Not Attend (DNA) Rate	Q4 2017/18	Q1 2018/19	Q2 2018/19	Q3 2018/19	Q4 2018/19	Q2 2019/20	Q2 2019/20	Q3 2019/20	Q4 2019/20	Q1 2020/21	Q2 2020/21
KLOE 2 - People											
Staff Retention Rate	March 2018	June 2018	September 2018	December 2018	December 2018	December 2018	December 2018	March 2020	March 2020	June 2020	Sept 2020
Sickness Absence Rate	February 2018	May 2018	August 2018	November 2018	November 2018	June 2019	October 2019	March 2020	March 2020	June 2020	Sept 2020
Pay Costs per Weighted Activity Unit	2016/17	2016/17	2017/18	2017/18	2017/18	2017/18	2017/18	This indicator has been moved to a "Legacy" area of the model hospital and is no longer being updated.			
Medical Costs per WAU	2016/17	2016/17	2017/18	2017/18	2017/18	2017/18	2017/18	2018/19	2018/19	2018/19	2018/19
Nurses Cost Per WAU	2016/17	2016/17	2017/18	2017/18	2017/18	2017/18	2017/18	2018/19	2018/19	2018/19	2018/19
AHP Cost per WAU (community adjusted)	2016/17	2016/17	2017/18	2017/18	2017/18	2017/18	2017/18	2018/19	2018/19	2018/19	2018/19
KLOE 3 – Clinical Support Services											
Top 10 Medicines - Percentage Delivery of Savings	March 2018	March 2018	March 2018	March 2018	March 2018	September 2019	November 2019	March 2020	March 2020	August 2020	November 2020
Pathology - Overall Costs Per Test	Q2 2017/18	Q4 2017/18	Q4 2017/18	Q2 2018/19	Q2 2018/19	Q4 2018/19	Q2 2019/20	Q3 2019/20	Q3 2019/20	Q3 2019/20	Q1 2020/21
KLOE 4 – Corporate Services											
Non Pay Costs per WAU	2016/17	2016/17	2017/18	2017/18	2017/18	2017/18	2017/18	This indicator has been moved to a "Legacy" area of the model hospital and is no longer being updated.			
Finance Costs per £100m Turnover	2016/17	2016/17	2017/18	2017/18	2017/18	2018/19	2018/19	2018/19	2018/19	2018/19	2018/19
Human Resource Costs per £100m Turnover	2016/17	2016/17	2017/18	2017/18	2017/18	2018/19	2018/19	2018/19	2018/19	2018/19	2018/19
Procurement Process Efficiency and Price Performance Score Clinics	Q4 2016/17	Q4 2016/17	Q4 2017/18	Q3 2018/19	Q3 2018/19	Q4 2018/19	Q4 2018/19	Q4 2018/19	Q4 2018/19	Q2 2019/20	Q2 2019/20
Estates Costs Per Square Meter	2016/17	2017/18	2017/18	2017/18	2017/18	2018/19	2018/19	2018/19	2018/19	2018/19	2018/19

KLOE 5 - Finance									
Capital Services Capacity*									
Liquidity (Days)*									
Income & Expenditure Margin*									
Agency Spend - Cap Value*									
Distance from Financial Plan*									

*the model hospital does not benchmark these indicators against the national median and therefore there is no RAG rating available.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

UoR

Use of Resource Graph Key

Trust Position	
National Median	
Peer Median	

Key

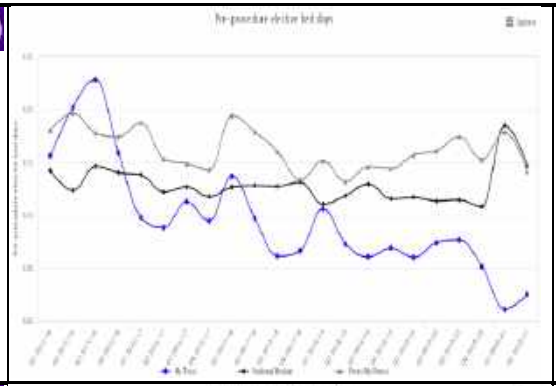
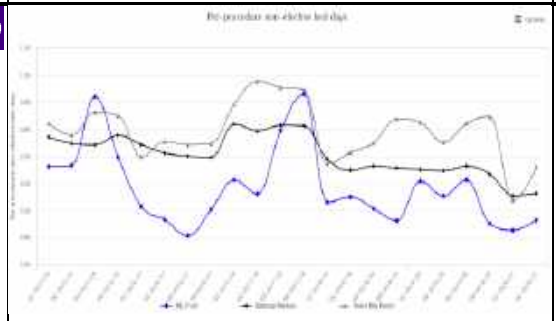
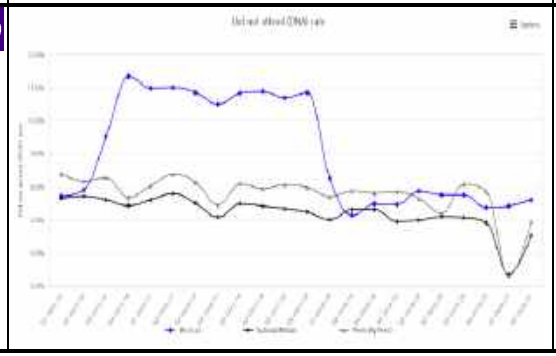
Green on the Model Hospital (Better than the National Median)
Red on the Model Hospital (Worse than the National Median)
Not RAG Rated on the Model Hospital

Use of Resources Assessment Dashboard - Q3 2020/21

Action/ Recommendation | **Benchmarking/Progress** | **Trend** | **Narrative - Warranted/Unwarranted & Justifiable**

KLOE 1: Clinical/Operational

KLOE Operational Lead: Hilary Stennings

Pre Procedure Elective Bed Days - The number of bed days between the elective admission date and the date that the procedure taken place.	**National Median: 0.15 days** **Q2 2020/21** **Peer Median: 0.14 days** **Target: Maintain** **Best Quartile: 0.8 days** **WHH Position:** **0.103 days** **Ranking:** **1/10 Peer Group** **Quartile:** **1 (Best)** **Monitoring: KPI Sub-Committee** **Source: Hospital Episode Statistics**		**The Trust is performing in the best quartile for this metric and is performing better than the national and peer medians.** The Trust continually reviews opportunities to provide same day admission. The surgical transformation programme supported the reduction in theatre cancellations and improving productivity and efficiency. Performance against this metric is further monitored via the Theatre Performance Dashboard. The Theatre dashboard has been enhanced using Power BI dashboards which allows a "Live" view of theatre performance and productivity. Further improvements have been made during the pandemic, however this is likely due to the reduction in the elective programme and the Trust would expect to see a slight rise in the number of bed days. However, the Trust was performing better than the national median prior to the pandemic.
Pre Procedure Non Elective Bed Days - The number of bed days between an emergency admission date and the date the procedure taken place.	**National Median: 0.56 days** **Q2 2020/21** **Peer Median: 0.66 days** **Target: Maintain** **Best Quartile: 0.40 days** **WHH Position:** **0.46 days** **Ranking:** **04/10 Peer Group** **Quartile:** **2 (2nd Best)** **Monitoring: KPI Sub-Committee** **Source: Hospital Episode Statistics**		**The Trust is performing in the best quartile for this metric and is performing better than the national and peer medians**. The Trust continually reviews opportunities to improve efficiency around emergency and non elective procedures. The surgical transformation programme is supporting the reduction in theatre cancellations and improving productivity and efficiency. Further improvements have been made during the pandemic, however this is likely due to the reduction in non elective activity. The Trust would expect to see a rise in the number of bed days. However, the Trust was performing better than the national median prior to the pandemic.
Did Not Attend Rate - Rate of patients not attending their outpatient appointment	**National Median: 6.54%** **Q2 2020/21** **Peer Median: 6.96%** **Target: National Median** **Best Quartile: 5.61%** **WHH Position:** **7.62%** **Ranking:** **07/10 Peer Group** **Quartile:** **4 (Worse)** **Monitoring: KPI Sub-Committee** **Source: Hospital Episode Statistics**		**The Trust is performing worse than the national and peer medians.** The Trust reintroduced a text reminder service which has resulted in a significant improvement in the DNA rate. Further improvements have been made to the text message and a communications campaign has been launched (Don't Let Me Down). DNA performance continues to be monitored through the Outpatient Steering Group. During the pandemic, the use of virtual and telephone appointments has been rapidly expanded and it is anticipated the Trust will see an improvement during future reporting periods.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

UoR

Use of Resource Graph Key

Trust Position

National Median

Peer Median

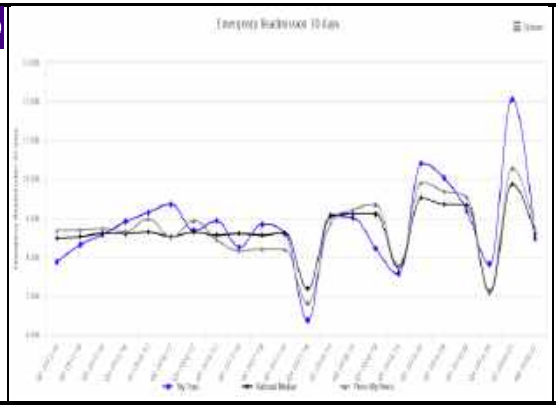
Key

Green on the Model Hospital (Better than the National Median)

Red on the Model Hospital (Worse than the National Median)

Not RAG Rated on the Model Hospital

Use of Resources Assessment Dashboard - Q3 2020/21

Action/ Recommendation	Benchmarking/Progress		Trend	Narrative - Warranted/Unwarranted & Justifiable
Emergency Readmission Rates (30 Days) - This indicator measures the percentage of admissions of people who returned to hospital as an emergency within 30 days of the last time they left hospital after a stay. Admissions for cancer and obstetrics are excluded as they may be part of the patient's care plan.	**National Median: 8.58%** **Peer Median: 8.73%** **Best Quartile: 7.42%** **WHH Position:** **Ranking:** **Quartile:** **Monitoring: KPI Sub-Committee** **Source: Hospital Episode Statistics**	**Q2 2020/21** **Target: 9.87%** **8.47%** **4/10 Peer Group** **2 (2nd Best)**	UoR 	**The Trust is performing better than national and peer medians.** Every effort is made when discharging patients to ensure that the discharge is appropriate. Readmissions are reviewed by the clinical directors to understand any inappropriate discharges and to ensure lessons are learned. The Trust is fully engaged with GIRFT and continues to use the intelligence to make improvements in efficiencies and the quality of services.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

UoR

Use of Resource Graph Key

Trust Position	
National Median	
Peer Median	

Key

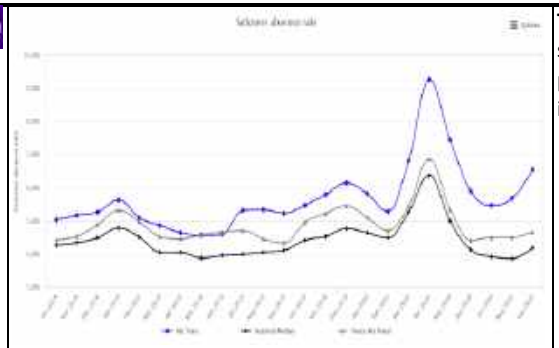
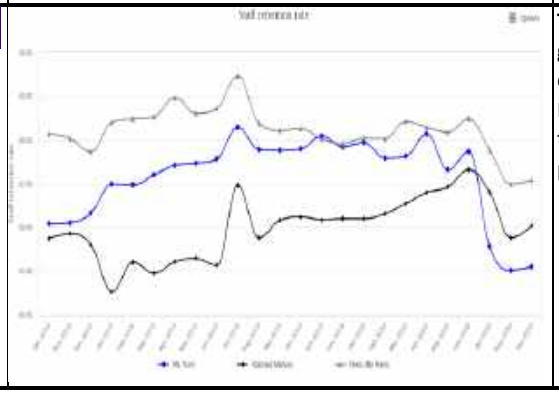
Green on the Model Hospital (Better than the National Median)
Red on the Model Hospital (Worse than the National Median)
Not RAG Rated on the Model Hospital

Use of Resources Assessment Dashboard - Q3 2020/21

Action/ Recommendation | **Benchmarking/Progress** | **Trend** | **Narrative - Warranted/Unwarranted & Justifiable**

