The Walton Centre
NHS Foundation Trust

Trust Board Meeting

Friday 22nd May 2020

Agenda and Papers

Excellence in Neuroscience

OPEN TRUST BOARD MEETING
AGENDA

Friday 22nd May
Virtual Meeting

V = verbal, d = document p = presentation

Item	Time	Item	Owner	Purpose	Reference
1	09.30	Welcome and Apologies	J Rosser	N/A	v
2	09.30	Declaration of Interests	J Rosser	N/A	v
3	09.32	Minutes and actions of meeting held on 30th April 2020	J Rosser	Decision	d
PERFORMANCE					
4	09.35	COVID-19 Update Report	H Citrine		d
5	09.45	Integrated Performance Report	H Citrine	Assurance	
QUALITY					
6	10.00	Guardian of Safe working Quarterly Report	C Burness	Assurance	
7	10.10	Infection Prevention Control Annual Report	L Salter	Assurance	d
8	10.15	Infection Prevention Control Assurance Statement	L Salter	Assurance	
9	10.20	Safeguarding Annual Report	L Salter	Assurance	d
10	10.25	Governance Annual Report	L Salter	Assurance	d
GOVERANCE					
11	10.30	Chairs Report Quality Committee – verbal	S Crofts	Assurance	(v)
12	10.30	Fit and Proper Persons Statement	J Rosser	Information	
CONCLUDING BUSINESS					
13	10.40	AOB	J Rosser	Information	v

Date and Time of Next Meeting: Monday 22nd June 2020

UNCONFIRMED

Minutes of the Open Trust Board Meeting

Meeting via MS Teams due to national lockdown and COVID19 outbreak

Thursday 30 April 2020

Present:

Ms J Rosser	Chair
Mr S Crofts	Non-Executive Director
Ms S Rai	Non-Executive Director
Ms S Samuels	Non-Executive Director
Ms B Spicer	Non-Executive Director
Professor N Thakkar	Non-Executive Director (part)
Ms H Citrine	Chief Executive
Mr M Burns	Director of Finance and IT
Dr A Nicolson	Medical Director
Ms J Ross	Director of Operations and Strategy
Ms L Salter	Director of Nursing and Governance
Mr M Gibney	Director of Workforce and Innovation

In attendance:

Ms J Hindle	Corporate Secretary
Ms B Strong	Lead Governor

Trust Board Attendance 2020-21

Members:	Apr	May	Ext May	Jun	Jul	Sept	Ext Oct	Nov	Jan	Mar
Ms J Rosser	✓									
Mr S Crofts	✓									
Ms S Samuels	✓									
Ms B Spicer	✓									
Ms S Rai	✓									
Prof N Thakkar	✓									
Ms H Citrine	✓									
Mr M Burns	✓									
Mr M Gibney	✓									
Dr A Nicolson	✓									
Ms J Ross	✓									
Ms L Salter	✓									

Agenda items listed in order of discussion.

TB01/ 20-21 **Welcome and apologies**

The Chair welcomed those present to the meeting via Microsoft Teams.

It was explained that questions on papers and any amendments to previous minutes had been requested in advance of the meeting. Questions received had been compiled by the Corporate Secretary and would be raised for the appropriate agenda items during the meeting.

TB02/ 20-21 **Declarations of interest**

There were no declarations of interest in relation to the agenda.

TB03/ 20-21 **Minutes and matters arising from the meetings of 26th March 2020 Open**

No amendments had been forwarded to the Corporate Secretary and so the minutes were agreed as an accurate record of the meeting.

All items on the action Log were updated.

TB04/ 20-21 **COVID - 19 Update Report**

Chief Executive introduced the report which summarised the approach to COVID-19 to date and informed the Board of new ways of working, emergency resilience and operational preparedness, recognising regional and national responses and directives.

The Executive Team had a joint teleconference each morning updating key points in their portfolios and participation in professional/regional /national calls. This assisted in preparedness, management of key priorities and business continuity. In addition, the Executive Team had a weekly meeting which discussed COVID related decisions and core governance, safety issues and critical business issues including the agreement of prioritisation, deferring and amalgamation of Trust Board matters.

Items discussed included assurances on:

- Patient and staff COVID -19 data;
- Quality Assurance and Communications update information and processes;
- Command and control;
- Staffing;
- PPE provision;
- Finance;
- Health and Wellbeing;
- Partnership arrangements;
- Charity;
- Ethics Committee;
- Service provision for Stroke, ENT Head and Neck Cancer; and
- Patient Experience.

It was acknowledged that within a fast moving developing situation it was difficult to maintain timely communications and that Command and Control necessitated the need to take Local, Regional and National unilateral decisions e.g. Finance and Contracts. The Trust was also adapting to receiving patients outside of its specialism and this had impacted on normal working processes and service provision.

The Chair provided an update from the Regional CEO and Chair's communication. It was anticipated that Regional Command and Control would continue until the end of the financial year including capacity planning, quality of access and there were likely to be long term implications for the NHS. It had also been subsequently confirmed that Governor Elections and the Annual Members meeting could be delayed.

Confirmation and assurance was received that all questions which had been raised by Non-Executive Directors in advance of the meeting had been answered.

A further question was raised within the meeting for assurance that governance issues had been put in place for the various WhatsApp groups being used by teams. Assurance was given that Information Governance were aware of the use of WhatsApp. Guidance had been circulated and NHP had recommended the use of WhatsApp as a communication tool but any decisions made should be logged.

Non-Executive Directors offered assurance to the Chief Executive and Board on the appropriateness, detail and timeliness of the information they had been given on CONVID-19.

The Board

- **Noted the report.**

TB05/ 20-21 **COVID -19 Staff Health and Wellbeing Report**

The Director of Workforce and Innovation presented the report which provided an update on the actions taken by the Trust to support the health and wellbeing of staff during the COVID-19 pandemic. The Trust acknowledged that it was more important than ever for staff to look after themselves and colleagues and to be mindful of longer term issues that could arise. All staff were being encouraged to be as patient as possible when interacting with others at a time when everyone was under increased pressure due to the unprecedented conditions both at work and home.

There has been a triad response to the health and wellbeing of staff from a local, national and charity perspective including the following internal guidance and advice:

- Posters
- Staff Facebook Group
- Advice and support from the Occupational Health helpline which included signposting
- NOSS provide the confidential Trusts staff counselling service
- Temporary 24/7 Employee Assistance Programme
- Additional confidential support via Vivup for problems at work and home including anxiety, stress, and depression
- Physiotherapy service offered through Occupational Health
- Psychology support through a staff wellbeing and psychological support line

External guidance and advice had been provided by the following organisations:

- Our NHS People.
- NHS Employers.
- Clinical Human Factors Group – this Charity had produced some key points on how to work as a team under pressure. The document was attached to the report.
- Mersey Travel had produced guidance advising on free transport for staff.
- Local Education Authorities who had facilitated a number of school places for key workers.

The Walton Centre Charity had supported the physical and mental wellbeing of staff. Clarification had been given to donors that remaining funds from the COVID-19 appeal would be utilised in supporting charitable projects within the hospital which had arisen due to the impact and loss of general fundraising activities and initiatives during this period. Key highlights included:

- Donations to a dedicated Covid19-appeal
- Product / gift in kind donations from community and corporate supporters.
- Membership of the NHS Charities Together had enabled that funding was made available for specific objectives. A first instalment grant of £35,000 had been received.
- Walton Centre Charity Appeal: a dedicated appeal has been set up on the charity website for supporters wishing to contribute during the crisis with over £12,000 raised to date.
- Scrubs/Scrub bags produced by volunteers.

- Portable Changing/Shower facilities provided by supporters of the charity from the construction industry.

The Board were asked to note the support offered to staff internally, externally and via the charity.

Confirmation and assurance was received that all questions which had been raised by Non-Executive Directors in advance of the meeting had been answered.

Non-Executive Directors raised the issue of availability of the support to non NHS contracted staff. Assurance was given that all key staff were included and that communications had been issued to all staff, including ISS, to make them aware of the support available to them.

The Board

- **Noted the report.**

TB06/ 20-21 **Integrated Performance Report**

The Chief Executive provided an overview on the 2020/21 end of year IPR report to provide assurance on integrated performance. Thanks were given to staff in meeting the Control Total and improving quality in what had been a tough and challenging year.

Feedback was provided from each Executive on their section.

The Director of Operations and Strategy reiterated the difficulties and challenges which staff had faced. It was important to recognise that the waiting list had increased and would be difficult to manage going forward. Concerns had been addressed and teams had undertaken innovative ways of working to reduce 36 week breaches. Whilst this had successfully reduced waiting lists it would be an ongoing issue whilst elective surgery and procedures were postponed due to COVID-19 and innovative alternative ways of working and waiting list management would continue to be explored. Assurance was given that there was no negative impact on patient care.

The Director of Nursing and Governance updated the Board on the infection prevention status. There had been significant progress and improvements in C.Difficile with 5 cases against a threshold of 8. COVID-19 had highlighted the need for robust hand hygiene and it was expected that this would have a positive impact on hand hygiene compliance going forward. Confirmation had been received that a KPI for COVID-19 would be implemented. Deprivation of Liberty Safeguards across the Trust had increased and this offered assurance that the education initiative following audit recommendations had been successful. Complaints would be reported by Divisional Triumvirates leads and monitored at Quality Committee and by Executives. Staffing numbers and issues were raised at the Daily Huddle and at local Command and Control. Assurance was given that there had been no staffing shortages at ward level during COVID-19 and incident reporting was continuing.

The Director of Finance and IT clarified the process around the reimbursement of COVID costs. The Trust was following National Guidance and COVID costs were recorded as a separate ledger item. It was expected that there would be a post pandemic audit which would assess the impact on normal Trust business. It was anticipated that any Top Up payments would be based upon average expenditure and income and expenditure above plan. Cheshire & Merseyside Directors of Finance had been in regular communication. The Governance Check List was in preparation and would be distributed once approved the Executives. The 19/20 Control Total had been met. Centralised collaborative Procurement

for PPE had taken place across Cheshire and Merseyside and it was expected that these costs would not being recharged to Trusts. There had been one Information Governance incident. NHSI/E contract had been agreed and spend allocated.

Confirmation and assurance was received that all questions which had been raised by Non-Executive Directors in advance of the meeting had been answered.

The Board

- **Noted the report.**

ACTION:
The Governance Check List to be sent to Non-Executive Directors once approved by the Executive Team

TB07/ 20-21 **Same Sex Accommodation Compliance Declaration**

The report had been circulated to provide the Board of Directors with assurance that the Trust met the requirement to provide an annual declaration against 'eliminating mixed sex accommodation'. The declaration of compliance was published on the Trust's website to ensure patients and their families could be assured of the arrangements the Trust has in place.

Assurance was given that the Trust had been compliant from April 2019 until March 2020 with no mixed sex breeches and staff continued to work hard to ensure the safety, wellbeing and privacy and dignity of patients was maintained as part of eliminating mixed sex accommodation.

The Board

- **Noted the report.**

TB08/ 20-21 **Q4 Governance Report**

The Director of Nursing and Governance presented the report to provide a quarterly summary of Governance activity across the Trust in Quarter 4 (19/20) comparing results of data over the past 3 months and to provide assurance to Trust Board that issues were being managed effectively, robust actions were in place to mitigate risk and reduce harm and that lessons were being learnt.

Questions had been provided in advance from Non-Executive Directors and responses were provided as follows:

- It was agreed that it would be useful to see the incidences against occupancy as a percentage to provide a more comparable figure. The Head of Informatics would look at the data to ensure it was fit for purpose and it would go to other committees in order to discuss.
- The RCA was nearing completion into the Serious Incident (SI) category 3 pressure ulcer. This would be discussed further at a meeting taking place that day and outcome to the next Quality Committee meeting.
- Information was provided as to the measures taken to ensure the safety of patients when being moved by hoists. It was confirmed there had been 2 further incidents of a similar nature and therefore all the previous kits had been moved from Chavasse Ward and CRU and replaced. A Duty of Candour had been completed for the patient who suffered moderate harm and a full investigation was underway which would go through to Health & Safety Executive (HSE) as a consequence. It was commented from a Non-Executive Director that the response following the incident had been strong.

- Clarification had been provided around the 2 complaints that had been re-opened. These were due to a timing issue rather than problematic.
- There was no update to provide on the long standing case with Hill Dickinson. The Action Plan had been taken forward.
- Explanation was provided as to why the Trust volunteers had not been on site and this was due to keeping them safe as the majority had long standing health conditions which would have put them as risk. The Trust had not needed to replace with people volunteering to help the NHS staff as some of the admin staff had been able to work on wards covering a lot of work done by volunteers. It the pandemic went into phase 2 the situation may be looked at again.

Confirmation and assurance was received that all questions which had been raised by Non-Executive Directors in advance of the meeting had been answered.

The Board

- **Noted the report.**

TB09/ 20-21 **Q3 and Q4 Morbidity and Mortality Reports 2019-20**

The Medical Director provided a brief summary of the Q3 and Q4 reports. The Executive Summary had been expanded and this section would include any lessons to be learnt going forward (none recorded for Q3 and Q4). There had been more deaths in Q3 than normal, particularly in October, but when examined there was no particular pattern for this other than more patients being admitted for procedures where there was a high mortality rate generally. There were no concerns around staffing on any particular days or periods of time. There was a spike in deaths on a weekend in Q3 but again there was no definite pattern and no issues with regards to the nature of the patients, any staffing issues or cause of death.

Questions had been provided in advance from Non-Executive Directors and responses were provided as follows:

- Bereaved Relatives Policy - The operations team in the Neurosurgical Division, with the Mortality Lead, were meeting with Liverpool Clinical Laboratories to design a formal bereavement service. It was acknowledged that our service was not equal to what Liverpool University Hospitals have in place and that had been an issue of ongoing discussion. A meeting had been arranged which was postponed when the Covid situation broke. There had been some changes during Covid around death certification that would probably continue. It was hoped the discussions would get under way shortly.
- It was confirmed that during incident reviews human factor issues were considered. All incidents were reviewed and all deaths looked at rapidly. Any unexpected cases considered to have a human factors element were reviewed by the Human Factors group.
- The Mortality and Morbidity divisional meetings had been put on hold temporarily. In the interim all deaths had continued to have a rapid review and would also be part of the Mortality and Morbidity meeting process when the meetings commenced.
- The Board were provided with information as to why two cases were unable to go ahead with organ donation. There had been no particular patterns. Organ donation was still taking place where appropriate.
- There was an update on the Medical Examiner role which had commenced regionally. A whole time equivalent Medical Examiner was needed per 3,000 deaths and the Trust averaged 80-100 deaths per year so would only require a small proportion. Liverpool University Hospitals, being the biggest to contribute, would lead

on the programme. The meeting due to progress the issue was postponed in early April. It was thought that the role would be predominantly from consultants from Liverpool University Hospitals but hopefully to any of the Trust consultants who may be interested.

Confirmation and assurance was received that all questions which had been raised by Non-Executive Directors in advance of the meeting had been answered.

Further assurance was provided around a question relating to a concern around deaths on weekends. The Chair of Quality Committee said it was challenged at the last Quality Committee meeting but the full report data was not available for total assurance.

Lessons learnt would continue to be highlighted in the report when it was considered the issue needed to be brought to light and learnt from.

It was not considered that the changes in organ donation legislation in April 2020 would have a major impact on donations. This legislation was already in place with Welsh patients and it was still practice that all cases were referred to the Specialist Nurse for Organ Donation and discussed with next of kin with only the minority of relatives not being supportive.

The request to have the deaths by admission day of the week data produced as an SPC chart in future reports was noted and agreed.

The Board

- **Noted the report.**

TB10/ 20-21 **Board Assurance Framework**

The Corporate Secretary presented the BAF to provide the Board with the current version of strategic risks and the year-end position for 2019-20 in order to demonstrate that a number of risks had been closed, scores adjusted and new risks identified.

The main focus was Risk ID 001 Covid-19 and a full risk assessment was provided should the pandemic continue for an extended period and what that would mean in terms of objectives and the Trust's reputation. The appendices contained assessments of the operational risks to provide an understanding of how the score was achieved and the detail beneath it. A more detailed report would be circulated to Non-Executive Directors in order to gain a greater appreciation.

All other strategic risks 2020-21 were highlighted in Table 1 of the report. These had changed slightly and based on the strategies approved by Board now included a risk around Innovation and Partnership Working (but no risk assessments at present).

The Board discussed the COVID risk recognising that it was a significant. Going forward there would be a reference to PPE to ensure no gaps in assurance. It was acknowledged the level of detail would normally be discussed at sub-committees and brought back to Board by exception. It was observed that although the risk was described as long term most of the information related to the day to day handling of the situation.

Discussion took place on the risk covering:

- The external environment and the resistance of patients to come to hospital;

- The current lack of guidance on how to ease out of the situation;
- The need for a list of actions to manage the long term risk; and
- Ensuring a business as usual focus is maintained as well as responding to the crisis for accountability reasons.

It was agreed that the Chair, Chief Executive and Corporate Secretary would meet in order to decide how to take the discussion of the risk forward. It was suggested a session with the Non-Executives and Corporate Secretary be arranged to discuss the BAF in further detail.

The Board

- **Noted the report.**

ACTION

BAF session involving Non Executives and Corporate Secretary to be arranged.

TB11/ 20-21 **Standing Orders and Emergency Powers, Urgent Decision Making**

The Corporate Secretary updated that the paper circulated around governance arrangements and financial limits would be discussed in the closed board session.

TB12/ 20-21 **AOB**

Audit Committee Meeting 21 April 2020

The Director of Finance and Chair of the Audit Committee provided an update on the recent Audit Committee meeting.

- Based on where internal audit reports were up to so far an Opinion of substantial assurance was received from the internal auditors.
- High assurance around financial controls was received from internal audit.
- Discussion took place with external audit around the approach to this year's audit through remote working. It was agreed this would likely extend beyond 22 May and therefore the extra-ordinary Audit Committee to approve the final accounts was likely to be in June 2020.
- The new audit team from Grant Thornton were introduced at the meeting and it was detailed how the handover was taking place with the new members of the GT team.
- The normal process for quality accounts would not be taking place.
- An update on work provided by the anti-fraud team was provided.

The Director of Finance informed the Board that the contract for external auditors Grant Thornton had been extended for one year and this had been ratified by the Council of Governors at the AMM in September 2019. Subsequently the auditors increased the fee of the contract quite substantially to produce the 20-21 accounts. Discussion took place around this and assurance was given by the Director of Finance that appropriate work had been undertaken to negotiate the fee; get examples of fees paid by other trusts; procurement department had looked at options on the framework but there had not been much success in receiving lower bids; acknowledged the difficulty in finding suitable auditors in time available (and during the current pandemic) and the concern of losing the auditors if we refused to pay the increased costs.

Discussion took place and the Board agreed to continue with the contract and pay the increased fee as it was considered too big a risk to lose the contract by not agreeing to the price increase and the consistency provided by Grant Thornton. It would be clarified if formal approval was required for this decision.

Non-Executive Directors extended thanks to all for the substantial assurance received.

ACTION
Confirmation required if formal approval was necessary for the increase in external audit fees

Comments from Lead Governor
The following comment were received:

- It would be helpful for governors to receive the reports contained in the Board papers particularly the Covid-19 Update, the Chief Executive's comments on that report and the Staff Health and Well-Being Report. These would be published on the website (and Chief Executive comments published in confirmed Open Board minutes next month).
- Governors may be interested in the fees payable to external audit and receive assurance that the sizeable fee was a benchmark of what a Trust the size of the Walton Centre should be paying. The Chair and Corporate Secretary would look at distributing the notes of the decision made around External Audit to provide some context.
- The offer of help from Governors to provide help and assistance if and when required.

ACTION
Notes to be provided and made available to Governors on the decision to agree to the fee increase paid to external auditors Grant Thornton.

Date and time of next meeting – Friday 22 May 09.30 – MS Team

There being no further business the meeting closed.

TRUST BOARD
Matters arising Action Log
May 2020

	Complete & for removal
	In progress
	Overdue

Date of Meeting	Item Ref	Agenda item & action	Lead	Update	Deadline	Status
27.06.2019	TB 78/19	**Annual Safeguarding Report/DBS Checks** Director of Workforce & Innovation to provide an update on benchmarking with other organisations regarding DBS check approach/ funding	M Gibney	M Gibney to provide a paper outlining the position, options and risks. **January 2020** Item on the agenda. Regional solution awaited. Update to be provided when agreement reached. **April 2020** Awaiting regional update.	~~Oct 2019~~ Jan 2020	
25.07.2019	TB 96/19	**Quality Committee Terms of Reference** To review the membership and Terms of Reference for all of the Board Committees	J Hindle	**Dec 2019** Quality Committee, BPC and Audit Committee complete. **Jan 2020** RDI, Charity and Rem Com to be agreed by each committee before approval by Board. **March 2020** Comments following Charity Committee to be included in the next version. RDI need to factor in the changes to the sub-groups. **April 2020** Would be recommenced when appropriate within the current climate.	~~Nov 2019~~ ~~March 2020~~ ~~April 2020~~ July 2020	

30.01.2020	TB/151/19-20	**Guardian of Safe Working** To provide the data for January for circulation to members.	C Burness	**March 2020** J Hindle requested the Jan data from Dr C Burness. No response received. **April 2020** No response received as responsible person was unavailable and return to work date not known. **May 2020** Item circulated to all members w/commencing 11th May.	~~March 2020~~ May 2020	
26.3.2020	TB163/19-20	**Freedom to Speak Up Guardian Report** Director of Nursing to discuss with FTSU Guardian the low response rate to the survey and feedback remotely.	L Salter	**April 2020** This was an in-house as opposed to a national survey and as such benchmarking was not possible. It had been agreed to schedule a further survey for 2021. Encouragement was given at the daily safety huddle that concerns should be raised with the FTSUG.		
30.01.2020	TB147/19-20	**Governance Report** To consider the most appropriate means of benchmarking complaints e.g comparison with other outstanding trusts or others with Neuro Services and provide appropriate narrative.	L Salter	**April 2020** On Agenda and would include data on compliance. It was noted that Governance priorities were likely to change going forward. Incidences against occupancy figures to be produced as a percentage to provide a more comparable figure going forward.		

30.01.2020	TB150/19-20	**Mortality & Morbidity report** Members to feedback comments re summarising the report to enable the Board to see the high level trends and enable Quality Committee to see a more detailed version.	A Nicolson	**April 2020** No comments received from NEDs. **May 2020** Comments received and shared with A Nicolson.		
26.3.20	TB06/20-21	**IPR** The Financial Governance Check List to be sent to Non-Executive Directors once approved by the Executive Team	M Burns	**May 2020** The Trust's position against the checklist was circulated to all NEDs on 15th May 2020.		
26.3.20	TB10/20-21	**BAF** Covid Risk - BAF session involving Non Executives and Corporate Secretary to be arranged.	J Hindle	**May 2020** Due to the reinstatement of the assurance committees the relevant BAF risks would be presented to QC and BPC in May 2020.		
26.3.20	TB12/20-21	**AOB** Audit Committee Update - Confirmation required if formal approval was necessary for the increase in external audit fees	J Hindle	**May 2020** As per para 37.2 the appointment of the auditor is a matter for the Council of Governors. A note has been circulated on 7th May 2020.		
26.3.20	TB13/20-21	**AOB** Full COVID Update to be provided to all Governors along with s of the increase to the External Auditors fee to on the decision to agree to the fee increase paid to external auditors Grant Thornton	J Hindle	**May 2020** Board papers for March and April 2020 circulated to all governors with a note from the Director of Finance on 7th May		

The Walton Centre NHS Foundation Trust

REPORT TO TRUST BOARD
Date 22nd May 2020

Title	**COVID-19 Update Report**
Sponsoring Director	Hayley Citrine Chief Executive
Author (s)	Jan Ross, Director of Strategy and Operations, Mike Gibney, Director of Workforce and Innovation, Lisa Salter, Director of Nursing and Governance, Mike Burns Director of Finance.
Previously considered by:	None
Executive Summary The purpose of the report is to summarise the approach to COVID-19 to date; to inform the Board of new ways of working, emergency resilience and operational preparedness, recognising regional and national responses and directives.	
Action required by the Board	The Board is requested to: • note the updated position
Related Trust Ambitions	1. Deliver best practice care and treatments on our specialist field. 2. Provide more services closer to patient's homes, driven by the needs of our communities, extending partnership working. 3. Be financially strong, meeting our targets and investing in our services, facilities and innovations for patients and staff. 4. Lead research, education and innovation, pioneering new treatments nationally and internationally. 5. Adopt advanced technology and treatments enabling our teams to deliver excellent patient and family centred care. 6. Be recognised as excellent in our patient and family centred care, clinical outcomes, innovation and staff wellbeing
Risks associated with this paper	BAF Risk ID001 COVID-19
Related Assurance Framework entries	BAF Risk ID001 COVID-19
Equality Impact Assessment completed	Not applicable
Any associated legal implications / regulatory requirements?	Follows national and regional guidance related to Coronavirus

1.0 INTRODUCTION

1.1 The purpose of this report is to update the Trust Board on key national, regional and local developments in relation to COVID-19.

2.0 NATIONAL CONTEXT

2.1 NHS Roadmap to Safely Bring Back Routine Operations

NHS England has published an Operating Framework for urgent and planned services in hospital settings during COVID-19. The guidance outlines how providers should maintain the capacity to provide high quality services for patients with COVID-19, whilst increasing other urgent clinical services and important routine diagnostics and planned surgery.

https://www.england.nhs.uk/Operating-framework

3.0 REGIONAL POSITION

3.1 Cheshire and Merseyside STP Restoration Plan

The Cheshire and Merseyside STP was required to submit a restoration plan to the NW regional team by close of play on 15th May and this will be returned as a NW submission the following week to the national team. The key purpose of this first submission is to identify plans to begin to restore some normal NHS activity over the subsequent 6 weeks to the end of June 2020.

As part of the Hospital Cell arrangements, a small team are working on a draft plan with the help of Acute Trust COOs, linking with the regional teams on Independent Sector capacity and linking together the Out of Hospital work to date in the region to try and present a coherent first stage plan.

Following this submission, there will be much more detailed work undertaken over the subsequent two weeks in order to turn this into a robust plan of how we will use the total C&M capacity over the 12 months ahead to recover the NHS system to whatever the new normal looks like. This will require some oversight from CEOs in both the Hospital and Out of Hospital groups and input from your leadership teams if we are to make it work.

3.2 Cheshire and Merseyside Hospital Cell

The C&M Hospital Cell has been established to enable identification of pan-CM issues and identifies individuals / groups responsible for their resolution. It reports into the the Regional Incident Coordination Centre and the Regional Incident Management Team.

It is chaired by the Ann Marr CEO of STHK and supported by Clinical and Operational Leads who have a key role in the overall C&M response. The Leads are stepping outside their organisational boundaries to represent their peer groups and functions across C&M.

NW HRD Leadership Forum/North SPF Chairs Weekly Call

The issue of annual leave has emerged as a hot topic across all trusts. Ideally, we would want all employees to take annual leave on a pro rata basis so that they are not storing up lots of untaken leave for the second half of the year with a potential impact on Trust performance levels. This is especially the case for absent employees who are shielding. Some trusts have tried to mandate the taking of annual leave for this staff group and it has become clear that this is unacceptable to trade union partners. Annual leave is deemed a statutory right rather than a perk and any Trust that does impose this will be open

to the allegation of disability discrimination.

The other potential solution is that additional/access annual leave is purchased back from employees and the cost is assigned to the COVID 19 budget. Both HRDs and regional union leaders have requested a national steer. Within this Trust, the taking of annual leave has been promoted and encouraged but not mandated.