KLOE 2: People

KLOE Operational Lead: Deborah Smith/Carl Roberts

Staff Sickness - Percentage of staff FTE sick days.	**National Median: 4.19%** **September 2020** **Peer Median: 4.68%** **Target: 4.2%** **Best Quartile: 3.62%** **WHH Position:** **6.55%** **Ranking:** **11/11 Peer Group** **Quartile:** **4 (Worse)** **Monitoring: Trust Board, TOB, SPC** **Source: HSCIC - NHS Digital iView Stability Index**		**The Trust is performing worse than the national and peer medians.** Significant strategic and operational work has been undertaken to improve the position. The position includes COVID-19 and Non COVID-19 related sickness but does not include shielding/medical suspensions as a result of COVID-19.
Staff Retention Rate - The percentage of staff that remained stable over 12 months period.	**National Median: 86.0%** **September 2020** **Peer Median: 87.1%** **Target: National Median** **Best Quartile: 88.2%** **WHH Position:** **87.90%** **Ranking:** **9/11 Peer Group** **Quartile:** **3 (2nd Worse)** **Monitoring: SPC** **Source: HSCIC - NHS Digital iView Stability Index**		**The Trust is performing worse than the national and peer median.** The Trust has generally performed well in regards to staff retention and turnover which has demonstrated the success of the programme of work implemented in line with the NHSI nursing retention programme. However, performance has been impacted by the significant number of temporary staff who supported the Trust during the pandemic and whom have now left their post.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Use of Resource Graph Key

Trust Position

National Median

Peer Median

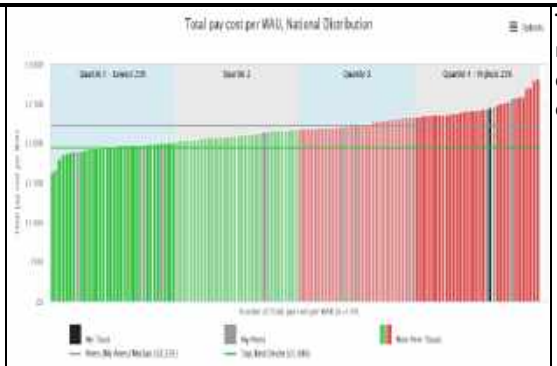
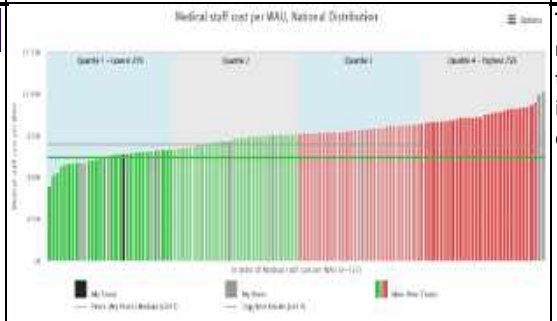
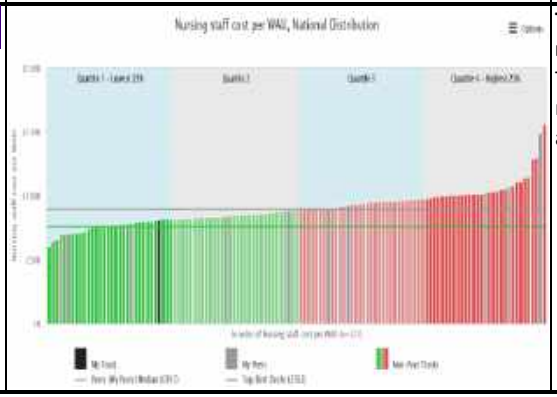
Key

Green on the Model Hospital (Better than the National Median)

Red on the Model Hospital (Worse than the National Median)

Not RAG Rated on the Model Hospital

Use of Resources Assessment Dashboard - Q3 2020/21

Action/ Recommendation	Benchmarking/Progress	Trend	Narrative - Warranted/Unwarranted & Justifiable
Pay Costs per Weighted Activity Unit - This metric shows the amount the trust spends on pay per WAU across all areas of NHS clinical activity. **This Metric is no longer being updated on the model hospital.**	**National Median: £2180** **2017/18** **Peer Median: £2312** **Target: £2312** **Best Quartile: £2014** **WHH Position:** **£2,455** **Ranking:** **9/11 Peer Group** **Quartile:** **4 (Worse)** **Monitoring: Trust Board, SPC (From March 2019), FSC, TOB** **Source: Trust consolidated annual accounts and reference cost data**		**The Trusts Pay costs per WAU are worse than the national and peer median.** This metric is no longer being updated on the model hospital. The Trust continues to explore ways to reduce pay costs whilst continuing to provide an excellent standard of patient care.
Substantive Medical Costs per WAU - This metric shows the amount the trust spend on pay for medical staff per WAU across all areas of NHS clinical activity.	**National Median: £763** **2018/19** **Peer Median: £697** **Target: Maintain** **Best Quartile: £672** **WHH Position:** **£642** **Ranking:** **4/11 Peer Groups** **Quartile:** **1 (Best)** **Monitoring: SPC** **Source: ESR, Trust consolidated annual accounts and reference cost**		**The Trusts medical pay costs per WAU are better than the national and peer median**. However vacancies within this workforce will have contributed to this. As the Trust seeks to recruit to these vacant posts, we could see costs per WAU increase, however this may lead to the reduction in other areas such as agency costs.
Substantive Nursing Cost Per WAU - Total pay costs for nursing staff, adjusted for the % of Trust expenditure reported in reference costs, the MFF, and the % of pay costs that are capitalised, divided by Cost Weighted Output in WAUs.	**National Median: £892** **2018/19** **Peer Median: £897** **Target: Maintain** **Best Quartile: £821** **WHH Position:** **£817** **Ranking:** **4/11 Peer Group** **Quartile:** **1 (Best)** **Monitoring: SPC** **Source: ESR, Trust consolidated annual accounts and reference cost**		**The Trusts Nursing Costs per WAU are better than the national and peer medians.** However, again the number of vacancies will have contributed to this. The Trust seeks to reduce reliance on temporary staffing by offering alternative retention and recruitment solutions with the expansion of the nursing workforce, advanced practice and specialist interest roles.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

UoR

Use of Resource Graph Key

Trust Position	
National Median	
Peer Median	

Key

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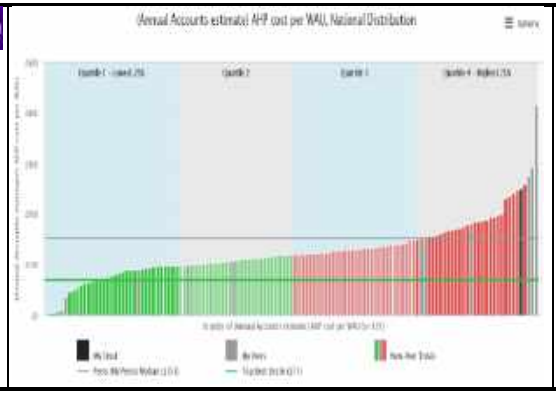
Red on the Model Hospital (Worse than the National Median)
Not RAG Rated on the Model Hospital

Use of Resources Assessment Dashboard - Q3 2020/21

Action/ Recommendation	Benchmarking/Progress	Trend	Narrative - Warranted/Unwarranted & Justifiable
Substantive AHP Cost per WAU Total pay costs for Allied Health Professionals, adjusted for the % of trust expenditure reported in Reference Costs, the MFF, and the % of pay costs that are capitalised, divided by Cost Weighted Output in WAUs.	**National Median: £121** **2018/19** **Peer Median: £153** **Target: £153** **Best Quartile: £99** **WHH Position:** **£251** **Ranking:** **08/11 Peer Group** **Quartile:** **4 (Worse)** **Monitoring: SPC** **Source: ESR, Trust consolidated annual accounts and reference cost**		**The Trusts AHP Costs per WAU are worse than the national and peer medians.** Across the therapy element of AHP, pay costs for community/other work has been included in the cost per WAU calculation on Model Hospital. This indicator includes costs for staffing who are outsourced via SLA to other Trusts. This activity is not included in the WAU, if these costs were removed, the revised estimated costs per WAU would be £123 which brings the Trust in line with the national median. • For example, we have Therapists working as 'first point of contact practitioners'. Rather than seeing a GP first, patients with musculoskeletal issues are triaged by a Therapist and either discharged, treated or referred to secondary care. Also Therapy staff within RARS form part of Halton integrated community teams and the activity sits with the borough council.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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National Median	
Peer Median	

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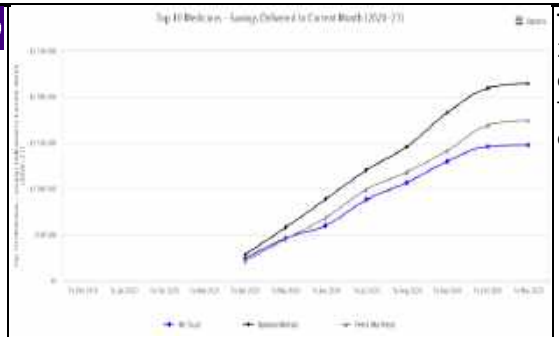
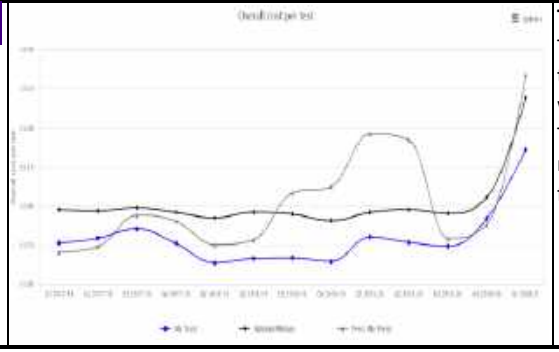
Use of Resources Assessment Dashboard - Q3 2020/21

Action/ Recommendation | **Benchmarking/Progress** | **Trend** | **Narrative - Warranted/Unwarranted & Justifiable**

KLOE 3: Clinical Support

KLOE Operational Lead: Diane Matthew
KLOE Operational Lead: Neil Gaskell
KLOE Operational Lead: Mark Jones

Top 10 Medicines - Percentage Delivery of Savings (Pharmacy)	**Benchmark: £943k** **November 2020** **Peer Median: £1.74m** **Target: Benchmark** **Best Quartile: N/A** **WHH Position:** **£1.48m** **Ranking:** **3/10 Peer Group** **Quartile:** **N/A** **Monitoring: Medicines Governance Committee** **Source: Rx-Info Define© (processed by Model Hospital)**		**The Trust is performing better than the national benchmark.** As of November 2020, the Trust has achieved £1.48m savings which is positive. The Trust continues to work with CCGs to identify opportunities for medication savings. The Trust is participating in a QIPP project to identify areas where prescribing is sub-optimal and where joint working could produce improvements/savings.
Pathology - Cost Per Test - The cost per test is the average cost of undertaking one pathology test across all disciplines, taking into account all pay and non-pay cost items.	**National Median: £3.38** **Q1 2020/21** **Peer Median: £3.68** **Target: Maintain** **Best Quartile: £1.52** **WHH Position:** **£2.72** **Ranking:** **2/4 Peer Group** **Quartile:** **2 (2nd Best)** **Monitoring: Pathology Business Meeting** **Source: NHSI Q Pathology Data Collection 19/20**		**The Trust is performing better than the national and peer medians.** Overall the Trust's pathology service is efficient with the use of streamlined processes, technology and procurement opportunities. It is anticipated that the cost per test will rise as a result of the COVID-19, as the number of tests performed has reduced. This will be in line with the National and Peer medians. Data collections have now resumed and the Trust has submitted up to date data including the annual position for 2019/20 and Q2 2020/21.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

UoR

Use of Resource Graph Key

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Use of Resources Assessment Dashboard - Q3 2020/21

Action/ Recommendation

KLOE 4: Corporate Services

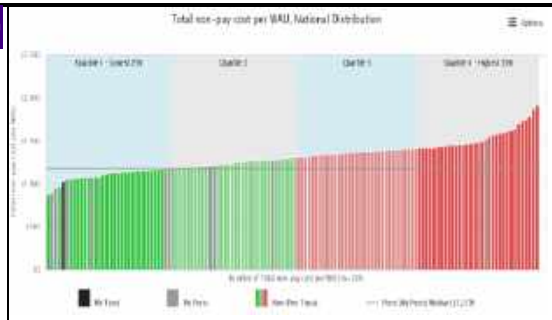
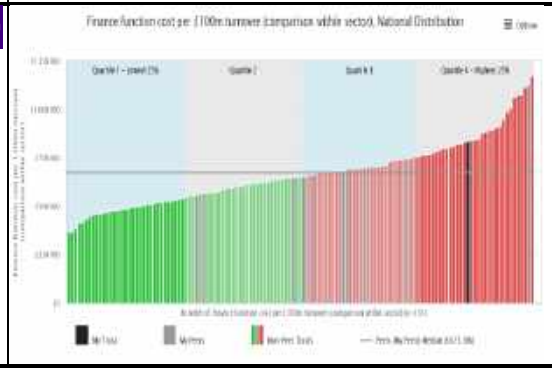
Benchmarking/Progress