4.0 WCFT POSITION

4.1 Patient Data

There are currently 91 inpatients within the Trust (15th May 2020), of which, 5 patients are positive and 11 are suspected to have Covid-19. To date there have been 53 patients with Covid-19 in the hospital. There have been 9 deaths reported as a consequence of the virus

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4.2 Staff Data

There have been 154 staff tested to date (4th April until 24th May), with 59 being identified as positive and 94 as negative. We are awaiting results for 1 staff member from the labs. Staff have been requested to contact their manager and Julie Kane if they are symptomatic or if one of their household contacts is symptomatic so that staff / household contact can be tested. A clear SOP was written and this is being managed well. Staff are being tested on day 3 as this is the optimum day for accurate results. Results are given to the staff member or household contact within 24 hours (max 36 hours) of being tested which supports staff within the workforce.

4.3 PPE

At the time of writing, an order of 10,500 gowns has been delivered on the 5th May and a further order of 10,000 is awaiting delivery.

Locally, the Trust continues to manage its PPE on an ongoing basis, regularly reviewing its stock and usage, and is in a relatively stable position, bar a couple of areas e.g. 3M 8833 FFP3 masks, although other alternatives FFP3 masks are available, but do not have the same fit test pass rate as the aforementioned product.

Procurement has sourced reusable FFP3 masks, these masks are currently being circulated to ITU/Theatres and COVID wards as a priority. As these masks are issued to identified staff and fit tested, this will reduce the usage of single use disposable masks, further conserving stock and mitigate the aforementioned issue with the 3M 8833 masks. High usage of PPE has reduced somewhat over the period of the virus, however, as services start to resume, management of stock will be vital especially in the event of any subsequent COVID resurgence. Regular deliveries of PPE are delivered daily to the wards via materials management

A letter was issued on 01 May 2020 by the Department of Health & Social Care stating local Procurement for PPE will not continue to ensure Trusts do not compete with the government for supplies. This means that no bulk purchases can be placed by the Trust for PPE.
Centralising Procurement of PPE

Finance

Finance updates take place on a regular basis, with a regional meeting held every Tuesday, a C&M meeting every Wednesday and national meetings taking place on a regular basis.

The last national meeting took place on 7th May and the key points were:

Capital

- Previously any capital related to Covid-19 that was below the £250k threshold was to be sanctioned at individual hospital level through their own processes and then reclaimed through Covid-19 reimbursement from the centre. This has now changed, with **any** capital expenditure related to Covid-19 to be pre-approved by the centre. If this process is not followed, reimbursement will be through the existing C&M HCP allocation, which effectively means individual trust allocations are reduced;
- The new capital regime is intended to support system working, enable quicker release of emergency capital funding, manage expenditure within available resources and support new cash regime which converts debt to PDC;
- Capital allocations can be flexed between places as long as they are within the overall envelope;
- Final plans to be submitted to the centre by 29th May;
- 2021/22 allocations will be set after the spending review;
- Important that multi-year commitments entered into this year are recognised as first call on next year's allocations.

Financial Framework

- The current temporary financial arrangements are due to expire 31st July;
- From 1st August until (at least) October:
    - We will continue with nationally calculated block contracts, with a refined top up mechanism (after reviewing the first 4 months);
    - No requirement for local contracting
    - Changes likely to include:
        - Adjustments to block contracts and top up values taking into account what we have learnt to date and latest financial information (to fund bulk of operating costs);
        - Adjustments to scope of retrospective top-ups for COVID costs (tighter/ clearer definition of reasonable costs) – anticipating them to be smaller moving forward;
        - Expectations about levels of activity systems anticipate to be delivering for the remainder of year.
- There will be continuing conversations with colleagues about moving forward;
- 2021/22 financial framework is still being discussed so no update.

General

- In terms of final accounts, some auditor concerns remain in respect of going concern though NHSI/E are working on guidance to support this and tie into recovery work streams;
- HMRC –have set a temporary zero rate of VAT that will apply to PPE (1 May – 31 July);
- Revenue costs of phase 2 – will be a note about definition of reasonable costs expected to be incurred (effective from the date of guidance – **will not be applied retrospectively)**

Trust Finance Updates

- Month 1 finances to be submitted to NHSI/E 18.05.20
- The Trust had to resubmit its capital plan to Cheshire and Merseyside Health Care Partnership on 14th May. The original plan was for £4m, and given the current HCP allocation, the request was for all trusts to review their plans on the basis of reducing overall capital expenditure by c14%. After reviewing the Trust plan, we had to increase

our bid by £0.5m given requests for expenditure within the Trust. The Trust may have to re-prioritise expenditure again should this not be agreed by the HCP.

4.4 Patient Experience

Ward teams continue to keep families connected to their loved ones via face-time, teams and lettersforlovedones.

- Patient Experience Team continue although some working from home to deal with incoming enquiries, providing support for families, as well as any concerns/complaints and escalating to senior teams where required. Whilst supporting staff in arranging for them to stay in Home from Home.

- While I'm on a roll can I just say thank you the staff at @Walton Centre Chavasse ward who looked after me on my recent stay they do an AMAZING job every single staff member who steps foot on that ward plays equally as important a role

- Two weeks ago the father in law couldn't walk or move his legs. Trip to A&E and referred to Walton where he found out he had a tumour on his spine. Had it removed 1 week ago and is already on his feet and back home today. He received the best care.

The Trust has ordered Memory Boxes for the bereaved. The Boxes will be branded with the bereavement tree of life and contain a candle, specifically designed condolences card from the Trust to give the opportunity for the nurse caring for the patient to write to the family, and special keepsakes including small organza bags to place locks of hair, handprints/thumb prints and an envelope containing forget-me-not seeds

5.0 Health & Wellbeing Update

5.1 Working practices during lockdown

The Trust is conducting a staff questionnaire to capture the learning from new working experiences over recent weeks. The aim is to collect this feedback while it is still fresh in everyone's mind and to inform our future working practices. Over 300 staff completed the questionnaire within the first few days it went live.

5.2 The Trust continues to support staff as detailed in last months update, in addition please find below an overview of new Health and Wellbeing related information and resources offered nationally to staff.

5.3 National Approach

Guides on a range of topics, developed by experts and available for local implementation, are available via the website Our NHS People.

5.4 Financial Wellbeing Guide

This guide for employers gives an insight into the context, challenges and resources supporting financial wellbeing.

5.5 Ramadan

A guide on how to support staff who may be fasting during Ramadan is available via Our NHS People: COVID-19 and Ramadan: how to support staff who may be fasting

5.6 NHS Employers guidance on risk assessments

NHS Employers have issued guidance for employers on how to carry out risk assessments for vulnerable groups, to understand the specific risks staff members face from exposure to

COVID-19 and actions which employers can take to keep staff safe.

5.7 Stay Alive app

Free access to the Stay Alive app is now available for all NHS and social care staff as we recognise that those with existing mental health concerns and others that are struggling in self isolation, would benefit from this positive self-help app which can positively support individual staff members. Stay Alive is an easily accessible suicide prevention resource, packed full of useful information to help colleagues stay safe. Colleagues can use it if they are having thoughts of suicide or if you they are concerned about someone else who may be considering suicide. NHS staff can also access a range of mental health self-help apps for free until 31 December 2020.

6.0 Walton Centre Charity

6.1 The emergency appeal set up through the charity website has received over £8,000 in on-line donations plus the £5,000 received from Investec in lieu of their corporate support of the Golf Day which was due to take place on 21 May. Adding the two grants received from NHS Charities Together (£35,000 and £10,500) takes the total received to support staff/patients during the covid-19 crisis to £58,500.

6.2 To date just over £20,000 has been spent on initiatives directly related to covid-19/staff/patient wellbeing including 2 weeks of free breakfasts/snack-bags for staff; PPE training/display (mannequins); 2 x temporary on-call rooms; aromatherapy treatment for ITU/Theatre staff; amazon vouchers for children whose parent/s (staff) had to work over Easter school holidays, meaning the children missed out on holidays and had to stay in school. The charity is also supporting a 'snack service' organised by the dieticians for patients during visiting restrictions.

6.3 Gifts-in-kind such as refreshments for staffrooms; treats for staff; and toiletries for patients have continued to be received from community and corporate partners. A central log of all donations to the hospital is maintained by the Fundraising Team to ensure appropriate acknowledgement/thanks as well as fair distribution across wards and departments.

6.4 An update on activities, income and proposed charitable expenditure is provided to the Charity Committee by the Head of Fundraising on a weekly basis.

7.0 Digital Support

7.1 During this period reliance on technology and new ways of working has increased. The work of the Trust's IT department has included the following:

- Distributed over 100 laptops to cover households with more than 1 person working from home. These are all documented on a full asset register
- MS Teams deployment and user setup to support virtual meetings. The Trust currently have 606 users;
- Managed remote user creations and software support for 814 home users;
- Expansion of the Barracuda remote solution, migrated from old VPN solution. The current VPN was coming to the end of its life April 2020. Although IT were in the process of migrating people over to the new system this had to be accelerated due to Covid. Barracuda is based on user numbers and is also based on server processes / memory so the trust had to extend the licence model to ensure we could use the full capacity of the

new servers as there had never been a need for so many users and the server architecture to support so many concurrent users;

- Creation of a new Terminal Server farm to include greater processing ability and flexibility of being in a virtual environment as well as latest Operating System, so we are now utilising Microsoft Windows 2019 to ensure security;

REPORT TO TRUST BOARD

Date 22/05/2020

Title	Integrated Performance Report
Sponsoring Director	Name: Jan Ross Title: Director of Strategy and Operations.
Author (s)	Name: Mark Foy Title: Head of Information & Business Intelligence
Previously considered by:	None
Action required by the Board:	The Board is requested to:

Executive Summary

This report gives assurance on all Integrated Performance Report measures aligned to the Business & Performance and Quality Committee. Measures have been grouped into three categories to highlight high performing measures, measures with opportunity for improvement and those measures currently under performing. Performance is based on four aspects; performance in month, trend/variation, whether the target is within variation and external benchmarking.

The ongoing COVID-19 situation has impacted the performance of a number of measures. Changes to Outpatient and Elective services in response has led to increased waiting times for overall RTT Pathways and for our 6 week wait diagnostic tests due to the reductive in elective and outpatient activity, the Trust has only seen and treated urgent patients throughout April. Cancer Performance has remained above targets as the Trust has continued to prioritise this activity. Healthcare Acquired Infections and Harms have remained within expected low levels.

Key Performance Indicators – Caring **Opportunity for Improvement Measures** Complaints – Due to covid19 all complainants were written to and advised there may be a delay in response. The divisions and patient experience team are now working closely together to respond to the backlog of complaints. **Key Performance Indicators – Well Led** **High Performing Measures** Agency Spend Staff Friends & Family Test **Opportunity for Improvement Measures** Finance **Underperforming Measures** Vacancy Levels Nursing Turnover Sickness/Absence	**Key Performance Indicators – Responsive** **High Performing Measures** Cancer Standards – Two Week Wait Cancer Standards – 31 Day First Definitive Treatment Cancer Standards – 31 Day Subsequent Treatment Cancer Standards – 28 Day Faster Diagnosis **Underperforming Measures** 6 Week Diagnostic Waits – a recovery plan is in place however this performance measure remains a risk. **Key Performance Indicators – Effective** **Underperforming Measures** Referral to Treatment – Wales as described in the paper the trust has only seen and treated urgent patients **Key Performance Indicators – Safe** **Opportunity for Improvement Measures** Infection Control

Related Trust Ambitions	Delete as appropriate: • Be financially strong • Research, education and innovation • Advanced technology and treatments • Be recognised as excellent in all we do
Risks associated with this paper	Failure to deliver performance may impact on patient experience and lead to regulatory scrutiny
Related Assurance Framework entries	Failure to see and treat patients in a timely manner
Equality Impact Assessment completed	Not applicable
Any associated legal implications / regulatory requirements?	The Trust is required to meet the standards defined in the Single Oversight Framework

The Walton Centre
NHS Foundation Trust

Board KPI Report
May 2020

Data for April 2020 unless indicated

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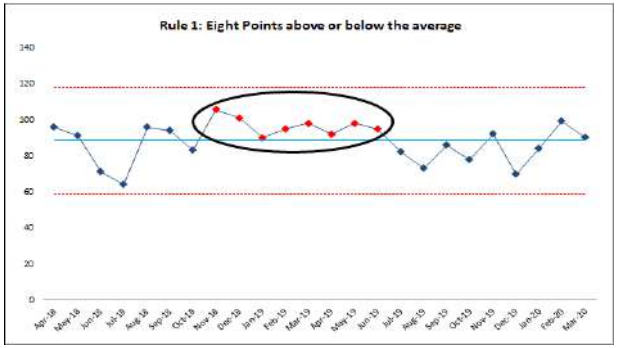
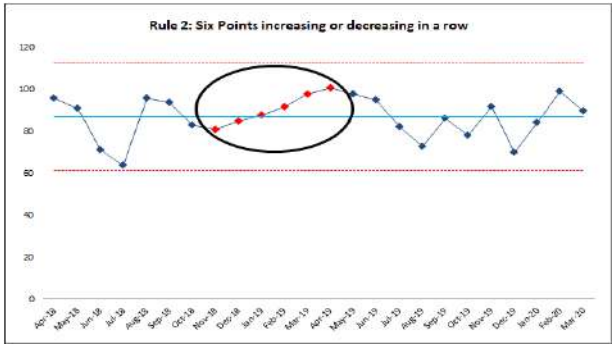
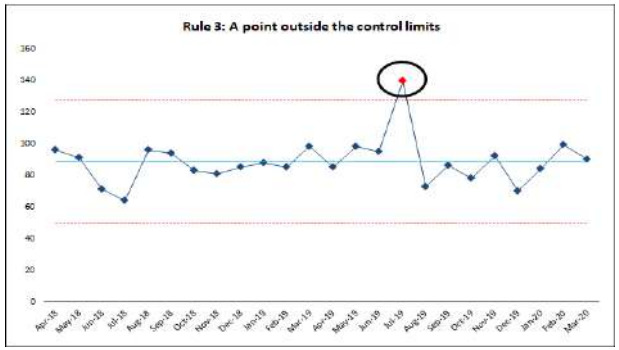
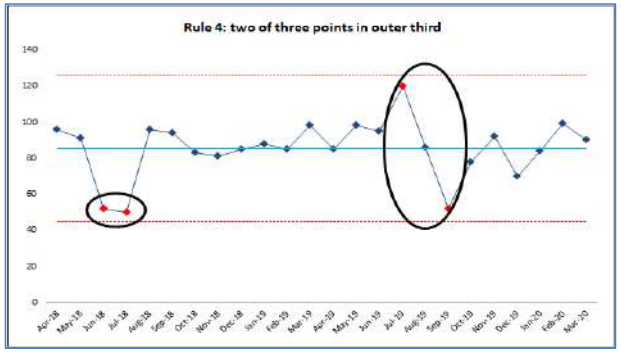
SPC Charts Rules

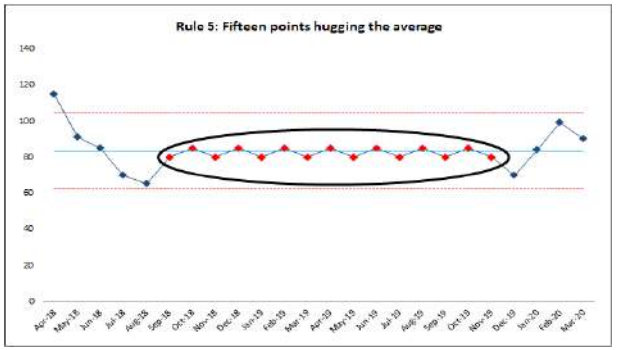
The Walton Centre
NHS Foundation Trust











All SPC charts will follow the below Key unless indicated

Actual — UCL — Average — LCL — National Average — Target

Quality of Care

Caring - Complaints

NHS
The Walton Centre
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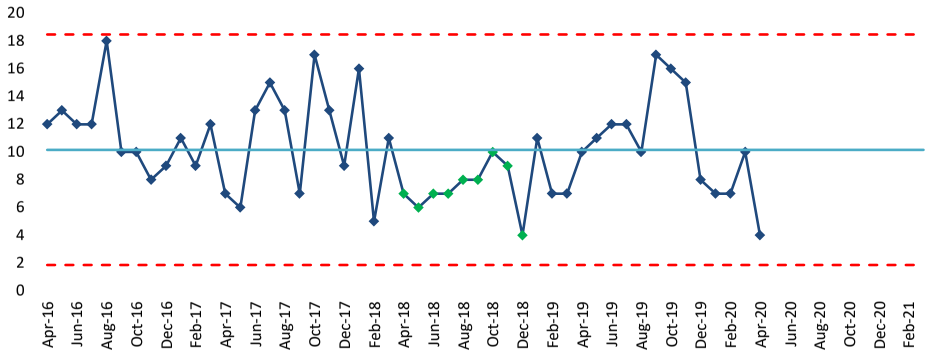
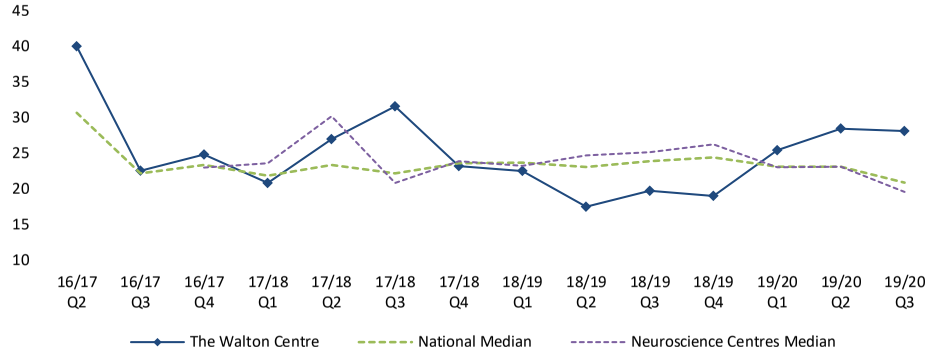
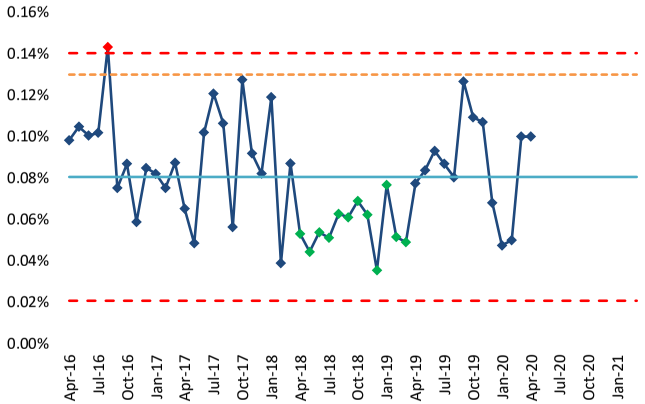
Total Complaints Received in month



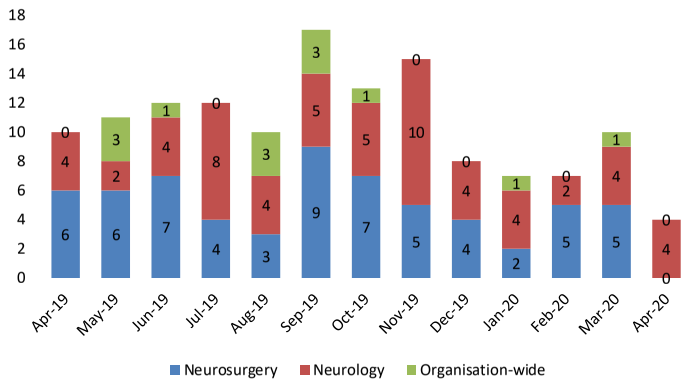
Quarterly Complaints per 1000 WTE



% Complaints Received against Activity



Total Complaints Received



Narrative

In April 2020 the Trust received 4 complaints (all Neurology).

The number of complaints the Trust receives has a wide variation range meaning the expected numbers range from 2 to 18 at an average of 10 per month. When balanced against patient contacts the number received is within normal variation. However when compared externally the number of complaints received per 1000 WTE is above both the national average and other Organisations with a large neurosciences service

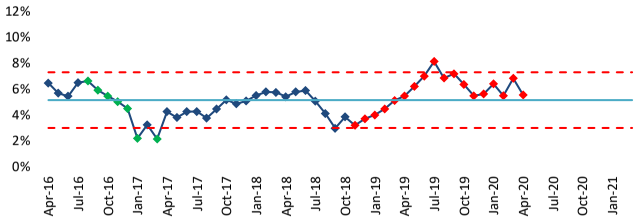
Excellence in Neuroscience

Quality of Care

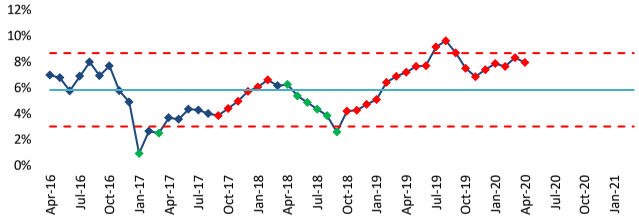
Well Led - Workforce KPIs

The Walton Centre NHS Foundation Trust

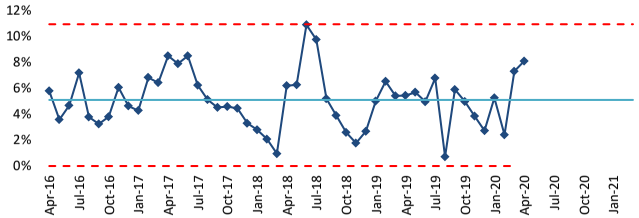
Overall Vacancy Level %



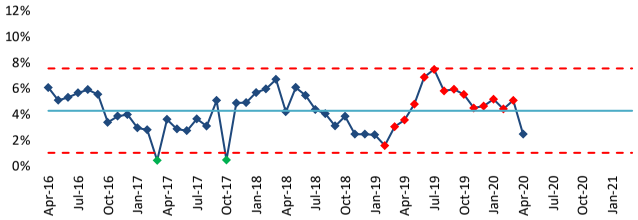
Nursing Vacancy Level %



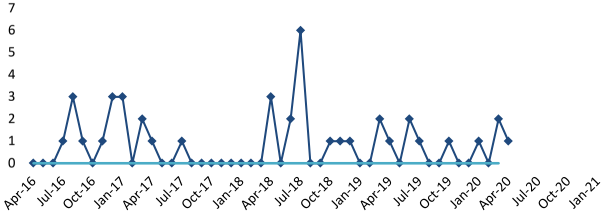
Medical Vacancy Level %



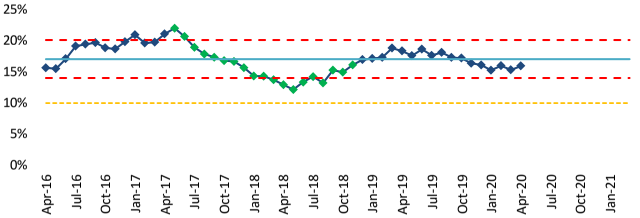
Other Staff Vacancy Level %



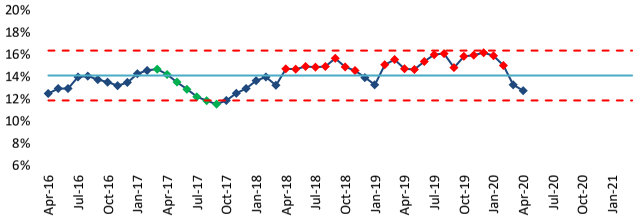
Medical Leavers



Nursing Turnover (Rolling 12 months)



Other Staff Turnover (Rolling 12 months)



Vacancy Levels

Overall vacancy levels are experiencing special cause variation and have increased significantly. This is also the case when broken down to staff group for nursing and other staff. Medical vacancies are within normal variation.

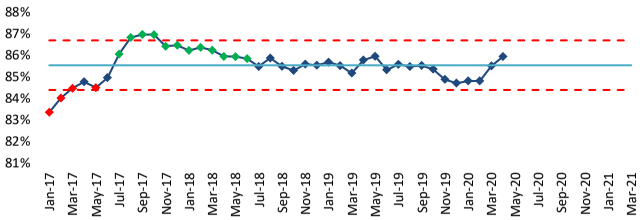
Nursing Turnover

Nursing turnover is within expected limits however the target is below the lower control limit meaning this target is unlikely to be met without a change of process. At division level, the target is also outside of the control limit for neurology and neurosurgery.

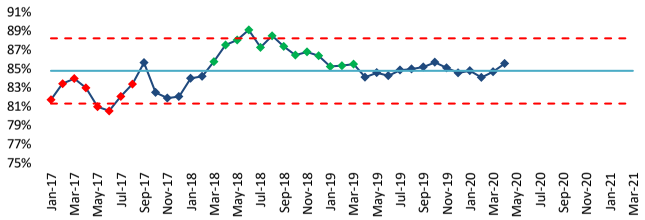
Sickness/Absence

Sickness/Absence is outside of expected levels for all types, there has been an additional 1800 lost days of sickness in April compared to the average.

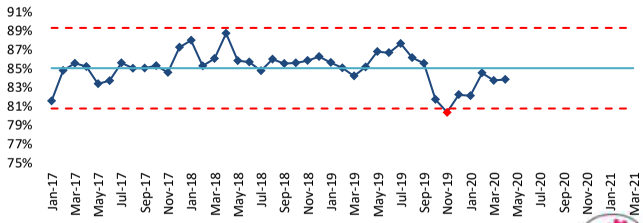
Staff Stability Index - All Staff



Staff Stability Index - Nursing



Staff Stability Index - Medical



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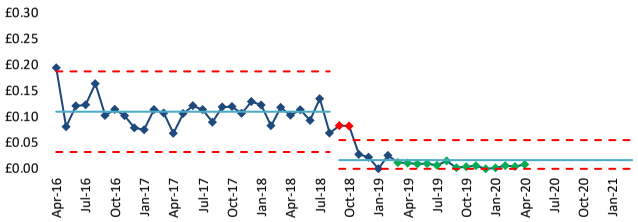
Quality of Care

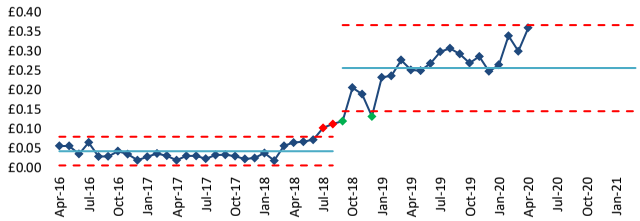
Well Led - Workforce KPIs

The Walton Centre NHS Foundation Trust

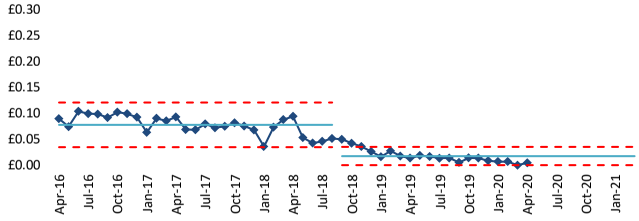
Nursing & HCA Agency Spend (£m)



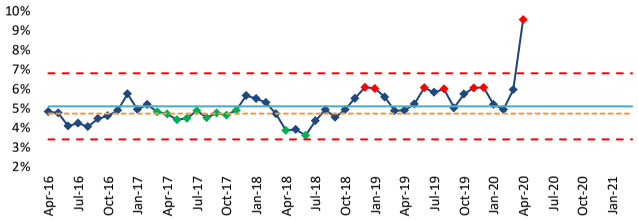
Nursing & HCA Bank Spend (£m)