Trend

Finance
Procurement
HR & OD
Estates & Facilities
IM&T

Narrative - Warranted/Unwarranted & Justifiable

KLOE Operational Lead: Jane Hurst
KLOE Operational Lead: Alison Parker
KLOE Operational Lead: Deborah Smith/Carl Roberts
KLOE Operational Lead: Ian Wright
KLOE Operational Lead: Matthew Gardner

Non Pay Costs per WAU - This metric show the amount the trust spends on non-pay per WAU across all areas of NHS clinical activity. **This Metric is no longer being updated on the model hospital.**	**National Median: £1307** Peer Median: £1200 **Best Quartile: £1172** **WHH Position:** £1,027 **Ranking:** 3/11 Peer Group **Quartile:** 1 (Best) **Monitoring: FSC** **Source: HSCIC - NHS Digital iView Stability Index**	**2017/18** **Target: Maintain**		**The Trusts non pay costs per WAU are better than the national and peer medians.** The Trust continues to review opportunities to reduce non-pay costs whilst maintaining quality. This indicator is no longer being updated on the model hospital.
Finance Costs per £100m Income - Total finance cost divided by trust turnover multiplied by a £100m	**National Median: £653k** Peer Median: £673k **Best Quartile: £541k** **WHH Position:** £838k **Ranking:** 10/11 Peer Group **Quartile:** 4 (Worse) **Monitoring: FSC** **Source: Trust consolidated annual accounts and NHSI improvement 18/19 data collection template**	**2018/19** **Target: Benchmark**		**The Trusts Finance costs per £100m income are worse than the national and peer medians based on national benchmarking data.** This indicator has not been updated since 2018/19, no national benchmarking has taken place for 2019/20. There has been an overall reduction in Finance costs per £100m income in 2018/19 from £852k to £839k which includes the restructure of some teams and the removal of posts. The Trust is currently above the national median based on costs per £100m income; however the absolute cost of the finance function is below the national median. There remains an issue with the way the SBS costs are treated and this has affected the position, if these costs were removed, it would bring the Trust to below the national median.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Use of Resource Graph Key

Trust Position

National Median

Peer Median

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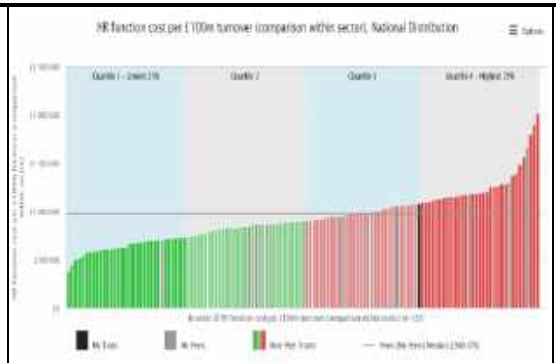
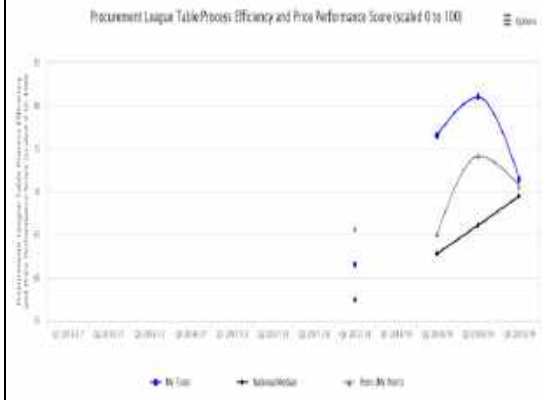
Use of Resources Assessment Dashboard - Q3 2020/21

Action/ Recommendation	Benchmarking/Progress	Trend	Narrative - Warranted/Unwarranted & Justifiable
Human Resource Costs per £100m Income - HR is made up of a number of sub compartments taken into consideration when considering total HR costs per £100m turnover.	**National Median: £911k** 2018/19 **Peer Median: £980k** **Target: Benchmark** **Best Quartile: £745k** **WHH Position:** **£1.09m** **Ranking:** **8/11 Peer Group** **Quartile:** **4 (Worse)** **Monitoring: SPC** **Source: Trust consolidated annual accounts and NHSI improvement 18/19 data collection template**		**The Trusts HR costs per £100m income is worse than the national median based on the national benchmarking data.** This indicator has not been updated since 2018/19, no national benchmarking has taken place for 2019/20. The Trust has seen a reduction in HR costs per £100m income in 2018/19 from £1.2m to £1.1m which brings the Trust to just above the national median. Payroll costs have reduced in 2018/19 from £114k to £97k and this is below the national median with core payroll in the national best quartile. HR costs per FTE are lower than the national and peer medians, with the exception of Medical Staffing & Education each sub-function is also below the national median based on this.
Procurement Process Efficiency and Price Performance Score - This measure provides an overall view of how efficient and how effective an NHS Provider is in it's procurement process and price performance, respectively, when compared to other NHS providers.	**National Median: 56** Q2 2019/20 **Peer Median: 44.7** **Target: 72** **Best Quartile: 72** **WHH Position:** **61** **Ranking:** **4/11 Peer Group** **Quartile:** **3 (2nd Best)** **Source: Purchase Price Index and Benchmark (PPIB) tool**		**The Trust is better the national median for Procurement Process Score.** Contributing to the League Table position is the use of EDI (Electronic Transfer of Orders and Invoices). The Trust has never used an external supplier to manage it's catalogues which is contributing factor in the use of EDI; the Trust manages its own catalogues resulting in the performance against the use of EDI being lower. The Trust is however, moving to Edge for Health (this has been suspended due to COVID-19) which will improve the EDI metric and therefore contribute to the Procurement League Table ranked position.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

UoR

Use of Resource Graph Key

Trust Position	
National Median	
Peer Median	

Key

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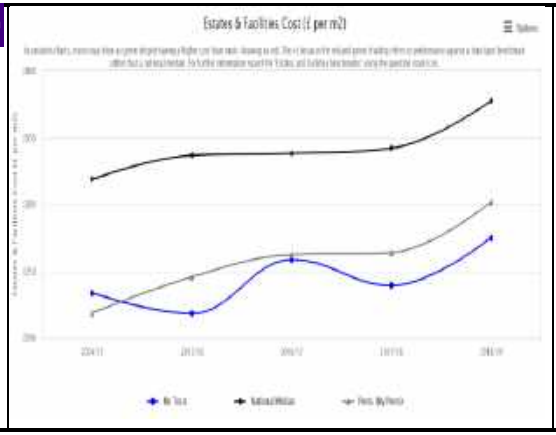
Not RAG Rated on the Model Hospital

Use of Resources Assessment Dashboard - Q3 2020/21

Action/ Recommendation	Benchmarking/Progress		Trend	Narrative - Warranted/Unwarranted & Justifiable
Estates & Facilities Costs (£ per m2) - The total estates and facilities running costs is the total cost of running the estate in an NHS trust including, staff and overhead costs. In-house and out-sourced costs, including PFI costs, will be included.	**National Median: £377** **Peer Median: £302** **Best Quartile: £322** **WHH Position:** **Ranking:** **Quartile:** **Monitoring: Estates and Facilities Operational Group** **Source: ERIC 2018-19 Total Estates and Facilities Running Costs**	**2018/19** **Target: Maintain** **£275** **3/11 Peer Group** **1 (Best)**		**The Trust Estates and Facilities costs are better than the national and peer medians.** The Trust has invested year on year to reduce backlog maintenance, however without a significant increase in investment, the amount of backlog to bring the estate up to appropriate standards will always rise. This in turn has and will continue to have an adverse effect on overall estates and facilities costs. The Trust has had the opportunity in 2020/21 to significantly invest in backlog maintenance and should see the benefits of this in 2021/22.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Use of Resource Graph Key

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National Median	
Peer Median	

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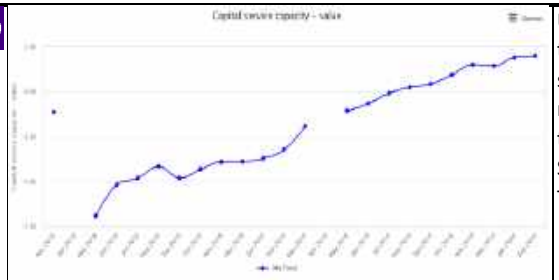
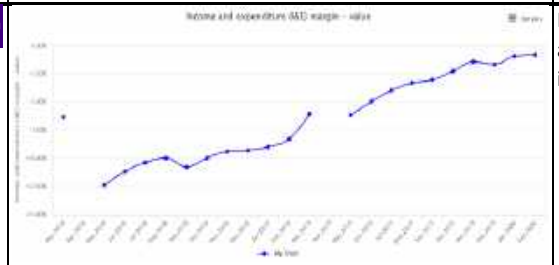
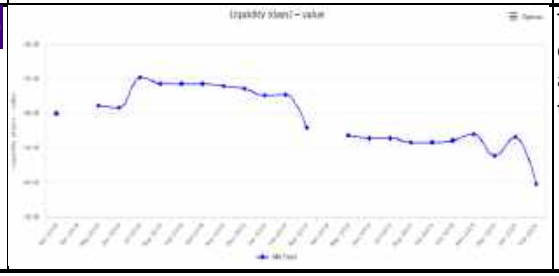
Use of Resources Assessment Dashboard - Q3 2020/21

KLOE 5: Finance

KLOE Operational Lead: Jane Hurst

Action/ Recommendation	Benchmarking/Progress	Trend	Narrative - Warranted/Unwarranted & Justifiable
Capital Services Capacity - The degree to which the provider's generated income covers its financial obligations	National Median: N/A Peer Median: N/A Best Quartile: N/A WHH Model Hospital 1.99 (February 2019) WHH Current Position: 2.22 (November 2020) **Monitoring: FSC/ Trust Board** **Source: Provider Returns**		Use of Resource (Finance) reporting has been suspended since March, therefore the information on the model hospital is out of date. The Finance position has significantly changed since April 2020 due to the COVID-19 pandemic under the new financial regime. For months 1-6 the Trust has shown a break even position, the Trust received top up income to address COVID-19 costs, this ended in September 2020. The current forecast for the end of the year is c£13.9m deficit. The Trust continues to respond to developments and awaits next steps.
Income & Expenditure Margin - The income and expenditure surplus or deficit, divided by total revenue.	National Median: N/A Peer Median: N/A Best Quartile: N/A WHH Model Hospital -0.85% (February 2019) WHH Current Position: -1.42% (November 2020) **Monitoring: FSC/ Trust Board** **Source: Provider Returns**		For months 1-6, the Trust showed a break even position. The Phase 3 plan assumed a £10.3m deficit on the basis that R=1. The current forecast at M9 including second wave is c£13.9m deficit.
Liquidity (Days) - Days of operating costs held in cash or cash-equivalent forms, including wholly committed lines of credit available for drawdown.	National Median: N/A Peer Median: N/A Best Quartile: N/A WHH Model Hospital -66.53 (February 2019) WHH Current Position: -23.29 (November 2020) **Monitoring: FSC/ Trust Board** **Source: Provider Returns**		The Trust's cash position has been c£20m, this was due to all Trusts receiving an extra income payment in M1 to support cashflow. As a result, the Trust has been able to pay suppliers promptly resulting in an improvement in compliance against the better practice payment code (BPPC) which was 89% (Cumulative) year to date.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

UoR

Use of Resource Graph Key

Trust Position	
National Median	
Peer Median	

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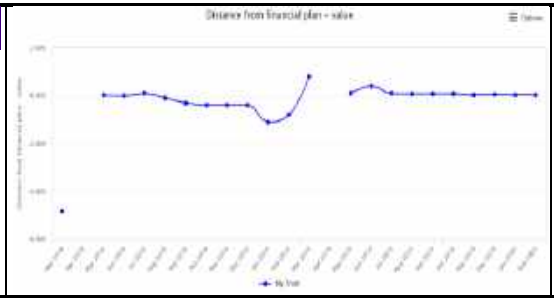
Not RAG Rated on the Model Hospital

Use of Resources Assessment Dashboard - Q3 2020/21

Action/ Recommendation	Benchmarking/Progress	Trend	Narrative - Warranted/Unwarranted & Justifiable
Distance from Financial Plan - Year-to-date actual I&E margin in comparison to year-to-date plan I&E margin. I&E margin calculated on a control total basis. Measure is in percentage points.	National Median: N/A Peer Median: N/A Best Quartile: N/A WHH Model Hospital 0.04% (February 2019) WHH Current Position: -0.53% (November 2020) **Monitoring: FSC/ Trust Board** **Source: Provider Returns**		In October 2020, the Trust submitted a revised plan (Phase 3). The revised plan assumed the COVID-19 R rate would continue to equal 1 or below and did not take into account a potential second wave. As at M9, the forecast is expected at £13.9m deficit due to wave 2 COVID-19.
Agency Spend - Cap Value - The extent to which the trust is meeting the target for the amount spend on agency workers for the financial year.	National Median: N/A Peer Median: N/A Best Quartile: N/A WHH Model Hospital 13.00% (February 2019) WHH Current Position: **Monitoring: FSC/ Trust Board** **Source: Provider Returns**		There is no agency cap for 2020/21, however the Trust continues to closely monitor agency spending for both business as usual and COVID-19 requirements.