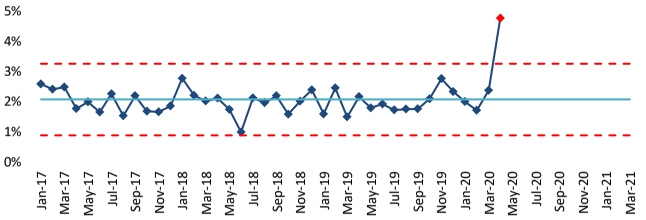
Nursing & HCA Overtime Spend (£m)



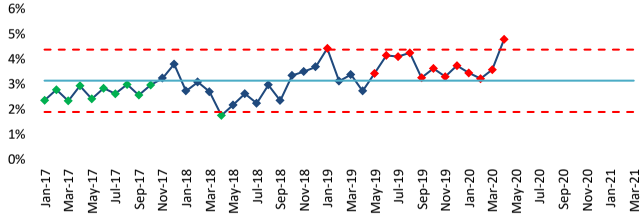
Sickness/Absence (Monthly)



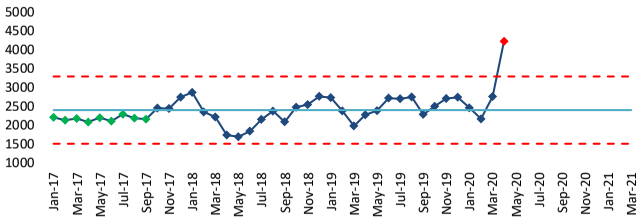
Short Term Sickness/Absence (Monthly)



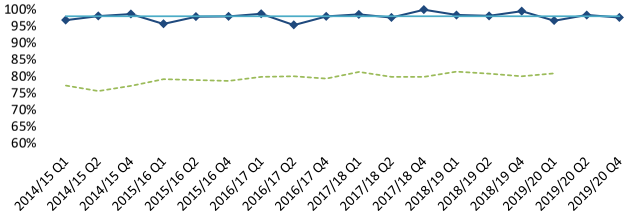
Long Term Sickness/Absence (Monthly)



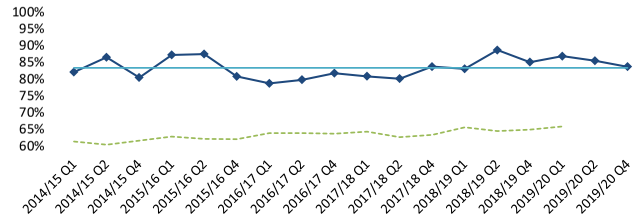
Lost Days due to Sickness/Absense (Monthly)



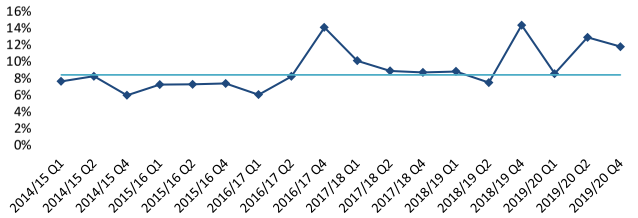
Staff FFT - % Recommend as Place of Care



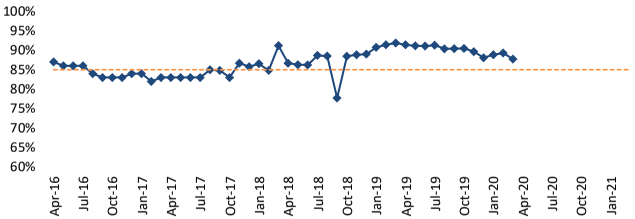
Staff FFT - % Recommend as Place of Work



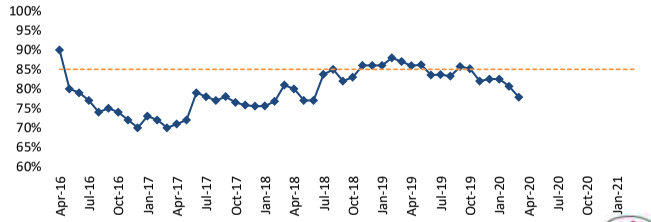
Staff FFT - % of Organisation Staff Responded



Mandatory Training Compliance (Rolling 12 months)



Appraisal Compliance (Rolling 12 months)



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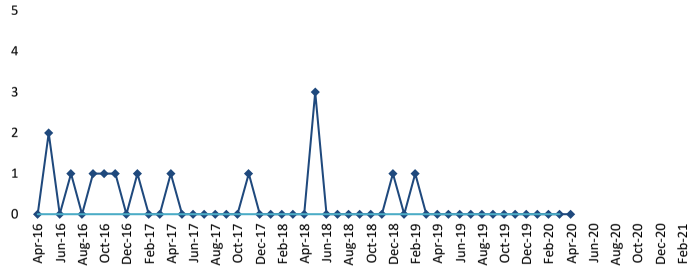
Quality of Care

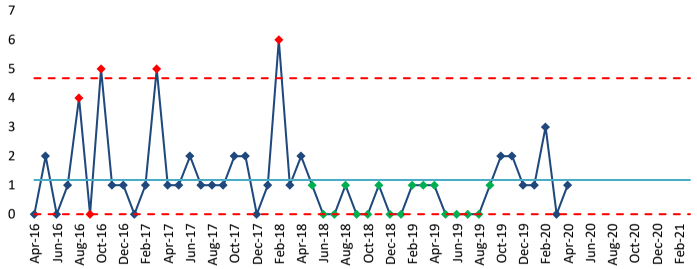
Safe - Harm Free Care

The Walton Centre NHS Foundation Trust

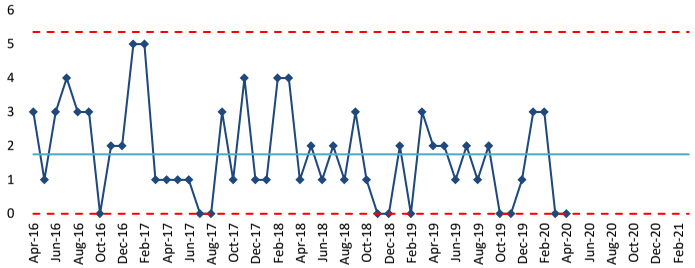
Total Moderate or Above Harm Patient Falls



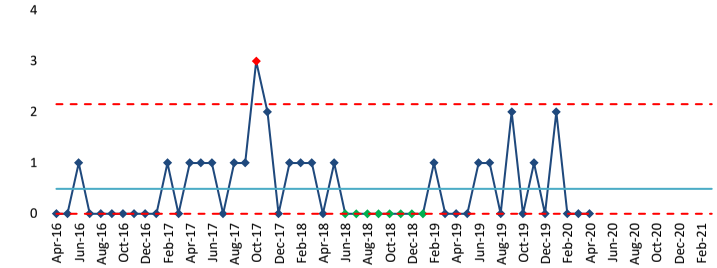
Total Hospital Acquired Pressure Ulcers (Category 2, 3, 4 & Unstageable)



CAUTI Incidences



VTE Incidences



Narrative

There were no fall which resulted in moderate or above harm in April 20.

There were one Hospital Acquired Category two Pressure Ulcer in April 20.

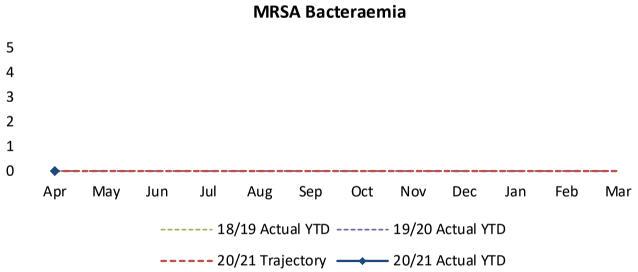
There were no CAUTI incidences in April 20

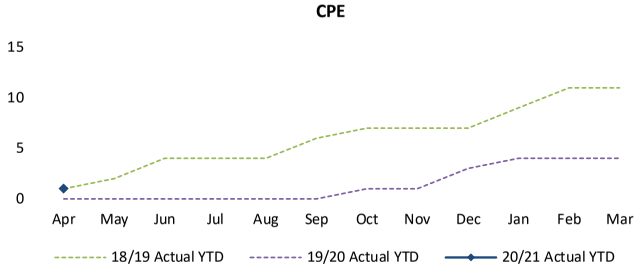
There were zero VTE incidence in April 20

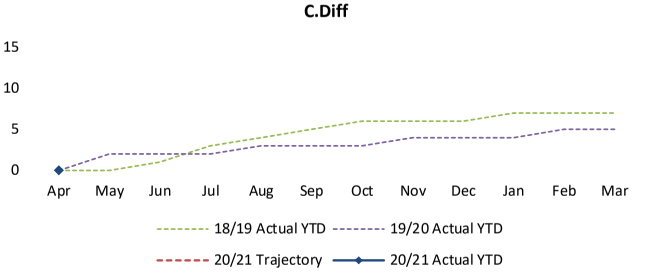
Quality of Care

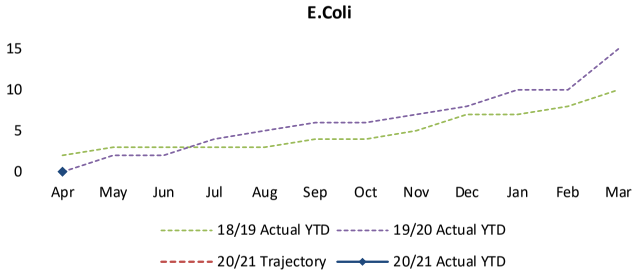
Safe - Infection Control

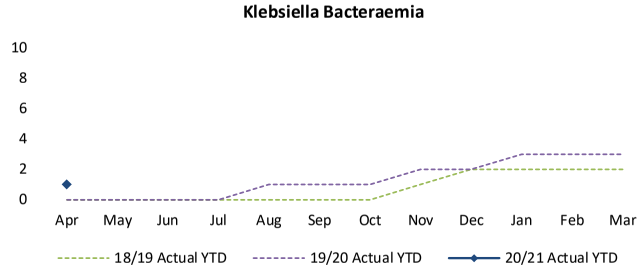
The Walton Centre NHS Foundation Trust

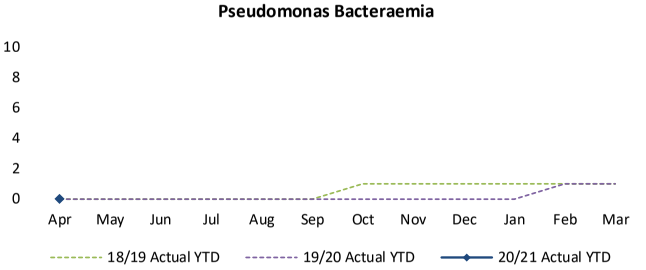


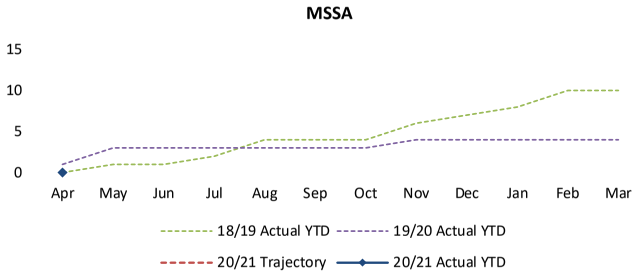












Total Healthcare Acquired Infections 20/21

	MRSA B	CPE	C.Diff	E.Coli	KB	PB	MSSA	Total
Cairns								0
Caton						1		1
Chavasse								0
CRU								0
Dott								0
Horsley					1			1
Lipton								0
Sherrington								0

April Breakdown

1x KB-Horsley

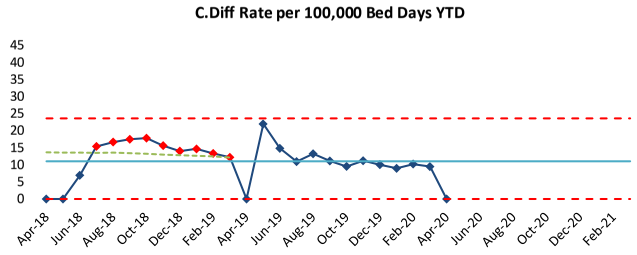
1x CPE-Caton

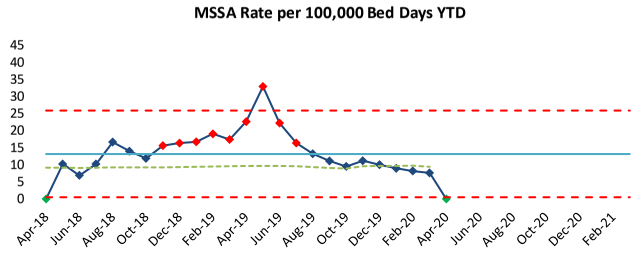
Excellence in Neuroscience

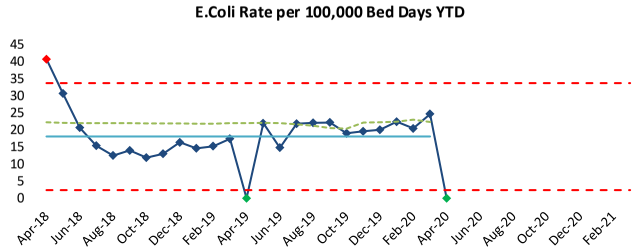
Quality of Care

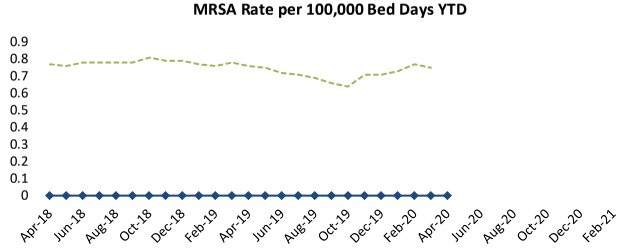
Safe - Infection Control

The Walton Centre NHS Foundation Trust









Narrative

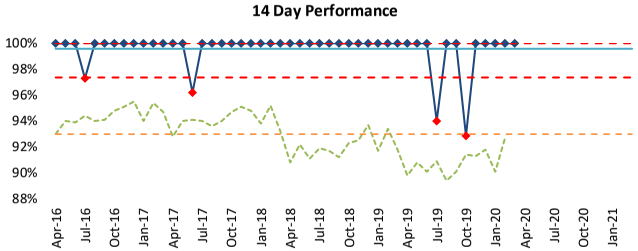
MSSA rates per 100,000 bed days had typically been above the national average since July 18. However performance has now improved and is in line with the national average.