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/21/01/21**
SUBJECT:	**Guardian of Safe Working for Junior Doctors Report - Q3 2020-21**
DATE OF MEETING:	27 January 2021
AUTHOR(S):	Mark Tighe, Guardian of Safe Working
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.
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): **(*Please DELETE as appropriate)***	#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. #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 2016 Junior Doctor Contract is fully established at WHH for all Foundation Doctors and the majority of the CT and ST grades and the monitoring of the safe implementation of the contract is the responsibility of the Medical Education Department under the direction of the Guardian of Safe Working (GSW). Issues regarding safe working hours, rota problems, educational or patient safety issues are recorded by Junior Doctors in the form of Exception Reporting via the Allocate System which are then escalated to their responsible Educational Supervisors and monitored by the GSW. During Quarter 3 2020-21, 32 Exception Reports (ER) were submitted; this is a reduction compared to the normal monthly average. A reduction in ERs was noted during the first wave of COVID, and it appears that this is being reflected again for Q3, with the surge in COVID inpatients at the Trust during this quarter. Over 84% of ERs relate to excess hours worked. One ER was submitted as a missed educational opportunity. One Immediate Safety Concern was reported in a urology trainee which has been addressed.

	Since the last report, it can be confirmed that rotas remain compliant, and the majority of Junior Doctors are happy with their allocations.			
PURPOSE: ***(please select as appropriate)***	Information	Approval	To note	Decision
RECOMMENDATION:				
PREVIOUSLY CONSIDERED BY:	**Committee**	Choose an item.		
	Agenda Ref.			
	Date of meeting			
	Summary of Outcome			
FREEDOM OF INFORMATION STATUS (FOIA):	Choose an item.			
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	Choose an item.			

REPORT TO BOARD OF DIRECTORS

SUBJECT	Guardian of Safe Working for Junior Doctors Report - Q3 2020-21	AGENDA REF:	BM/21/01/21

1. BACKGROUND/CONTEXT

The 2016 Junior Doctor Contract is now well established at WHH; rotas for medical trainees are fully compliant, and systems are in place to allow work schedule reviews to be undertaken if there are persistent problems with individual rotas. Most medical trainees engage with their Educational Supervisors (ES) and Guardian of Safe Working (GSW) if any new issues develop. Issues can also be highlighted via the Junior Doctors Forum, held bi-monthly, which is attended by the Director of Medical Education, Executive Medical Director, HR Colleagues and the Guardian of Safe Working (GSW).

The GSW attends the Regional Guardian Forum to ensure the Trust is performing in-line with its peers.

It is important to remember that the vast majority of the Junior Doctors (employed by the Lead Employer) have now transitioned onto the new 2016 Contracts. However, some will retain the 2002 pay protection until the end of their Training Contract.

As part of the monitoring of the 2016 Contract for Junior Doctors, the GSW is also required to submit data relate to the number of trainees hosted by WHH on the 2016 contract to the Lead Employer, who is responsible for presenting a quarterly report to the St Helens and Knowsley Trust Board.

2. KEY ELEMENTS

During Quarter 3 2020-21, 32 Exception Reports (ER) submitted; this is a reduction of 50% compared to Q2. A reduction in ERs was noted during the first wave of COVID, and it appears that this is being reflected again for Q3, with the surge in COVID inpatients during this quarter.

The majority of the ERs still relate to Foundation Doctors working past their allocated time, usually on an ad-hoc basis. These were equally divided between medicine and surgical specialties. Only one related to missed educational opportunities, which is encouraging. There was one immediate safety concern, (ISC) submitted in this quarter, and one relating to lack of service support for a junior doctor.

Assurance can be provided that all Foundation Programme Doctors employed during this period were well on track to progress through their current year of training.

Historically, there have been significant delays in the review meetings between the ES and Junior Doctor, once an ER has been submitted. At the end of Q3, there were 47 ERs outstanding (down from 56 at the end of Q2). The need for sign-off of ERs is continually reinforced to trainees at the Junior Doctors Forum and Trust Induction. There has been a big improvement in January 2021, and further improvement is expected in Q4. This is because

the Junior Doctors are now receiving an email reminder to have their ER signed off within 2 weeks, if they want to receive compensatory payment or time off in lieu (TOIL).

Any difficulties with the sign-off process will be escalated to the Medical Education Service and / or the Guardian of Safe Working.

Exception Reporting - Q3

Quarter	Reporting Period	Deadline for Data Provided by the Host
Q3 Report	**1st October 2020**	**31st December 2020**

Exception Reports (ER) over past quarter	
Reference period of report	01/10/20 - 01/01/21
Total number of exception reports received	32
Number relating to immediate patient safety issues	1
Number relating to hours of working	27
Number relating to pattern of work	3
Number relating to educational opportunities	1
Number relating to service support available to the doctor	1

***Note**: Within the system, an exception relating to hours of work, pattern of work, educational opportunities and service support has the option of specifying if it is an Immediate Safety Concern (ISC). ISC is not an exception type by itself.*

Summary

- number of exception reports raised = 32
- number of work schedule reviews that have taken place = 1
- immediate safety concerns = 1
- fines that were levied by the Guardian = NIL
- The majority of ERs have been submitted by FY1 doctors (72%) reflecting the busy workload of medical trainees on the wards. Equal numbers have been received from General Surgery and Medicine. Undoubtedly, the general workload in medicine is higher, but it also reflects the variable work patterns of the surgical specialties.

Over 84% of ERs relate to excess hours worked. Trainees comment that they have to stay late to complete ward duties or review and manage sick inpatients, which they feel they cannot handover to the on-call teams. This is entirely understandable and predictable, although routine duties should not need to be done out of hours generally.

Only 1 ER was submitted as a missed educational opportunity, which is encouraging to see.

Another Immediate Safety Concern was reported from a urology F1. The junior felt unsupported by a couple of the middle grade urologists, and were left managing patients

out of their depth. This ER was beginning of Q3 (October 5th), and has been addressed with regular meetings with the consultant urologists. There have been no recent ERs submitted on this subject.

ER outcomes: resolutions	
Total number of exceptions where TOIL was granted	9
Total number of overtime payments	18
Total number of work schedule reviews	1
Total number of reports resulting in no action	2
Total number of organisation changes	0
Compensation	0
Unresolved	53
Total number of resolutions	**29**
Total resolved exceptions	**32**

Note:
** Compensation covers obsolete outcomes such as 'Compensation or time off in lieu' and 'Compensation & work schedule review'.*

** Some exceptions may have more than 1 resolution i.e. TOIL and Work schedule review.*

** Unresolved is the total number of exception where either no outcome has been recorded or where the outcome has been recorded but the doctor has not responded.*

Reasons for ER over last quarter by specialty & grade

ER relating to:	Specialty	Grade	No. ERs carried over from last report	No. ERs raised	No. ERs closed	No. ERs outstanding
Immediate	Urology	FY1	0	1	0	1
Total			**0**	**1**	**0**	**1**
No. relating to hours/pattern	Acute Medicine	Foundation house officer 1	3	0	2	0
	Acute Medicine	FY1	0	7	1	7
	Acute Medicine	FY1 *	0	0	0	2
	Anaesthetics	CT1	1	0	1	0
	Gastroenterology	Foundation house officer 1	4	0	0	2
	Gastroenterology	FY2	0	0	0	1
	General surgery	Foundation house officer 1	11	0	0	11
	General surgery	FY1	7	6	10	5
	General surgery	FY1 *	5	0	0	5
	General surgery	FY2	0	3	0	3
	Geriatric medicine	CT1	0	1	0	1
	Geriatric medicine	FY1	1	7	6	2
	Ophthalmology	ST3	4	3	7	0
	Psychiatry	FY1	1	0	1	1
	Respiratory Medicine	CT1	0	1	1	0
	Trauma & Orthopaedic Surgery	Foundation house officer 1	1	0	0	1
	Trauma & Orthopaedic Surgery	FY2 *	2	1	0	3
	Urology	Foundation house officer 1	1	0	0	1
	Urology	FY1	0	1	0	2
Total			**41**	**30**	**29**	**47**
No. relating to educational opportunities	Acute Medicine	Foundation house officer 1	1	0	1	0
	Anaesthetics	CT2	0	1	0	1
	Gastroenterology	CT1	0	0	0	1
	General surgery	Foundation house officer 1	1	0	0	1
	General surgery	FY1	1	0	1	0
	Trauma & Orthopaedic Surgery	FY2 *	1	0	0	1
	Urology	FY1	0	0	0	1
Total			**4**	**1**	**2**	**5**
No. relating to service support	Anaesthetics	CT1	1	0	1	0
	Urology	FY1	0	1	0	1
Total			**1**	**1**	**1**	**1**

3. ACTIONS REQUIRED/RESPONSIBLE OFFICER

The rotas at WHH are all compliant – the ophthalmology middle grade on call rota was recently adjusted to account for increased weekend workload.

Longstanding issue with the delay in sign-off of Exception Reports has improved. Some supervisors are slow to respond to receipt of ERs, but the junior doctor delay sign off once the exception meeting has taken place. Regular email communication has led to an increase in sign-offs recently.

The issue of Foundation Year 1 Doctors having adequate time off for mandatory training has been addressed and as with compliance rates for completion, this too has been evidenced in the ER's submitted. The Medical Trainees' Workforce Administrator has formulated a Standard Operating Procedure for completion of mandatory training, which has been disseminated to junior doctor representatives and CBU Rota Managers for comment.

No further issues have been raised related to break times in AED (previously a fine was issued in 2019).

4. IMPACT ON QPS?

Quality – The Guardian of Safe Working and Exception Reporting Processes have been designed to ensure there are controls in place which prevent medical trainees from working extended hours which would in turn impact on the delivery safe, high quality care.

Performance – Ensuring safe working practices of medical trainees and their wellbeing and listening to their concerns through Junior Doctors Forum and via other channels demonstrates that the Trust cares and provides increased opportunities for a satisfied and engaged workforce, fit for the future.

The Medical Workforce is an invaluable asset to the Organisation. The Guardian of Safe Working Hours has been introduced to protect patients and doctors by making sure doctors are not working unsafe hours. The **guardian** will: act as the champion of safe working hours for doctors in approved training programmes.