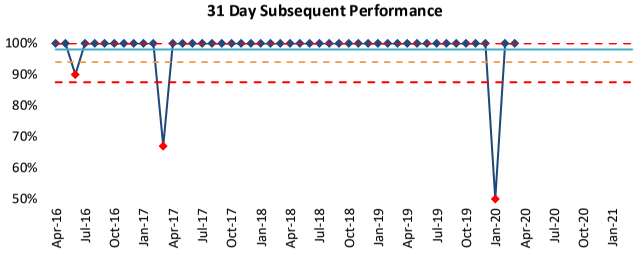
E.Coli rates have been better or inline with the average, while MRSA has been consistenly better.

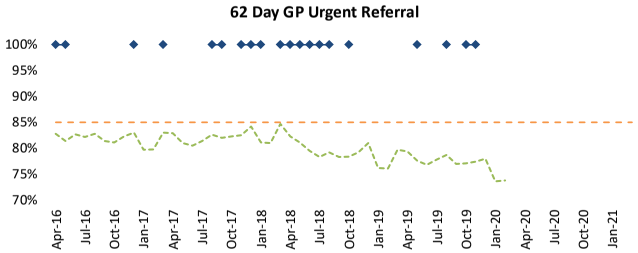
As of March 19 the C.Diff rate is no longer published.

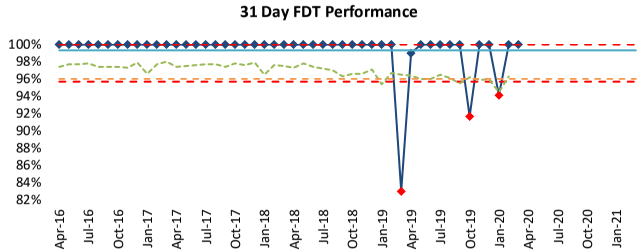
Operational
Responsive - Cancer

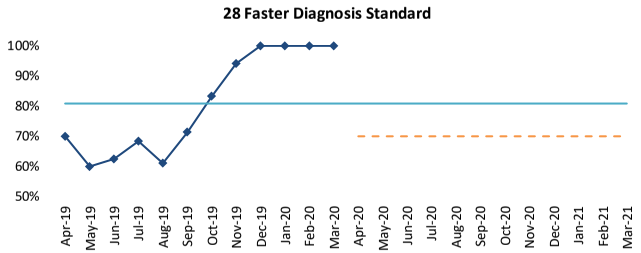
The Walton Centre NHS Foundation Trust











Narrative

All Cancer Access Standards have been met in the latest reporting period of March 2020.

The Trust has continued to see and treat all cancer patients throughout April as these patients were urgent, therefore the impact of covid-19 is minimal.

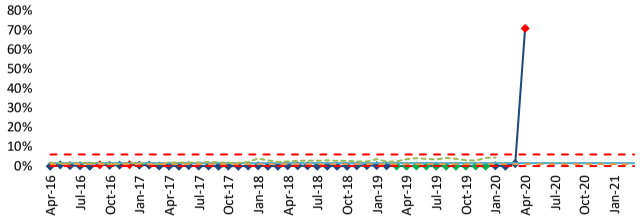
From April 2020 the new 28 Day faster diagnosis standard begins following a period of shadow monitoring. The target has been set nationally at 70%. The Trust has been above this point since September 2019 and performing at 100% for the last 4 months.

Operational

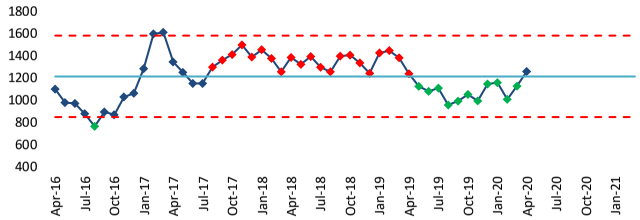
Responsive - Diagnostics

The Walton Centre
NHS Foundation Trust

6 Week Diagnostic Performance



Total Diagnostic Waits at Month End

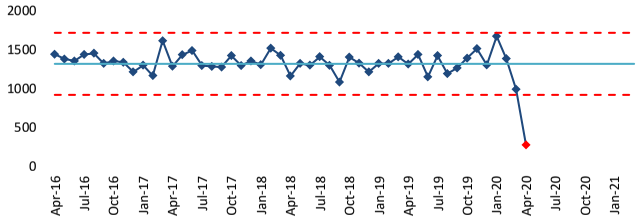


Narrative

Diagnostic performance in April 20 was 70.9 Activity has been severely impacted by the ongoing COVID-19 situation and is running at 20% of expected levels, as only urgent cases were seen.

The Trust is working through plans to increase activity however performance against the diagnostic standard remains a risk.

Total Diagnostic Activity in Month



There were 894 six week diagnostic breaches in month.

THE WALTON CENTRE NHS FOUNDATION TRUST
SUMMARY FINANCIAL INFORMATION

Trust I&E	In month		
	Plan £'000	Actual £'000	Variance £'000
Main Contract	8,681	8,309	(372)
Exclusions	1,786	1,786	0
Private Patient	20	0	(20)
Other Operating	613	512	(101)
Total Operating Income	**11,100**	**10,607**	**(493)**
Pay	(6,116)	(6,058)	58
Non-Pay	(2,660)	(2,204)	456
Exclusions	(1,798)	(1,158)	640
Reserves	31	(598)	(629)
Total Operating Expenditure	**(10,543)**	**(10,018)**	**525**
EBITDA	**557**	**589**	**32**
Depreciation	(387)	(411)	(24)
Profit / Loss On Disp Of Asset	0	0	0
Interest Receivable	14	5	(9)
Financing Costs	(53)	(52)	1
Dividends on PDC	(131)	(131)	0
I & E Surplus / (Deficit)	**0**	**0**	**0**

At month 1, the Trust reported a breakeven position, in line with NHSI/E guidance. To note that the plan shown has been set by NHSI/E based on average expenditure incurred in months 8-10 in 2019/20 (plus inflation).

The position includes £0.5m spend incurred as a result of COVID-19, which has been partially offset by a reduction in clinical supplies and excluded drugs and devices spend due to the majority of elective activity being cancelled in April.

The underperformance in income is primarily due to Wales and IOM not paying at the levels of income assumed by NHSI/E in their plans for the Trust – this has been raised with NHSI/E (please see the risks sections for further explanation).

STATEMENT OF FINANCIAL POSITION - 2020/21	Mar-20	Apr-20	Movement
	£'000	£'000	£'000
Intangible Assets	49	44	(5)
Tangible Assets	82,591	82,313	(278)
TOTAL NON CURRENT ASSETS	**82,640**	**82,357**	**(283)**
Inventories	1,232	1,319	87
Receivables	9,287	7,592	(1,695)
Cash at bank and in hand	26,673	40,814	14,141
TOTAL CURRENT ASSETS	**37,192**	**49,725**	**12,533**
Payables	(17,903)	(30,276)	(12,373)
Provisions	(226)	(226)	0
Finance Lease	(52)	(52)	0
Loans	(1,396)	(1,396)	0
TOTAL CURRENT LIABILITIES	**(19,577)**	**(31,950)**	**(12,373)**
NET CURRENT ASSETS/(LIABILITIES)	**17,615**	**17,775**	**160**
Provisions	(639)	(467)	172
Finance Lease	(115)	(113)	2
Loans	(25,216)	(25,267)	(51)
TOTAL ASSETS EMPLOYED	**74,285**	**74,285**	**0**
Public Dividend Capital	27,554	27,554	0
Revaluation Reserve	2,544	2,544	0
Income and Expenditure Reserve	44,187	44,187	0
TOTAL TAXPAYERS EQUITY AND RESERVES	**74,285**	**74,285**	**0**

STATEMENT OF CASH FLOW - 2019/20	Apr-20 Actual
	£'000
SURPLUS/(DEFICIT) AFTER TAX	**0**
Non-Cash Flows In Operating Surplus/(Deficit)	590
OPERATING CASH FLOWS BEFORE MOVEMENTS IN WORKING CAPITAL	**590**
Increase/(Decrease) In Working Capital	15,932
Increase/(Decrease) In Non-Current Provisions	(173)
Net Cash Inflow/(Outflow) From Investing Activities	(2,261)
NET CASH INFLOW/(OUTFLOW) FROM INVESTING ACTIVITIES	**14,088**
Net Cash Inflow/(Outflow) From Financing Activities	53
NET INCREASE/(DECREASE) IN CASH	**14,141**
OPENING CASH	**26,673**
CLOSING CASH	**40,814**

COVID-19 expenditure:

£520k expenditure has been incurred on COVID-19 in April (and is included within the reported financial position).

COVID -19 Expenditure	Apr-20 Actual £'000
Pay cost (incl. additional shifts, on-call, etc)	99
Annual leave provision	287
PPE	62
Decontamination	9
Remote working	21
ITU	5
Other	37
TOTAL	**520**

Other spend includes providing free car parking for staff and increasing the number of staff uniforms for staff.

The annual leave provision is the anticipated cost that would be incurred providing backfill or paying clinical staff for annual leave that they have not been able to take in April due to COVID.

Capital

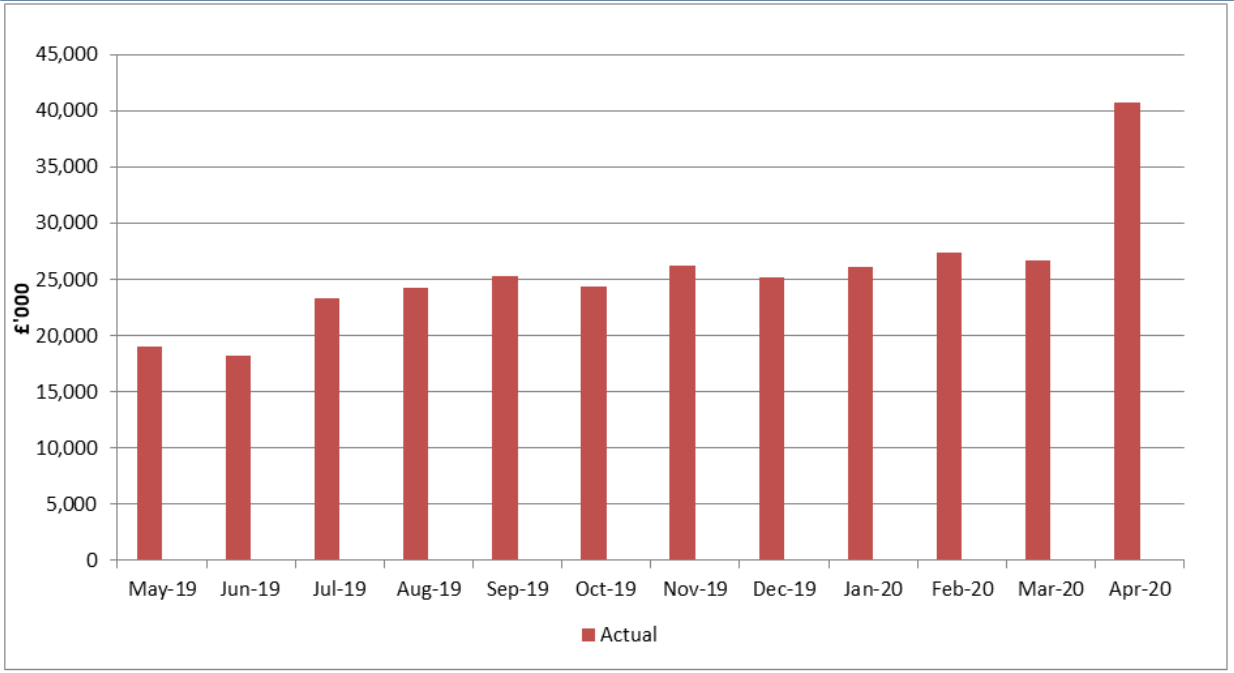
In month actual - £128k

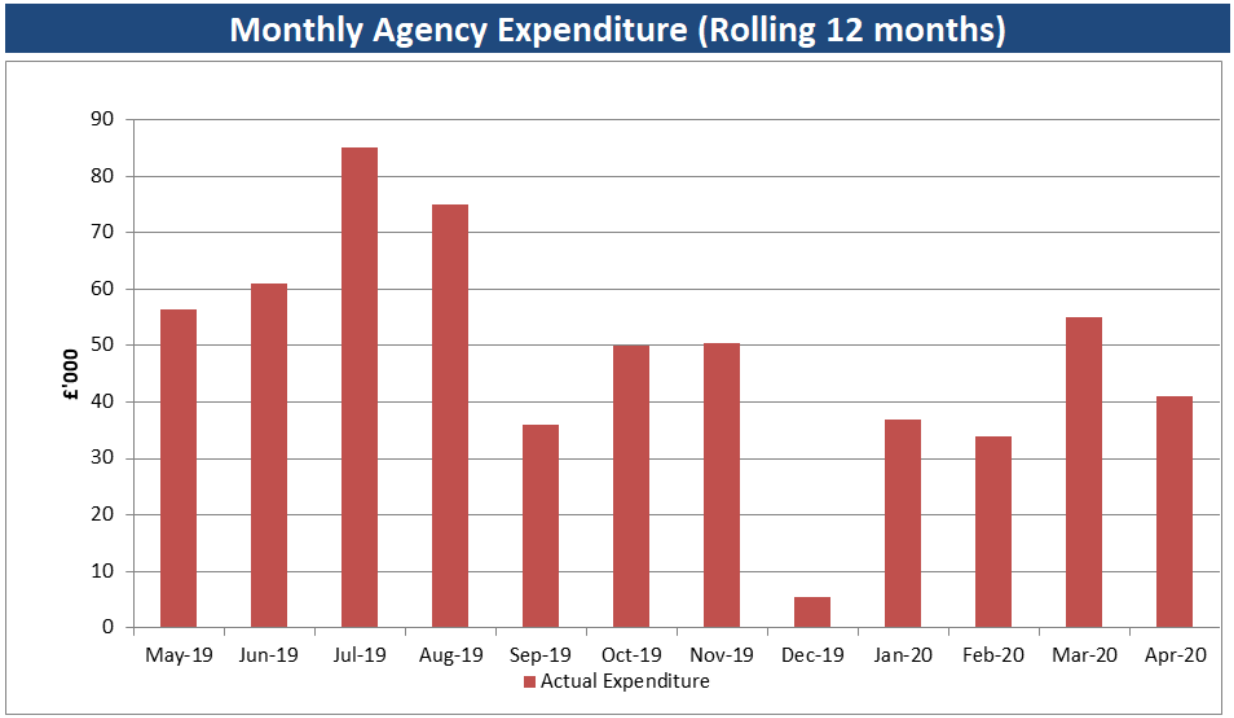
CAPITAL	Apr-20 Actual £'000
Division	
Estates	0
IM&T	25
Neurology	1
Neurosurgery	0
Corporate	0
COVID-19	102
TOTAL	**128**

Capital spend in month is £128k, of which £102k is in relation COVID-19 expenditure. This will be refunded as per the guidance from NHSI/E so will not score against the Trusts capital plan.

The COVID-19 expenditure include the building works in ITU, medical equipment and IM&T hardware and software licences in relation to setting up remote working.

The Trust are in discussions with the Cheshire and Merseyside Health Partnership in terms of capital limits for providers across the partnership to determine the overall 20/21 plan for the Trust.

As of the end of April: Actual Cash Balance: £40.8m Number of days operating expenses = 120 days	**Cashflow against plan (Rolling 12 months)** 	The Trust cash balance at the end of April was £40.8m. This is an increase of £14.1m from the end of March. This is largely due to two months (April & May) block payments received in April for the new financial arrangements to cover the COVID-19 pandemic.

Agency Expenditure: In month Actual: £41k		Agency spend incurred in March was £41k, a reduction of £14k compared to March. A proportion of the in month expenditure relates to the Aintree stroke service, and the COVID 19 response.

Key Risks and Actions for 2020/21

As a result of the covid-19 pandemic financial regulations have changed for 2020/21, with the main changes being:

- Suspension of 2020/21 business planning;
- Payment by Results (PbR) being suspended for the 1st 4 months of the year and income being based on block values determined nationally (based on 2019/20 expenditure between October and December 2019). The suspension of PbR is anticipated to remain in place at least for the remainder of 2020/21. To note that income has not been reduced for the national efficiency target;
- 'Top-up' payments from national block being made to cover additional costs incurred in relation to responding to reasonable covid-19 and other known cost increases from 2019/20 (e.g. CNST contributions);
- The expectation that trusts will deliver breakeven during the pandemic but it is currently not clear what financial targets will be set after July 2020 (although it has been mooted that similar arrangements will exist until October 2020);
- 2020/21 capital levels to be set at a Health & Care Partnership level and to be prioritised and agreed across the C&M footprint;
- Financial governance and regulations remain in place and any financial management will be addressed in the same way it would regardless of the pandemic.

Even though the NHS and Trust are responding to the pandemic, there are a number of potential risks in 20/21 that may impact in the delivery of the financial plan in the future;

RISK	COMMENT/ ACTIONS
Wales/ IOM expectations	NHSI/E have stated that block income will be based on average levels of income and spend for months 8-10 in 2019/20 plus 2.8% inflation. However Welsh commissioners are currently only paying 2019/20 contract levels with no inflation applied (resulting in an underpayment on expected levels of income). IOM have also stated that they plan on only paying for actual activity that has been delivered, again resulting in an under payment compared to expected levels of income. Both issues have been raised with NHSI/E and in month 1, the shortfall in income is assumed to be covered by NHSI/E (as well as a reduction in spend on excluded drugs and devices). However this could create an additional pressure for the Trust if NHSI/E do not agree to fund this income shortfall.

Current/ Future financial architecture	Currently guidance has been issued for NHS financial architecture until August 2020, however it is not clear what the financial architecture will be beyond this time. Due to the level of uncertainty it is not possible to undertake financial planning or understand the future financial position of the Trust.
Efficiency requirements going forwards	Due to the current uncertainty around the financial architecture beyond July 2020, it is not clear what the efficiency requirements of the Trust will be and as such planning to deliver recurrent savings is difficult.
Changes to 2020/21 capital limits	2020/21 capital targets will be set at a Health and Care Partnership level and will need to prioritised across the C&M area. There has been an increase in the capital requirements from the Trust that will be covered by cash reserves but there is a risk that the HCP will not accept the higher capital plan submissions.
Future delivery of clinical services whilst still managing COVID19	Organisations have to plan on how to deliver safe services whilst still managing COVID19. The delivery of services will have to fundamentally change to take account of social distancing requirements, PPE availability, willingness of patients to come into hospital and availability of staff to deliver services. This is likely to cause a cost pressure to the Trust in order to put the required measures in place to provide safe services. However there is also likely to be an impact on the size of waiting lists and how quickly patients can be treated (as less patients will be able to be seen given the additional requirements).

REPORT TO TRUST BOARD
Thursday 30th April 2020

Report Title	**Guardian of Safe Working Quarterly Report - February – April 2020**
Meeting Date	21 May 2020
Report Author	Dr Christine Burness, Guardian of Safe Working
Lead Executive	Dr Andrew Nicolson, Medical Director
Action required by the Board:	The Board is asked to: receive, review and comment upon the Guardian's quarterly report.
Current Situation	The coronavirus pandemic is impacting junior doctors at the Walton Centre in a number of ways:- • The BMA and NHS Employers issued a joint statement suspending the 2016 T&C during the Coronavirus pandemic (Appendix 1). Adaptations to rotas will need to be considered and pragmatic The safety of junior doctors and minimising the risk of fatigue and burnout remains a priority. • At the Walton Centre, rotas have had to be updated due to the changes and doctors are required to provide cover for colleagues, often at short notice. New rotas have been implemented across all specialties since 25th March and are continuously updated and adjusted in response to changing demands. Each rota includes a standby doctor for each shift and there are less junior doctors on site at any one time. In some cases, doctors working hours have actually reduced. • Rotations for Foundation Year and Core trainees have been suspended in many specialties (at the Walton Centre, the only rotation that has taken place during the report period was of the F2 doctor in Neuroanaesthetics). • Training has been impacted due to the cancellation of routine clinical work including face to face clinics and elective surgery. As routine specialty work resumes, the College Tutors and Training Programme Directors are supporting junior doctors to ensure that opportunities for training are optimised (for example via weekly online tutorials in anaesthetics, specialist trainees have continued to provide telephone advice and will soon be undertaking telephone clinics, core and foundation trainees will be encouraged to attend theatre sessions and face to face clinics). • The impact of coronavirus both professionally and personally is a threat to the wellbeing of all members of staff. Junior doctors require support during this time. The Trust regularly circulates details of how staff may access support via an internal Neuropsychology service and also external sources. The junior doctor's mess has been cleaned and a coffee machine has been provided. The Trust have also provided a breakaway area for staff to use. The GoSW has set up an online group for junior doctors to allow easy communication between colleagues who may not all be on site. Junior Doctor Forum Meetings will be held remotely during the pandemic and one-to-one meetings (in person with social distancing or by telephone or zoom) with the guardian of safe working are available on several days each week. The training programme directors and rota co-ordinators are working closely with junior doctors to ensure that they are supported and updated as the situation changes.

Background	The 2016 Junior Doctors Contract has been phased in since August 2016. The Trust does not directly employ junior doctors in training, they are however, seconded to work at the Trust via a Lead Employer model. The Lead Employer is St Helens and Knowsley Hospitals NHS Trust. The junior doctors in training have various rotation dates, the main rotations take place on the 1st Wednesday in August, December, February and April each year. The Anaesthetic trainees rotate every 3 months. We currently have 52 junior doctors' placed in the Trust on the 2016 terms and conditions of service. In June 2019, amendments to the 2016 were agreed as follows: • Changes to rest requirements during a 24 hour shift (minimum of 8 hours rest to include 5 hours between 7pm and 7am) • Maximum of 72 hours to be worked within any 7 day period. • Increased pay for weekend a night shifts (shifts ending between midnight and 4am) • £1000 per year extra for LTFT trainees • A fifth nodal point on the payscale when doctors reach ST6 • Improvements in rest and stay entitlements (no more 'pay to stay' when too tired to drive) • Exception reporting for all ARCP/ portfolio requirements • Guaranteed annual pay uplift of 2% per year for the next 4 years • Fines to be levied by the GoSW for any breach of safe working hours The purpose of exception reports is to ensure prompt resolution and/or remedial action to ensure that safe working hours are maintained The purpose of work schedule reviews is to ensure that a work schedule for a doctor remains fit for purpose, in circumstances where earlier discussions have failed to resolve an issue. Exception reporting is the mechanism used by doctors to inform the employer (or Host Organisation in our case) when their day to day work varies significantly and/or regularly from the agreed work schedule. Primarily these variations will be; • Differences in the total hours of work (including opportunities for rest breaks) • Differences in the pattern of hours worked • Differences in the educational opportunities and support available to the doctor • Differences in the support available to the doctor during service commitments We use an electronic system from Skills for Health to manage the exception reporting process allowing for any variations from the trainees to be resolved in a timely manner. Exception reports can be resolved in consultation with the trainee. The Terms and Conditions allow for time off in lieu (TOIL) or additional pay and depending on the breach, the Guardian may also fine the Trust. Exception reports may also trigger work schedule reviews and if necessary, fines can be raised against the directorates by the Guardian. **During the report period, there has been 1 exception report at the Walton Centre.** (see below) The Guardian of Safe working and the Director of Medical Education (DME) hold a joint junior doctor's forum every two months alternating with the forum held by the junior doctors and the GoSW each month. The Guardians meet locally and nationally and share a NHS network hosted forum to discuss progress and issues related to the new contract. The Quarterly Board report from the Guardian will be considered by the CQC, GMC and NHS employers during any review.

Report

High Level Data (requested by NHS Employers)

Number of doctors in training (total) 52

Number of doctors on 2016 T&C (total) 52

Amount of time in job plan for guardian to fulfil the role 1PA

Admin support provided to the guardian 0
Support provided by Heather Doyle

Amount of job-planned time for educational supervisors 0.25
(for education and training)

Locum and agency hours and spend to cover junior doctors rota gaps

	February 2020	March 2020	April 2020	**Total**
Neurology	£5,551	£5,640	£0	**£11,191**
Neurosurgery	£14,581	£16,778	£18,171	**£49,530**
Total	**£20,132**	**£22,418**	**£18,171**	**£60,721**

a) Exception reports
There has been 1 exception report during this period.

b) Work schedule reviews
We have not had to undertake any work schedule reviews.

c) Vacancies
The Trust has 52 established training posts,.

d) Fines
No directorate within the Trust has received a fine.

Qualitative Information
There has been one exception report within this period (in January).

Issues arising
The hours monitoring exercise within the specialist trainee Neurology group has been postponed due to rota changes during the COVID pandemic..
The change in the junior doctors contract will have the most impact on the senior neurosurgery registrar 24 hour on call rota. For the next 3-4 years, we will have 2 or 3 doctors on the new contract who must comply with the new T&Cs from February 2020.
As specialist trainees leave the Trust, the Neurology StR rota has decreased from a 1 in 12 to a 1 in 10 and in February will go to a 1 in 9. This will have a significant impact on workload for this group of junior doctors. Again, rota patterns have changed currently but work on this including hours monitoring will resume once a normal working pattern has resumed.
The Fatigues and Facilities charter have awarded £30,000 to every trust in England and Wales to improve the facilities for junior doctors in their hospital. This money has to be allocated by the end of the financial year.

	The DME and the GoSW have been working with the junior doctors on a plan to improve the mess facilities at the Walton Centre which are currently not fit for purpose. An estimate for the work needed has been calculated and the project has been put out to tender. The cost of the proposed improvements would require financial support from the Trust (this is under discussion). **Actions taken to resolve issues** The hours monitoring plans have been put on hold due to the changes in junior doctor working during the coronavirus pandemic and will be resumed when possible. The work on the junior doctor's mess has been delayed but continues. Additional support is available for junior doctors who are working flexibly under constantly changing conditions. **Summary** There are currently 52 doctors at the Walton Centre on the new 2016 terms and conditions. Overall, the feedback from junior doctors is very positive. Since the introduction of the new contract in August 2016, there have been 16 exception reports. All have been resolved with TOIL The current coronavirus pandemic leads to new challenges for rota compliance and working patterns. Work schedules and working hours have not been changed (the latter have in some cases reduced).All rotas have had to be amended so that less junior doctors are on site at any one time and to allow for planned cover for absences. We are conscious of the potential impact of the current situation on junior doctors training and wellbeing and are taking all opportunities to offer support and educational experiences throughout this time.