5. MEASUREMENTS/EVALUATIONS

Q3 2020-21

Quarterly Report on Safe Working Hours Data	
Reporting Time Period:	1st October to 31st December 2020
Trust Name:	Warrington & Halton Teaching Hospitals NHS Foundation Trust
Guardian of Safe Working Hours Name:	Mr Mark Tighe
GOSW Email Address:	mark.tighe@nhs.net
No.of doctors/dentists in training (total)	197
No.of doctors/dentists in training on the 2016 contract TCS (total)	197
No. of lead employer trainees on the 2016 contract at your Trust	125
Amount of time available in job plan for Guardian to do the role	1.5 PA's
Admin support provided to the Guardian (if any)	Under review
Amount of job-planned time for educational supervisors	0.25 PA's per trainee

Exception Report submitted by Lead Employer doctors – Q3 2020-21

Quarterly Report on Safe Working Hours Data	
Reporting Time Period:	1st October until 31st December 2020
Trust Name:	Warrington & Halton Teaching Hospitals NHS Foundation Trust
Guardian of Safe Working Hours Name:	Mr Tighe
GOSW Email Address:	mark.tighe@nhs.net
No.of doctors/dentists in training (total)	197
No. of lead employer trainees on the 2016 contract at your Trust	125
Amount of time available in job plan for Guardian to do the role	1.5 PA's
Admin support provided to the Guardian (if any)	Under review
Amount of job-planned time for educational supervisors	0.25 PA's per trainee

Exception reports												
Specialities	No.at CT1/2 Level		No. given TOIL or payment at CT1/2 Level			No.at ST3+ Level		No. given TOIL or payment at ST3+ Level				
	Raised	Closed	TOIL	Payment	No. that are on-going	Raised	Closed	TOIL	Payment	Other - Please Specify	No. that are on-going
General Surgery (Inc HPB/OG/CR)											
Urology											
Gynaecology & obstretrics											
Orthopaedics											
Vascular											
ENT/ Head & Neck											
Plastics (Inc. Burns)											
Neuro											
Cardiothoracic											
Maxillofacial											
Transplant											
Anaesthetics	1	1									
ITU											
Paediatrics											
Aemergency medicine (A&E)											
General medicine (AMU)											
Cardiology											
Respiratory	1	1	1								
Gastroenterology											
Nephrology											
Endocrinology (Inc. Diabetes)											
Neurology											
Stroke Medicine											
Elderly care											
Ophthalmology						3	3		3		
Dermatology											
Oncology											
Haematology											
Chemical / Histopathology											
Microbiology											
Radiology											
Other (e.g. Psychiatry)											

Only 5 ERs were submitted by trainees with central contracts from the Lead Employer 2019/20. No significant events or issues related to these ERs

6. TRAJECTORIES/OBJECTIVES AGREED

1. Exception Reports should be completed ASAP, but no later than 14 days of the Exception being submitted through Allocate.
2. Where the trainee is seeking payment as compensation, the report should be submitted within 7 days.
3. For EVERY Exception Report submitted, ether for payment or TOIL; it is the Educational Supervisor who is required to respond to the Exception Report within 7 days.
4. The Trainees need to indicate “acceptance” or “escalate” to the next stage (Level 1 Review). It is only following confirmation of acceptance, that the Exception Report can be closed.
5. If an ER is not actioned within 7 days, the GSW will issue an email to expedite sign-off.

The GSW will be provided with timely data reports to support his role in the coming year, with particular reference to improvement in response times for ERs.

7. MONITORING/REPORTING ROUTES

Quarterly and Annual Guardian of Safe Working Hours’ Reports should be provided to the Local Negotiating Committee (LNC). The Annual Report is also required to be included in the

Trust's Annual Quality Account and signed off by the Chief Executive; the contents of both reports may be included or referenced in Annual Reports provided by the Employer to Health Education England (HEE), Care Quality Commission (CQC) and/or the General Medical Council (GMC).

It is also normal practice for the Trust's Executive Committee (Strategic People Committee) to have sight of the Reports before they are submitted to the Board as the Executive Committee may be able to describe to corporate responses to the issued raised by the Guardian of Safe Working and to provide relevant advice.

It might also be good practice to share a copy of the report with the Junior Doctors Forum of the employing/host Organisation. Guardians of Safe Working may also wish to share the data across regional networks to allow for aggregated regional and/or national analysis.

8. TIMELINES

SPC – Strategic People Committee
Guardian of Safe Working - Quarterly Reports, Safe Working Hours Junior Doctors in Training:-

- (Q1 – end of June 2020) –submitted November 2020
- (Q2 – end of Sept 2020) – submitted November 2020
- (Q3 - end of Dec 2019) – to be submitted January 2021
- (Q4 – end of March 2020) – to be submitted May 2020

Trust Annual Board Report
Guardian of Safe Working Annual Report, Safe Working Hours Jnr Doctors in Training:-

- submitted May 2020

9. ASSURANCE COMMITTEE

N/A

10. RECOMMENDATIONS

This Report covers Q3 of the 2020-21 the financial year. This remains a turbulent time for the Trust due to COVID pressures which is reflected in relatively low numbers of ERs submitted by medical trainees. The 32 ERs received are much less compared with the average numbers of ERs received over the last 4 years (average 20-25 per month, total 932 since introduction of New Contract in October 2016).

There was only one immediate safety concern raised in October 2020 within urology, which has been addressed. The work schedule review has been completed for Ophthalmology ST3+ trainees.

No fines were submitted by the Guardian in Q3.

To conclude, The Trust will continue to monitor ERs and ER sign-offs, to ensure any persistent issues in departments are addressed. To date, the trust continues to provide fully compliant and safe rotas for the junior doctors, and all doctors are in-line with safe working hours. Persistent issues are dealt with in a timely manner.

Please note the findings of the report and consider the assurances made accordingly. The GSW can attend subsequent board meetings if any queries or concerns are raised.

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/21/01/22**	
SUBJECT:	**Digital Update Report**	
DATE OF MEETING:	27th January 2021	
AUTHOR(S):	Phillip James, 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 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 purpose of this report is to provide Board oversight of performance of the Digital Services Department.	

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

RECOMMENDATION:	The Trust Board is asked to note the: • Digital Board Standing Items highlights; • EPR Procurement status; • Maternity EPR status inc;luding delayed contract award; • National Infrastructure Incident – 13th/14th January 2021.	
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	Digital Update Report	AGENDA REF:	BM/21/01/22

1. BACKGROUND/CONTEXT

The purpose of this report is to provide Board oversight of performance of the Digital Services Department.

The report summaries assurances tabled through the Finance And Sustainability Committee, complemented with pertinent additional information.

2. KEY ELEMENTS

Digital Services governance focuses upon two key forums, the Digital Board and the Information Governance Sub-Committee whom report respectively to the Finance & Sustainability Committee and Quality Assurance Committee.

Ad-hoc reports regarding areas of interest are submitted at the request of the committee chairs.

Digital Board Standing Items

Digital Programme

- Reported progress remains limited to priority schemes due to COVID with E-Observations and E-Rostering the main beneficiaries;
- 0-19s Health Visitor notifications scheme agreed as high priority due to its care impact;
- Results & Reporting scoping work and Audiology upgrade are being raised in priority, utilising resources directed away from projects paused due to COVID pressures;
- Tranche 1 projects are reporting as delayed result in no material impact to Trust financial plans.

DXC Vendor Management Meeting

- The work to migrate Lorenzo EPR to a new cloud platform, key to improving performance, is expected to occur between February and March 2021.

IT Services Update

- Service Desk and change requests performance remains stable;
- 3 of 8 deployments reporting amber due to resources and acting upon lessons learnt;
- Capital investments are on track with 5 additoinal due to be brought forward from 21/22.

Digital Analytics Programme

- The reporting backlog remains stable with plans in place to close down delayed requests including resolving design issues with stakeholders;
- The workload prioritisation process is now being expanded to the entire Digital Services department to address interdependencies. Terms of Reference are being developed in support of 3rd party engagement.

Digital Compliance & Risks

- The status of audits remains stable whilst a deep dive of audit actions has been submitted to FSC and proposes safe, pragmatic means to closing legacy actions;
- Risks continue to be regularly reviewed resulting in fewer risks of lower scores but with additional actions;
- An oversight report of the quality/safety impact of open risks and their actions timescales was submitted to QAC in January 2021.

Clinical Safety and Risk Review

- EPR Customer Safety Notices and Product Alert Notices remain under control.

EPR Procurement

- Following approval of the Strategic Outline Case, Pre-Market engagement has not started due to COVID Wave 3. Anticipated start date February 21 / March 21 to secure involvement of frontline colleagues;
- Potential EPR collaborations continue to be explored;
- Benefits development for the Outline Business Case continues;
- Contract schedules for the new Tactical Lorenzo contract under review;
- Lorenzo Theatres financial impact under review with one further demonstration required to resolve stakeholder queries.

Maternity EPR

- Target contract award date delayed due to COVID pressures and additional scoring due diligence;
- Tactical reporting including offline remote working pilot progressing;
- CTG Monitoring and archiving has been assessed by the supplier and continues to require further resolution activity;
- Digital Midwife recruitment is being supported;
- High priority Electronic 0-19s notifications development with Local Authority and Community stakeholders is progressing at pace.

National Infrastructure Incident – 13th/14th January 2021

A national Digital infrastructure issue occurred at approximately 23.00 on 13th January 2021 and continued to 05.30 on 14th January 2021, resulting in operational challenges for frontline personnel:

- The issue affected a number of national digital services including SMART card access;

- The Trust suffered loss of access to Lorenzo EPR including Electronic Prescribing And Medication Administration;
- The Senior On-Call Manager co-ordinated the immediate response with support from IT Support, Chief Pharmacist and Executive On-Call;
- The Senior On-Call Manager and Chief Pharmacist supported the revertion to business continuity processes at ward level;
- The ongoing incident was esclataed to Senior Digital Management at approximately 03.30 by the Executive On-Call;
- An urgent review meeting was chaired at 05.30 by the Executive On-Call just prior to the resolution being declared;
- Two Emergency Preparedness reviews have been subsequently conducted by the EPRR Team with support from Clinical Governance with lessons learnt formally recorded and resulting actions agreed;
- Immediate infrastructure reliability assurances were gleaned from NHSX. The formal Root Cause Analysis report is to be received whilst a new management escalation process has been provided for the remainder of the pandemic in response to national service desk communications feedback submitted to NHSX;
- A formal Datix incident was recorded and no patient harm reported;
- An executive report will be formulated when the Root Cause Analysis report has been received and the Datix Incident finalised;
- The incident highlighted the reliance the Trust places upon its Digital infrastructure for safe and efficient care.

3. ACTIONS REQUIRED/RESPONSIBLE OFFICER

None required.

4. IMPACT ON QPS?

Modern Digital Health infrastructure now has a clear link to the quality and safety of patients and performance and sustainability of services.

Programme prioritisation has enabled E-Observations and some ePMA deployments to continue during the COVID-19 response, thus contributing to quality and safety improvements to patient care.

The contribution of the Trust Digital infrastructure to efficient care processes, including the Patient Administration System / Electronic Patient Record and ePMA, was prevalent throughout the incident period.

5. MEASUREMENTS/EVALUATIONS

With performance trends now available in respect of planned activities and service desk operations, industry standard benchmarks will be considered for future reporting.

Staffing resources are benchmarked against the model hospital data.

6. TRAJECTORIES/OBJECTIVES AGREED

Target delivery timescales are managed via the Digital Programme Of Works and encompass the activities of all Digital Services Departments.

7. MONITORING/REPORTING ROUTES

Digital Governance is described in section 2.

8. TIMELINES

Target delivery timescales are managed via the Digital Programme Of Works and encompass the activities of all Digital Services Departments.

9. ASSURANCE COMMITTEE

Assurance for Digital Services responsibilities is sought by the Finance And Sustainability Committee with support from the Quality Assurance Committee.

10. RECOMMENDATIONS

The Trust Board is asked to note the:

- Digital Board Standing Items highlights;
- EPR Procurement status;
- Maternity EPR status inc;luding delayed contract award;
- National Infrastructure Incident – 13th/14th January 2021.

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/21/01/23**			
SUBJECT:	**Infection Prevention and Control Covid-19 and orthopaedic trauma cases**			
DATE OF MEETING:	27 January 2021			
AUTHOR(S):	Lesley McKay, Associate Chief Nurse Infection Prevention & Control; Dr Zaman Qazzafi, Consultant Microbiologist/ Infection Control Doctor, Mr Rajiv Sanger Orthopaedic Consultant			
EXECUTIVE DIRECTOR SPONSOR:	Kimberley Salmon-Jamieson, Chief Nurse			
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)***	N/A			
EXECUTIVE SUMMARY *(KEY ISSUES):*	This report is provided in response to a Journal publication related to Covid-19 infection prevention and control in trauma orthopaedic cases and a request from NHSE/I to review the paper and ensure oversight by the Board of Directors.			
PURPOSE: *(please select as appropriate)*	Information	Approval	To note √	Decision
RECOMMENDATION:	The Board of Directors are asked to receive the report.			
PREVIOUSLY CONSIDERED BY:	**Committee**	Choose an item.		
	Agenda Ref.	N/A		
	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	Infection Prevention and Control – Covid-19 and hip fracture	AGENDA REF:	BM/21/01/23

1. BACKGROUND/CONTEXT

The WHO declared a global pandemic of Covid-19 on 12 March 2020. A number of risk factors from underlying health conditions and older age have been highlighted as contributing to adverse outcomes from Covid-19. Public Health England have published guidance on reducing the risk of nosocomial infection within the hospital setting.

The Northwest Chief Nurse circulated a pre-publication article (appendix 1) on 21 December 2020 on infection prevention and control precautions for Covid-19 in trauma orthopaedic (hip fracture) patients, requesting Trust Board oversight on the Trust position before the end of January 2021. This paper provides the response to this request.

2. KEY ELEMENTS

The journal article relates to Infection Prevention and Control (IPC) precautions for Covid-19 and hip fracture patients. The article details findings from a small scale cross sectional survey. The authors do not make any recommendations. Gap analysis against survey questions and points to note from the discussion section of the article are detailed below:

No.	Question or discussion point	Trust position	Comments	Recommended action	Timescale and Lead
1.	Covid-19 swab on admission to hospital	Patients admitted via the Emergency Department (ED) are screened for Covid-19 whilst in ED. An audit has identified some concerns with taking and transporting samples to the laboratory timely.	30% of samples taken are delivered to the laboratory within 1 hour (data excludes the overnight period). 95% of all routine (onsite panther testing) Covid-19 results are available within 6 hours and rapid testing result within 90 minutes of receipt in the laboratory.	Ensure robust process in ED to ensure samples are taken and transported to the laboratory timely.	Jan 21 SFD
		Some patients attend ED with community positive Covid swab result.	Testing turn around times are monitored at IPC Silver Cell meetings.	Monitoring of Covid-19 testing turn around times is a standing agenda item at silver cell meetings.	Compliant
		The latest guidance advises 2 negative swabs are required before moving patients.	Test of change for introducing LFD testing on symptomatic patients week commencing 18/01/21.	Task and finish group set up to provide a robust protocol for LFD testing (or alternative) in ED .	Jan 21 SFD
2.	Do hip fracture patients have a confirmed negative swab before they arrive at the trauma ward?	Admission protocol to request results of Covid-19 test prior to admission to ward A6 At time of Covid-19 outbreaks, patients with a positive Covid-19 result are admitted in to Covid cohort bays or an isolation room on ward A6.	On-site Covid-19 testing supports timely turnaround of results.	Nil	Compliant
3.	Following admission, are trauma	As far as reasonably practicable results are obtained prior to admission to the trauma ward.	Six side rooms on ward A6. Patient safety risk is assessed and patients are isolated if safe.		Compliant

No.	Question or discussion point	Trust position	Comments	Recommended action	Timescale and Lead
	patients barrier* nursed until a negative swab result is obtained?	ED areas are segregated into suspected Covid and non-Covid areas to reduce the risk of exposure in ED.	Orthopaedic patients transfer directly to the orthopaedic trauma ward subject to: bed availability, operational issues i.e. not closed due to an outbreak of infection and Covid-19 negative.		
4.	Is it possible for a hip-fracture patient to be nursed in a bay with another patient in whom the COVID-19 status is not known as the COVID-19 result has not arrived?	As far as reasonably practicable Covid-19 results are obtained prior to admission to the trauma ward. Clear screens are in place to provide a physical barrier between patients on ward A6. It remains possible for Covid-19 cases to arise in a bay due to lengthy (14 day) incubation period and when exposure incidents occur.	Adherence to the Covid-19 swabbing SOP which includes: admission swab, day 3 swab, day 5 swab and weekly thereafter if SARS-CoV-2 negative on admission. Known post-operative complication of hospital acquired pneumonia (HAP).	Daily review of screening compliance to ensure patients undergo Covid-19 swabbing as per Trust SOP. Any patient developing a post-operative HAP should be swabbed for Covid-19.	CF/ CB Jan 21 PS/RS Jan 21
5.	Are doctors working in orthopaedic trauma wards having regular COVID-19 tests?	Voluntary Lateral Flow Device (LFD) testing has been introduced for a 12 week period for all front line staff. Medical staff participation is reported as: 6 Consultants 1 Foundation year 1 4 Foundation year 2	Within SS CBU 52 staff (range of roles) are registered to participate in LFD testing with 44 staff returning results.	Review with a view to increasing uptake of LFD: • staff coming out of the 90 day time period who would now be eligible to participate • promote again with other staff who declined in the first instance • remind staff who are registered to participate to submit their data twice weekly	CF/ CB/ PS/FW Jan 21
6.	Are all elective patients tested for COVID-19 before admission?	SOP in place which complies with guidance on pre-admission screening as per NICE 179 guidelines and isolation pre-admission.	Separate pathways for trauma (Warrington site) and elective (Halton) cases.	Audit compliance with pre-admission screening.	CF/CB/FW Jan 21
7.	Are elective theatre staff regularly tested for COVID-19?	Routine asymptomatic screening by PCR test is not recommended or carried out. Until recently, routine asymptomatic staff testing was not recommended by NHSE/I unless an outbreak incident identified. Voluntary Lateral Flow Device (LFD) testing has been introduced for a 12 week period. Although now LFD testing is recommended, it is not mandatory.	A small number of staff participated in testing in green pathway areas which has now ceased. Some staff are participating in the SIREN study Report compliance with LFD testing by ward/department to monitor compliance. The sensitivity of LFDs test is not very high especially if not used by trained staff.	In outbreak situations staff screening with PCR testing is undertaken. Audit uptake of LFD testing of theatre staff.	Compliant NC/VMD Jan 21
8.	Are doctors moving between COVID-19-free and COVID-19-contaminated pathways?	Medical staff move between both hospital sites. As far as reasonably practicable nursing staff do not move between elective and emergency pathway wards. Training has been provided in	It would be necessary to consider all members of the multidisciplinary group including nursing and therapy staff in addition to medical staff.	Audit PPE training for Covid-19 donning and doffing. Review PPE audit data and address areas where improvement is required. Review cohorting of staff groups to assess feasibility of	FW/PS/ CF/CB Jan 21

No.	Question or discussion point	Trust position	Comments	Recommended action	Timescale and Lead
		correct donning and doffing of personal protective equipment.		maintaining staff segregation to amber/green and red pathways.	
9.	Segregation of elective (green pathway) and emergency cases (red/amber pathway) including operating theatres	Elective pathway cases via Halton site – green pathway and some amber less urgent pathway cases Emergency pathway patients – hip fracture and other orthopaedic surgical emergencies at Warrington site red/amber pathway patients	Orthopaedic theatres have a higher air change per hour rate and undergo rigorous cleaning in between cases.	Assess if any planned orthopaedic cases are being carried out at Warrington site (would be dependent on anaesthetic risk i.e. ASA score).	CF/CB Jan 21
10.	Delay in time from admission to surgery	Process in place for rapid Covid-19 swab (90 minutes to process from receipt in laboratory). In the event of an emergency and swab result not being available patients are treated as per amber pathway	Delays in surgery may be due to medical issues requiring optimisation e.g. low Hb.	Audit admission to surgery timescales and identify reasons if delays occur	CF/CB/ PS/FW Jan 21

*Barrier nursing defined as side room or a Covid-19 ward

CB	Carol Basket Matron Surgical Specialities
NC	Natalie Crosby Associate Chief Nurse Planned Care
VMD	Val Doyle Associate Director of Planned Care
CF	Cheryl Finney Lead Nurse Surgical Specialities
SFD	Sheila Fields Delaney CBU Manager
RS	Dr Rajiv Sanger Orthopaedic Consultant
PS	Dr Paul Scott Clinical Director Surgical Specialities
FW	Fiona Wheelton Surgical Specialities CBU Manager

Additional comments

- One orthopaedic trauma ward, not specifically for hip fracture on Warrington site. It has been necessary to outlie orthopaedic cases in surgery when the orthopaedic ward has been closed due to Covid-19 outbreaks
- Delaying elective cases to mitigate Covid-19 transmission would need clinical oversight to ensure there are no risks to patient safety and Chief Operating Officer involvement

Limitations

This article primarily focusses on swabbing results. At WHH the focus on prevention of nosocomial Covid-19 is: isolation, appropriate PPE use, hand hygiene and environmental decontamination.

The JHI article does not detail these essential elements of IPC practice.

3. ACTIONS REQUIRED/RESPONSIBLE OFFICER

Guidance is in place across the Trust on IPC precautions for Covid-19 to reduce the risk of nosocomial transmission.

4. IMPACT ON QPS?

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

P: Risk to staff health and wellbeing from anxiety associated with the unknown situation and risk of infection of self and family members. A number of staff are absent from work due to 'shielding' requirements.

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

5. MEASUREMENTS/EVALUATIONS

Incident reporting of nosocomial Covid-19 cases.

6. TRAJECTORIES/OBJECTIVES AGREED

To ensure compliance with IPC precautions for Covid-19.

7. MONITORING/REPORTING ROUTES

Infection Control Sub-Committee

Quality Assurance Committee

Senior Executive Oversight Group

Trust Board

8. TIMELINES

For the duration of the Covid-19 pandemic.

9. ASSURANCE COMMITTEE

Infection Control Sub-Committee

10. RECOMMENDATIONS

The Board of Directors are asked to receive this report.

11. Appendix 1

Journal Article

Limited implementation of measures to reduce nosocomial spread of COVID-19 in hip fracture patients in the North West of England

Mastan, S., Cash, T., Malik, R.A., Charalambous, C.P., Abdulla, S., Collins, T., Dupley, L., Ferns, J., Halim, U., Hill, T. and Hodhody, G., (2020). Limited implementation of measures to reduce nosocomial spread of COVID-19 in hip fracture patients in the North West of England. *Journal of Hospital Infection* [online]
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[Accessed 01 01 2021]

COVID-19 in hip-fracture patients

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journal homepage: www.elsevier.com/locate/jhin

Short Report

Limited implementation of measures to reduce nosocomial spread of COVID-19 in hip-fracture patients in the North West of England

S. Mastan [a,*], T. Cash [a], R.A. Malik [b,c], C.P. Charalambous [d,e], on behalf of the COVIDHipFracture Study Group [†]

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SUMMARY

Hip-fracture patients are vulnerable to the outcomes of COVID-19. We performed a cross-sectional survey to determine measures employed to limit nosocomial spread of COVID-19 in 23 orthopaedic trauma departments in the North-West of England. Nineteen (87%) hospitals admitted patients to a ward prior to a negative swab, and only 9 (39%) patients were barrier nursed. Hip-fracture patients were operated in non-COVID-19-free theatres in 21 (91%) hospitals. Regular screening of doctors working in trauma and elective areas for COVID-19 was undertaken in three (13%) and five (22%) hospitals, respectively. Doctors moved freely between trauma and elective areas in 22 (96%) hospitals.

Introduction

In the first surge of the COVID-19 pandemic, a substantial proportion of patients were infected whilst being treated in hospital for another condition. In the UK about 12.5% of cases were contracted in hospital [1]. The CDC recommended prioritizing acute care and delaying elective care to mitigate the nosocomial spread of COVID-19.

Older age, male sex, obesity, diabetes and recent surgery may increase vulnerability to adverse outcomes from COVID-19 infection [2]. Indeed, hip-fracture patients were found to be extremely vulnerable, with a seven-fold increase in 30-day mortality of up to 36% [3] compared with 6.9% in the pre-COVID-19 era [4].

Therefore, strict infection control measures are essential, to allow acute and elective orthopaedic services to function whilst minimising nosocomial spread of the disease. Public

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† COVIDHipFracture study group members are listed in Appendix A.

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0195-6701/

Table I
Trauma and elective questions in survey

Question	Yes (n = 23)	No (n = 23)
Are all trauma patients swabbed for COVID-19 upon in-patient admission to hospital?	23	0
Do hip-fracture patients have a confirmed negative swab before they arrive at the trauma ward?	4	19
Following admission, are trauma patient's barrier nursed until a negative swab result is obtained? (Barrier nursing was defined as side room or a COVID-19 ward.)	9	14
Is it possible for a hip-fracture patient to be nursed in a bay with another patient in whom the COVID-19 status is not known as the COVID-19 result has not arrived?	19	4
Are doctors working in orthopaedic trauma wards having regular COVID-19 tests?	3	20
Are all elective patients tested for COVID-19 before admission?	23	0
Are elective theatre staff regularly tested for COVID-19?	5	18
Are doctors moving between COVID-19-free and COVID-19-contaminated pathways?	22	1

Health England (PHE) published guidelines for remobilization of services with high-, medium- and low-risk pathways. High-risk patients included those who were clinically suspected or confirmed COVID-19 positive and were to be nursed in a single room or in a specific area until the COVID-19 test results were known. Medium-risk patients were asymptomatic with no recent contact with a known case and awaiting COVID-19 test results and were to be nursed using screens or privacy curtains between beds. Low-risk individuals had no symptoms or contact with a positive case and had a confirmed negative RTPCR swab test within 72 h of admission. Acute hip-fracture patients would qualify as high or medium risk. PHE have also published guidelines for elective cases, including self-isolation, assessment of symptoms, and testing prior to planned surgery, placing them in the low-risk pathway [5]. The purpose of these pathways is to try to reduce cross-contamination of patients. Keeping potentially COVID-19 contaminated trauma patients separate from COVID-19 negative elective patients is crucial to help control nosocomial spread of the virus.

In the second surge of the pandemic the North West (NW) of England has witnessed an exponential growth of cases, far surpassing other areas in the UK [6]. The assessment of current clinical practice in hip-fracture patients may help to identify deficiencies and limit nosocomial COVID-19 in a highly vulnerable population. The aim of this study was to determine infection control measures and their implementation in orthopaedics in National Health Service (NHS) hospitals across the NW of England, and to see whether there was potential for cross-contamination between high-risk acute trauma pathways and low-risk elective pathways.

Methods

Orthopaedic trainees in each hospital (identified through a regional trainee social media group and the NW Orthopaedic Research Collaborative) were invited to participate and become a study collaborator (COVIDHipFracture study group). If an orthopaedic trainee could not be recruited, the orthopaedic doctor on call (ST1/2 or ST3+ level) was invited to participate. A cross-sectional survey was administered via telephone or e-mail between 12th and 23rd October 2020. Data were analysed on Microsoft Excel.

Table II
White space questions in survey

Question	N = 23
What is the turnover time for urgent and non-urgent COVID-19 swabs? (n = 21)	Urgent swab within: 1 h: 4 2–4 h: 9 4–48 h: 8 Non-urgent <12 h: 2 <48 h: 17 <72 h: 2
Do hip-fracture patients have their surgery in a COVID-19 free theatre or in a theatre where COVID-19-positive patients may also be operated on?	COVID-19-free theatre: 2 COVID-19 may be operated: 21
Are COVID-19-positive patients nursed in an orthopaedic ward or in an isolated COVID-19 ward?	Orthopaedic ward: 13 Isolated COVID-19 ward: 9 Other ward: 1

Results

The survey was undertaken in 23 orthopaedic trauma departments in the NW with a 100% response rate (Tables I and II).

Acute trauma

All 23 (100%) of the hospitals who took part undertook COVID-19 testing in patients admitted with trauma. However, 19 (87%) admitted hip-fracture patients to a trauma ward prior to a confirmed negative COVID-19 swab and only nine (39%) undertook barrier nursing before confirmation of a negative COVID-19 test. Only one (5%) hospital had a curtain or screen between patients. Most hospitals (78%) nursed hip-fracture patients in general orthopaedic wards with only four (17%) in a dedicated hip-fracture ward. Of the patients who were COVID-19 positive only nine (39%) were nursed on an isolated COVID-19 ward. Hip-fracture patients were operated in non-COVID-19 free theatres in 21 (91%) hospitals.

Elective patients

All 23 (100%) hospitals undertook COVID-19 testing in patients admitted for elective surgery.

Screening for COVID-19

Regular screening for COVID-19 in doctors working in orthopaedic trauma and elective surgery was undertaken in

only 3 (13%) and 5 (22%) hospitals, respectively. Furthermore, doctors moved freely between trauma and elective areas in 22 (96%) hospitals. The turnaround time for the result from an urgent swab taken at admission for trauma was less than 1 h in only four (19%) hospitals and for non-urgent swabs the result was available in less than 12 h in two (9.5%) hospitals with the majority (81%) being reported in less than 48 h.

Discussion

There has been an extensive effort to recommence elective surgery, given that elective lists in the first surge of the pandemic were extensively cancelled [7]. Indeed, in August 2020, an estimated 111,000 UK patients had been waiting for elective surgery more than a year, up from around 10,000 at the beginning of 2020 [8]. In the Royal College of Surgeons' survey, 33% of surgeons reported not having done any elective work during the first surge [9]. This study examined infection control measures in orthopaedics amongst hospitals in the NW of England, a region currently identified as a COVID-19 hotspot with an R rate between 1.3 and 1.5 [6,10]. Our survey clearly identifies major deficiencies in the implementation of PHE recommendations for limiting nosocomial infection in hip-fracture patients. We show that whilst prior testing for COVID-19 was undertaken in all hospitals, the majority of patients were allocated to their beds before the result was available, thus allowing spread of COVID-19 not only between patients but also between nursing and medical staff. Doctors working with acute hip-fracture patients were regularly tested in only 13% of hospitals and even in elective areas COVID-19 testing was only undertaken in 22%. Staff in one NHS hospital were not regularly tested and only underwent testing when they delivered NHS work in a private-sector institution. With lack of regular testing, and doctors moving freely between high-risk and low-risk pathways in 96% of hospitals, there was risk of cross-contamination.

We appreciate that resources are stretched in NHS hospitals, especially in small orthopaedic departments, and that this may hinder the segregation of patients and medical staff. However, implementation of rapid and regular reverse transcription-polymerase chain reaction (RT-PCR) testing would enable a more streamlined and efficient means to limit nosocomial infection in the most vulnerable patients, including hip-fracture patients. We did not specifically assess whether delays in swab results delayed surgery; however, anecdotally there are often delays when awaiting confirmation of a negative swab, especially prior to a general anaesthetic being administered. High-risk patients should be given priority in testing as not all trauma admissions have the same vulnerability to COVID-19 outcomes [1]. We gathered data on elective testing of patients and staff, and hence resource allocation within these NHS hospitals. There seemed to be a bias towards ensuring that elective patients remain COVID-19 negative, with more testing for staff and patients working within these pathways. Testing priority and nursing in low-risk COVID-19 areas based on patient risk stratification and vulnerability rather than on the mode of admission (acute trauma or elective) may be preferable. At a societal and professional level, in times of limited resources, priority should be given to the most vulnerable and the most clinically needy, rather than the duration on an elective waiting list. Regional COVID-19 institutions for the treatment of COVID-19-positive patients and the more urgent treatment of the most vulnerable patients who have tested negative, should also be considered.

In conclusion, we have identified substantial deficiencies in the implementation of PHE infection control measures to limit nosocomial spread of COVID-19 amongst hospitals in the NW of England. There is an urgent need to address the delayed reporting of COVID-19 testing to limit the inevitable increased morbidity and mortality associated with the current second and subsequent surges of the COVID-19 pandemic.

Conflict of interest statement
The authors have no conflicts of interest to declare.

Funding sources
None.

Appendix A. COVIDHipFracture study group collaborators

Mr Samir Abdulla, Mr Thomas Collins, Miss Leanne Dupley, Mr John Ferns, Mr Usman Halim, Dr Tristan Hill, Miss Ghazal Hodhody, Dr Isabel Hughes, Mr Aral Jamalfar, Mr Chris Jump, Mr Shoaib Khan, Mr Kenneth Koo, Mr Weisang Luo, Mr Waleed Moussa, Mr Mustafa Abdullah, Mr Mobeen Quereshi, Mr Dhawal Patel, Mr Neelam Patel, Mr Mohammed Ahmed Sajid, Miss Nastaran Sargazi, Mr Samir Talha, Miss Mona Theodoraki, Mr Abhimanyu Ved, Miss Anna Walsh, Mr Naz Zreik.

References

[1] Carter B, Collins JT, Barlow-Pay F, Rickard F, Bruce E, Verduri A, et al. Nosocomial COVID-19 infection: examining the risk of mortality. The COPE-Nosocomial Study (COVID in Older PEople). J Hosp Infect 2020;106:376—84.

[2] Guan Wei-jie, Wen-hua Liang, Zhao Yi, Heng-rui Liang, Zi-sheng Chen, Yi-min Li, et al. Comorbidity and its impact on 1590 patients with COVID-19 in China: a nationwide analysis. Eur Respir J 2020;55:2000547.

[3] Lim MA, Pranata R. Coronavirus disease 2019 (COVID-19) markedly increased mortality in patients with hip fracture — a systematic review and meta-analysis. J Clin Orthop Trauma 2020. https://doi.org/10.1016/j.jcot.2020.09.015.

[4] Royal College of Physicians. National Hip Fracture Database (NHFD) annual report. 2019. Available at: https://www.nhfd.co.uk/files/2019ReportFiles/NHFD_2019_Annual_Report_v101.pdf. [Accessed 25 October 2020].

[5] Public Health England. COVID-19: guidance for the remobilisation of services within health and care settings. Infection prevention and control recommendations. 2020. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/910885/COVID-19_Infection_prevention_and_control_guidance_FINAL_PDF_20082020.pdf. [Accessed 25 October 2020].

[6] Office of National Statistics. Coronavirus (COVID-19) infection survey, UK: 25 October. 2020. https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/conditionsanddiseases/bulletins/coronaviruscovid19infectionsurveypilot/latest. [Accessed 25 October 2020].

[7] COVIDSurg Collborative. Elective surgery cancellations due to the COVID-19 pandemic: global predictive modelling to inform

surgical recovery plans. Br J Surg 2020;107. https://doi.org/10.1002/bjs.11746.

[8] Statistical Press Notice NHS referral to treatment (RTT) waiting times data July. NHS; 2020. Available at: https://www.england.nhs.uk/statistics/wpcontent/uploads/sites/2/2020/09/Jul20-RTT-SPN-publication-v0.pdf. [Accessed October 2020].

[9] Survey findings: elective surgery during COVID-19. Royal College of Surgeons of England; 2020. Available at: https://www.rcseng.ac.uk/news-and-events/news/archive/survey-results-elective-surgery-under-covid/. [Accessed October 2020].

[10] The R number and growth rate in the UK. The latest reproduction number (R) and growth rate of coronavirus (Covid-19) in the UK. 2020. Available at: https://www.gov.uk/guidance/the-r-number-in-the-uk [last accessed October 2020].

North West Directors of Nursing

Sent via email

Jackie Bird
Chief Nurse North West
NHS England & NHS Improvement
3 Piccadilly Place
Manchester
M1 3BN

21 December 2020

Dear Director of Nursing, Medical Director & DIPC – NW Acute Trusts,

Potential limited implementation of measures to reduce nosocomial spread of COVID-19 in hip fracture patients in the NW of England

We ask that the Executive lead for IPC , **immediately review and** consider the attached document which has been approved for imminent publication in the *Journal of Hospital Infection.*

Please undertake stocktake or gap analysis of your own trust orthopaedic and non-elective pathways against the variance identified in this cross- sectional survey which reviewed the measures in place to minimise the risk for hip fracture patients vulnerable to the outcomes of COVID-19. The purpose of the afore mentioned survey was to determine which measures were deployed to limit nosocomial spread of COVID-19. This survey was undertaken across 23 hospital with orthopaedic trauma provision in North-West England.

There may be learning for your organisation. We ask that you present your organisations stocktake/ gap analysis and learning to your own trust board by the end of January 2020 and feedback any issues identified to the NW IPC cell at covid-19.ipcnw@nhs.net

Many thanks

Jackie Bird
Chief Nurse North West
NHS England & NHS Improvement

David Levy
Regional Medical Director (North West)
NHS England & NHS Improvement

Journal Pre-proof

Limited implementation of measures to reduce nosocomial spread of COVID-19 in hip fracture patients in the North West of England

S. Mastan, T. Cash, R.A. Malik, C.P. Charalambous, on behalf of the COVIDHipFracture study group

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Limited implementation of measures to reduce nosocomial spread of COVID-19 in hip fracture patients in the North West of England

Mastan S[1], Cash T[1], Malik RA[2,3], Charalambous CP[4,5] on behalf of the COVIDHipFracture study group [Appendix1]

1. **Health Education North West, UK**
2. **Weill Cornell Medicine-Qatar, Doha, Qatar**
3. **University of Manchester, Manchester, UK**
4. **School of Medicine, University of Central, Lancashire, UK**
5. **Blackpool Teaching Hospitals NHS Trust, Blackpool UK**

Abstract

Hip fracture patients are vulnerable to the outcomes of COVID-19. We performed a cross-sectional survey to determine measures employed to limit nosocomial spread of COVID-19 in 23 orthopaedic trauma hospitals in North-West England. 19 (87%) hospitals admitted patients to a ward prior to a negative swab, and only 9 (39%) were barrier nursed. Hip fracture patients were operated in non-COVID-19 free theatres in 21 (91%) hospitals. Regular screening of doctors working in trauma and elective areas for COVID-19 was undertaken in 3 (13%) and 5 (22%) hospitals, respectively. Doctors moved freely between trauma and elective areas in 22 (96%) hospitals.

Introduction

In the first surge of the COVID-19 pandemic a substantial proportion of patients were infected whilst being treated in hospital for another condition. In the UK about 12.5% of cases were contracted in hospital [1]. The CDC recommended prioritising acute care and delaying elective care to mitigate the nosocomial spread of COVID-19.

Older age, male sex, obesity, diabetes and recent surgery may increase vulnerability to adverse outcomes from COVID-19 infection [2]. Indeed, hip fracture patients were found to be extremely vulnerable, with a 7-fold increase in 30-day mortality of up to 36% [3] compared to 6.9% in the pre-COVID-19 era [4].

Therefore, strict infection control measures are essential, to allow acute and elective orthopaedic services to function whilst minimising nosocomial spread of the disease. Public Health England (PHE) published guidelines for remobilisation of services with high, medium and low risk pathways. High risk patients included those who were clinically suspected or confirmed COVID-19 positive and were to be nursed in a single room or in a specific area until the COVID-19 test results was known. Medium risk patients were asymptomatic with no recent contact with a known case and awaiting COVID-19 test results and were to be nursed using screens or privacy curtains between beds. Low risk individuals had no symptoms or contact with a positive case and had a confirmed negative RTPCR swab test within 72 hours of admission. Acute hip fracture patients, would qualify as high or medium risk. PHE have also published guidelines for elective cases, including self-isolation, assessment of symptoms, and testing prior to planned surgery, placing them in the low risk pathway [5]. The purpose of these pathways is to try and reduce cross contamination of patients. Keeping potentially COVID-19 contaminated trauma patients separate from COVID-19 negative elective patients is crucial to help control nosocomial spread of the virus.

In the second surge of the pandemic the North West (NW) of England has witnessed an exponential growth of cases, far surpassing other areas in the UK [6]. The assessment of current clinical practice in hip fracture patients may help to identify deficiencies and limit nosocomial COVID-19 in a highly vulnerable population. The aim of this study was to determine infection control measures and their implementation in orthopaedics in National Health Service (NHS) hospitals across the NW of England, and to see whether there was potential for cross-contamination between high risk acute trauma pathways, and low risk elective pathways.

Methods
Orthopaedic trainees in each hospital (identified through a regional trainee social media group and the NW Orthopaedic Research Collaborative) were invited to participate and become a study collaborator (COVIDHipFracture study group). If an orthopaedic trainee could not be recruited, the orthopaedic doctor on call (ST1/2 or ST3+ level) was invited to participate. A cross-sectional survey was administered via telephone or email between 12th and 23rd October 2020. Data were analysed on Microsoft Excel.

Results
The survey was undertaken in 23 orthopaedic trauma hospitals in the NW with a 100% response rate (Tables 1, 2).

Acute Trauma
All 23 (100%) of hospitals undertook COVID-19 testing in patients admitted with trauma. However, 19 (87%) admitted hip fracture patients to a trauma ward prior to a confirmed negative COVID-19 swab and only 9 (39%) undertook barrier nursing before confirmation of a negative COVID-19 test. Only 1 (5%) hospital had a curtain or screen between patients. Most hospitals (78%) nursed hip fracture patients in general orthopaedic wards with only 4 (17%) in a dedicated hip fracture ward. Of the patients who were COVID-19 positive only 9 (39%) were nursed on an isolated COVID-19 ward. Hip fracture patients were operated in non-COVID-19 free theatres in 21 (91%) hospitals.

Elective Patients
All 23 (100%) hospitals undertook COVID-19 testing in patients admitted for elective surgery

Screening for COVID-19
Regular screening for COVID-19 in doctors working in orthopaedic trauma and elective surgery was undertaken in only 3 (13%) and 5 (22%) hospitals, respectively. Furthermore, doctors moved freely between trauma and elective areas in 22 (96%) hospitals. The turn-around time for the result from an urgent swab taken at admission for trauma was less than 1 hour in only 4 (19%) hospitals and for non-urgent swabs the result was available in less than 12 hours in 2 (9.5%) hospitals with the majority (81%) being reported in less than 48 hours.

Discussion
There has been an extensive effort to recommence elective surgery, given that elective lists in the first surge of the pandemic were extensively cancelled [7]. Indeed, in August 2020, an estimated 111,000 UK patients had been waiting for elective surgery more than a year, up from around 10,000 at the beginning of 2020 [8]. In the Royal College of Surgeons' survey, 33% of surgeons reported not having done any elective work during the first surge [9]. This study examined infection control measures in orthopaedics amongst hospitals in the NW of England, a region currently identified as a COVID-19 hotspot with an R rate between 1.3 – 1.5. [6, 10]. Our survey clearly identifies major deficiencies in the implementation of PHE recommendations for limiting nosocomial infection in hip fracture patients. We show that whilst prior testing for COVID-19 was undertaken in all hospitals, the majority of patients

were allocated to their beds before the result was available, thus allowing spread of COVID-19 not only between patients but also between nursing and medical staff. Doctors working with acute hip fracture patients were regularly tested in only 13% of hospitals and even in elective areas COVID-19 testing was only undertaken in 22%. Staff in one NHS hospital were not regularly tested and only underwent testing when they delivered NHS work in a private sector institution. With lack of regular testing, and doctors moving freely between high risk and low risk pathways in 96% of hospitals, there is risk of cross-contamination

We appreciate that resources are stretched in NHS hospitals, especially in small orthopaedic departments that may hinder the segregation of patients and medical staff. However, implementation of rapid and regular RT-PCR testing would enable a more streamlined and efficient means to limit nosocomial infection in the most vulnerable patients, including hip fracture patients. We did not specifically assess whether delays in swab results delayed surgery; however anecdotally there are often delays when awaiting confirmation of a negative swab, especially prior to a general anaesthetic being administered. High-risk patients should be given priority in testing as not all trauma admissions have the same vulnerability to COVID-19 outcomes [1]. We gathered data on elective testing of patients and staff, and hence resource allocation within these NHS hospitals. There seems to be a bias towards ensuring that elective patients remain COVID-19 negative, with more testing for staff and patients working within these pathways. Testing priority and nursing in low risk COVID-19 areas based on patient risk stratification and vulnerability rather than on the mode of admission (acute trauma or elective) may be preferable. At a societal and professional level, in times of limited resources, priority should be given to the most vulnerable and the most clinically needy, rather than the duration on an elective waiting list. Regional COVID-19 institutions for the treatment of COVID-19 positive patients and the more urgent treatment of the most vulnerable patients who have tested negative, should also be considered.

In conclusion, we have identified substantial deficiencies in the implementation of PHE infection control measures to limit nosocomial spread of COVID-19 amongst hospitals in the NW of England. There is an urgent need to address the delayed reporting of COVID-19 testing to limit the inevitable increased morbidity and mortality associated with the current second and subsequent surges of the COVID-19 pandemic.

References

[1] Carter B, Collins JT, Barlow-Pay F, Rickard F, Bruce E, Verduri A et al. Nosocomial COVID-19 infection: examining the risk of mortality. The COPE-Nosocomial Study (COVID in Older PEople). J Hosp Infect 2020;106:376-384. https://doi.org/10.1016/j.jhin.2020.07.013

[2]Guan Wei-jie, Liang Wen-hua, Zhao Yi, Liang Heng-rui, Chen Zi-sheng, Li Yi-min et al. Comorbidity and its impact on 1590 patients with COVID-19 in China: a nationwide analysis. Eur Respir J. 2020;14;55(5); https://doi.org/10.1183/13993003.00547-2020

[3] Lim MA, Pranata R. Coronavirus disease 2019 (COVID-19) markedly increased mortality in patients with hip fracture – A systematic review and meta-analysis. J Clin Orthop Trauma. 2020; https://doi.org/10.1016/j.jcot.2020.09.015

[4] Royal College of Physicians. National Hip Fracture Database (NHFD) Annual Report https://www.nhfd.co.uk/files/2019ReportFiles/NHFD_2019_Annual_Report_v101.pdf; 2019. [accessed 25 October 2020].

[5] Public Health England. COVID-19: Guidance for the remobilisation of services within health and care settings. Infection prevention and control recommendations. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/910885/COVID-19_Infection_prevention_and_control_guidance_FINAL_PDF_20082020.pdf; 2020 [accessed 25/10/2020].

[6] Office of National Statistics. Coronavirus (COVID-19) Infection Survey, UK: 25 October https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/conditionsanddiseases/bulletins/coronaviruscovid19infectionsurveypilot/latest; 2020. [accessed 25 October 2020].

[7] COVIDSurg Collborative. Elective surgery cancellations due to the COVID-19 pandemic: global predictive modelling to inform surgical recovery plans. British Journal of Surgery. 2020;107. https://doi.org/10.1002/bjs.11746

[8] Statistical Press Notice NHS referral to treatment (RTT) waiting times data July. NHS. https://www.england.nhs.uk/statistics/wpcontent/uploads/sites/2/2020/09/Jul20-RTT-SPN-publication-v0.pdf; 2020 [accessed 25 October 2020].

[9] Survey findings: Elective Surgery during COVID-19. Royal College of Surgeons of England. https://www.rcseng.ac.uk/news-and-events/news/archive/survey-results-elective-surgery-under-covid/; 2020 [Accessed 25 October 2020].

[10] The R number and growth rate in the UK. The latest reproduction number (R) and growth rate of coronavirus (Covid-19) in the UK. https://www.gov.uk/guidance/the-r-number-in-the-uk; 2020 [accessed 25 October 2020].

Table 1. Trauma and Elective Questions in Survey.

Table 2. White space questions in survey.

Appendix 1

COVIDHipFracture study group Collaborators

Mr Samir Abdulla, Mr Thomas Collins, Miss Leanne Dupley, Mr John Ferns, Mr Usman Halim, Dr Tristan Hill, Miss Ghazal Hodhody, Dr Isabel Hughes, Mr Aral Jamalfar, Mr Chris Jump, Mr Shoaib Khan, Mr Kenneth Koo, Mr Weisang Luo, Mr Waleed Moussa, Mr Mobeen Quereshi, Mr Dhawal Patel, Mr Neelam Patel, Mr Mohammed Ahmed Sajid, Mr Nas Sargazi, Mr Samir Talha, Miss Mona Theodoraki, Mr Abhimanyu Ved, Miss Anna Walsh, Mr Naz Zreik

Table 1. Trauma and Elective Questions in Survey.

Question	Yes (n=23)	No (n=23)
Are all trauma patients swabbed for COVID-19 upon in-patient admission to hospital?	**23**	**0**
Do hip fracture patients have a confirmed negative swab before they arrive to the trauma ward?	**4**	**19**
Following admission, are trauma patient's barrier nursed until a negative swab result is obtained? (*Barrier nursing was defined as side room or a COVID-19 ward*)	**9**	**14**
Is it possible for a hip fracture patient to be nursed in a bay with another patient in whom the COVID-19 status is not known as the COVID-19 result has not arrived?	**19**	**4**
Are doctors working in orthopaedic trauma wards having regular COVID-19 tests?	**3**	**20**
Are all elective patients tested for COVID-19 before admission?	**23**	**0**
Are elective theatre staff regularly tested for COVID-19?	**5**	**18**
Are doctors moving between COVID-19 free and COVID-19 contaminated pathway?	**22**	**1**

Table 2. White space questions in survey.

Question	**n=23**
What is the turnover time for urgent and non-urgent COVID-19 swabs? (n=21)	**Urgent swab** **Within:** **1 hour -> 4** **2 - 4 hours -> 9** **4 - 48 hours -> 8** **Non-urgent** **<12 hours -> 2** **<48 hours -> 17** **<72 hours -> 2**
Do hip fracture patients have their surgery in a COVID-19 free theatre or in a theatre where COVID-19 positive patients may also be operated on?	**COVID-19 Free Theatre - 2** **COVID-19 may be operated - 21**
Are COVID-19 positive patients nursed in an orthopaedic ward or in an isolated COVID-19 ward?	**Orthopaedic Ward - 13** **Isolated COVID-19 Ward- 9** **Other ward- 1**