Terms and Conditions of Service for NHS Doctors and Dentists in Training (England) 2016 – joint statement on the application of contractual protections during the pandemic

The COVID-19 pandemic, and the immense demands it is placing upon the NHS, represents an unprecedented challenge to this country. The past few weeks have already seen junior doctors alongside other healthcare workers across the country demonstrating extraordinary levels of commitment and willingness to go above and beyond usual expectations. To ensure that these efforts are sustainable in the weeks and months to come, it is of paramount importance that staff are not working in a manner that compromises their health or safety or that of their patients.

The Terms and Conditions of Service for NHS Doctors and Dentists in Training (England) 2016 (TCS) contain a range of safe working hours restrictions and rest requirements, designed to protect trainees from excessive fatigue and burnout. Where it is feasible to do so, these protections should continue to be applied as far as possible during the coming weeks and months spent facing the COVID-19 pandemic.

We do, however, recognise that during this current crisis it may not be realistic to maintain all of the contractual limits and that a more pragmatic approach will be necessary. NHS Employers and the BMA agree that when not possible to implement, relevant working hours restrictions and rest requirements in the TCS will be suspended and that the Working Time Regulations 1998 (WTR) will be the fallback position for the duration of the pandemic.

Initial flexibilities that we have identified for consideration can be found in the appendix below. This is not an exhaustive list and the application of any contractual variations will very much depend on local circumstances. It does however summarise some examples of acceptable first steps whilst maintaining much of the intended safeguards within the current TCS as a whole. Any rota that deviates from the existing contractual safeguards will nevertheless need to adhere to the Working Time Regulations, which set out the absolute minimum standards of safe working for trainees. Such variations should, wherever possible, be agreed in collaboration with the junior doctors affected.

During the exceptional operational challenges of the current pandemic, the health and wellbeing of staff remains a key consideration. In this regard, should an employer need to consider invoking regulation 21 of the WTR, they must first seek to engage with NHS Employers and the BMA (nationally) to discuss whether alternative options to this course of action have been fully considered.

We will be working with NHS England and NHS Improvement to identify 'hot spots' of intensity in the NHS during this crisis, to aid in coordinating measures to provide support and ensure that rotas remain safe for doctors and for patients, in what is undoubtedly the most challenging and pressurised time that our health service has seen since its inception.

Individual doctors may find themselves unable to work a particular rota, for a variety of reasons, or take on certain clinical responsibilities during the COVID-19 pandemic. These individual circumstances should be managed sensitively on a case-by-case basis to identify and address any potential barriers and ensure that they can contribute as they are able.

When a new or amended rota is implemented, less-than-full-time (LTFT) doctors must have their LTFT status protected, unless they agree otherwise. An LTFT trainee may voluntarily agree to increase their usual LTFT percentage temporarily or work additional shifts on an ad-hoc basis where this is more practicable or sustainable. Consideration needs to be given to trainees in category 1 and category 2 LTFT status as to how their hours can be distributed depending on personal circumstances or requirements. If an LTFT trainee is able to offer additional hours by increasing their proportion of full-time equivalent, this should be reflected in a new work schedule or equivalent mechanism, with revised pay arrangements. Where a doctor provides additional hours on an ad hoc basis, this should be paid on a bank locum basis. A decision by a trainee to offer to work additional hours to aid in the national response to the pandemic must not prejudice any application the doctor makes to work less than full time in future.

All new and amended rota patterns require a work schedule or equivalent mechanism for the purposes of correct hours and pay calculation, to ensure that there is appropriate remuneration for all work done. As specified in schedule 2 of the TCS, no individual should suffer financial detriment as a result of changes made to their working pattern that is outside their control.

These are unprecedented times, and all of those working in the NHS are likely to find that they are working harder and in circumstances more challenging than those they have faced before. We know that all staff involved will pull together to support each other. Rest and time to recover both during and between shifts is essential to enable the workforce to face these challenges to the very best of their ability. This guidance is designed to ensure that staff wellbeing remains paramount throughout this difficult period for us all, whilst recognising the need for flexibility and adaptation to an evolving situation.

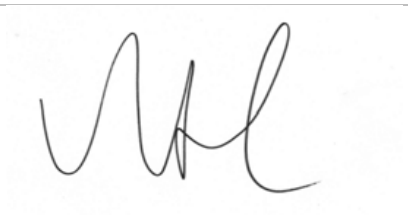
NHS Employers is grateful for the commitment made by junior doctors and the BMA at this time and will take this into account when preparing for future negotiations once the COVID-19 pandemic is resolved.

This statement does not constitute a permanent contractual variation, and is intended to cover the current emergency situation.

This agreement will be subject to monthly review.

Either the BMA or NHS Employers may unilaterally withdraw from this agreement with one month's notice. Both the BMA and NHS Employers recognise that any such a withdrawal will only be used as a last resort after all reasonable alternatives have been explored. This will have the effect of terminating any agreed contractual changes at local level and reverting the contractual position to that in the TCS.

It is also agreed that any return to normal working arrangements will need to be carefully managed in order to minimise disruption to employers, trainees and care to patients.

 Paul Wallace Director of Employment Relations and Reward NHS Employers	 Sarah Hallett Chair, BMA Junior Doctors Committee

Appendix

During the outbreak, where an employer is unable to meets its obligations under the definitions of safe and appropriate levels of cover within the limits of the TCS, they might consider the following areas in discussion with trainees and, where possible, the guardian of safe working hours*:*

- Removing the limit on the frequency of weekend working, which is currently no more than one in two weekends.
- Up to five consecutive long shifts rostered, where upon conclusion of the fifth shift, 48 hours of rest must be provided.
- Up to eight consecutive days of work, where 48 hours of rest must be provided upon the conclusion of the shift on the eighth day.
- Five consecutive nights could be worked through a junior doctor choosing to undertake additional shifts on top of the normal maximum of four consecutive nights.
- Lifting the limit on consecutive non-resident on-call periods to allow two consecutive 24-hour duties, provided the following shift has no fixed clinical activity the morning after (i.e. theatre list or clinic) which can't be cancelled to allow compensatory rest if required.
- Increasing the maximum average weekly hours from 48 to 56, however, consideration must be given to doctors who may not for many reasons feel able to work to this intensity. As such, this should be a measure of last resort and implemented for only as long as it remains absolutely necessary.

As ever, trusts should continue to work in partnership with trainees and accredited trade union representatives when developing new patterns of working. Trusts should discuss proposed new patterns of work with affected trainees prior to implementation, and for doctors who cannot work to the new rota to be accommodated accordingly.

The Walton Centre
NHS Foundation Trust

Infection Prevention and Control

Annual Report

April 2019 to March 2020

1 Introduction

The Trust has a responsibility to ensure that appropriate arrangements are in place to protect patients, staff and visitors against the risk of acquiring a healthcare associated infection (HCAI), as detailed in the Health and Social Care Act (2008). There is also a requirement to produce an annual report on Trust activities, in relation to infection prevention.

The purpose of this report is to inform patients, public, staff, Trust Board and commissioning organisations of the infection control activity undertaken from 01 April 2019 to 31 March 2020, the position of infection prevention and control within The Walton Centre, and progress against performance targets.

The report acknowledges the support, hard work and diligence of all The Walton Centre staff, both clinical and non-clinical who play a key role in improving the quality of patient and stakeholders experience, in addition to reducing the risk of infections.

In addition, the Trust continues to work collaboratively with a number of external agencies as part of its IPC and governance arrangements including:

- NHS England Specialist Commissioning
- Liverpool CCG
- Sefton CCG
- Public Health England
- Acute and community colleagues

Good infection prevention (including environmental cleanliness) and prudent antimicrobial stewardship is essential to ensure that patients receive safe and effective care.

Highlights include:

- There were no MRSA bloodstream infections attributed to the Trust in 2019-20
- There was a reduction in the number of patients acquiring MRSA (colonisation) during their treatment in the Trust
- Reduction in MSSA bloodstream infections
- Reduction in catheter associated infections (CAUTI)
- Reduction in CDT infections
- Reduction in the transmission of CPE
- Introduction of ANTT
- Continued compliance with Care Quality Commission regulations relating to Infection Prevention and Control and remaining an outstanding trust
- The Trust achieved the national target of 80%% for staff influenza immunisation; achieving 80.3%
- Presenting at the Infection Prevention Society national conference September 2019
- Reduction External Ventricular Drain (EVD) infections by collaborative working with the specialist teams

The Health and Social Care Act 2008 - *code of practice on the prevention and control of infections and related guidance*

The Code is taken into account by the CQC when it makes decisions about registration against the infection prevention requirements. The regulations also say that providers must have regard to the Code when deciding how they will comply with registration requirements.

The table below details the compliance criteria within the Code.

Criterion	What the registered provider will need to demonstrate
1	Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider how susceptible service users are and any risks that their environment and other users may pose to them.
2	Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.
3	Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance
4	Provide suitable accurate information on infections to service users their visitors and any person concerned with providing further support or nursing/medical care in a timely fashion
5	Ensure prompt identification of people who have or at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people
6	Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection
7	Provide or secure adequate isolation facilities.
8	Secure adequate access to laboratory support as appropriate.
9	Have and adhere to policies, designed for the individual's care and provider organisations that will help to prevent and control infections.
10	Providers have a system in place to manage the occupational health needs and obligations of staff in relation to infection

2. Infection Prevention and Control Arrangements

Infection Prevention and Control Team

The Trust has an established infection and prevention control team.

Mrs L Salter	Director of Nursing and Governance/Director of Infection Prevention and Control (DIPC)
DR S Larkin	Consultant Microbiologist/Deputy Director of Infection Prevention and Control
DR R Gupta	Consultant Microbiologist/Antimicrobial Lead
Mrs H Oulton	Lead Nurse Infection Prevention and Control/Tissue Viability
Mrs C Chalinor	Senior Nurse Specialist Infection Prevention and Control
Mrs C Jessop	Nurse Specialist Infection Prevention and Control
Mrs Z Rushton	Nurse Specialist Infection Prevention and Control
Mrs A Stockley	Nurse Specialist
Mrs J Smith	Administrative support

The Chief Executive has overall responsibility for ensuring that there are effective arrangements in place for infection prevention and control and supporting the infection prevention and control team in their agreed objectives.

Medical Microbiology is provided by Liverpool Clinical Laboratory. Dr S Larkin Consultant Microbiologist and Dr R Gupta Consultant Microbiologist are the named microbiology consultants for the Walton Centre.

The Trust has access to 24 hour microbiology/infection prevention and control via the on call Microbiologist. The infection prevention control nurses provide an on call service at weekends and bank holidays.

The Lead Nurse for infection prevention and control also provides leadership to the tissue viability nurse and is involved in broader work streams within the Trust as a member of the senior nursing leadership team.

Commissioning Arrangements

NHS England (NHSE) Specialist Commissioning is The Walton Centres main commissioning organisation. In addition there are also services commissioned by Liverpool CCG.

Infection prevention is reported monthly via the HCAI assurance framework and discussed at Quality and Performance meeting.

The Infection Prevention and Control Committee (IPCC)

The Committee is chaired by the DIPC and meets monthly with a minimum of 9 meetings a year. Membership involves representation from across all clinical areas within the Trust, Non-Executive Director, Partnership/Staff Governors and external representation from Public Health England (PHE).

Functions of the Committee are to support the development of a proactive organisational culture which ensures staff at all levels prioritise and engage in infection prevention and control and to establish and monitor the implementation of the infection prevention and control work plan and monitor compliance with the Health and Social Care Act 2008.

There have been 10 Infection Prevention and Control Committee meetings held over the financial year 2019 to 2020.

3 HCAI Surveillance

National mandatory reporting for healthcare associated infections has continued throughout the year via the PHE Data Capture System (DCS**).**

Table 1. HCAI reduction thresholds 2019-2020 and performance against 2018-2019 thresholds

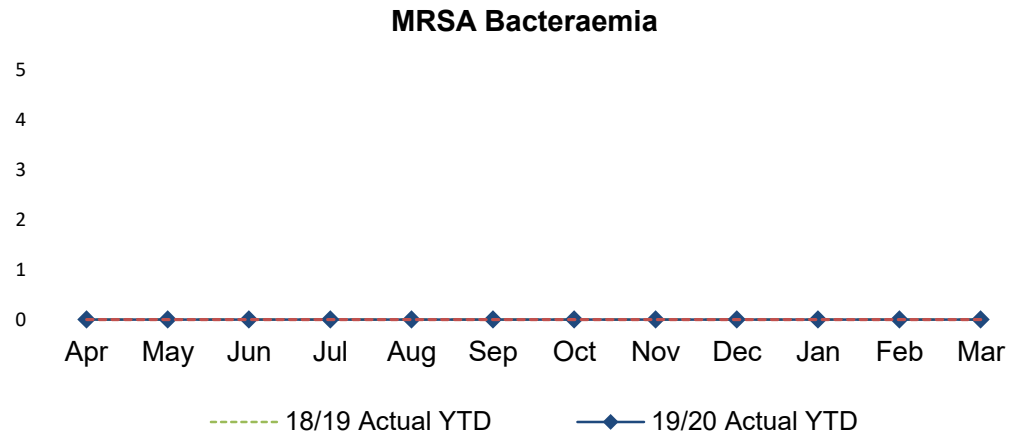
Organism	Objective 2019-2020	31st March 2020	Objective 2020-2021
MRSA	0	0	0
Clostridium difficile	8	5	7
MSSA BSI	9	5	8
E.coli BSI	12	15	11
Klebsiella BSI	No threshold set	4	No threshold set
Pseudomonas BSI	No threshold set	0	
CPE	No threshold set	4	

3.1 Meticillin Resistant Staphylococcus Aureus (MRSA)

MRSA lives harmlessly on the skin of around 1 in 30 people, usually in the nose, armpits, groin or buttocks. This is known as "colonisation" or "carrying" MRSA but the person is not sick with an MRSA infection. However, if MRSA is passed on to other people it may cause infection if they have broken skin or a have an indwelling device such as a catheter or drip.

Nationally there is a zero tolerance for MRSA bloodstream infections for all Trusts.

Graph 1 - MRSA bacteraemia April 2018 – March 2020

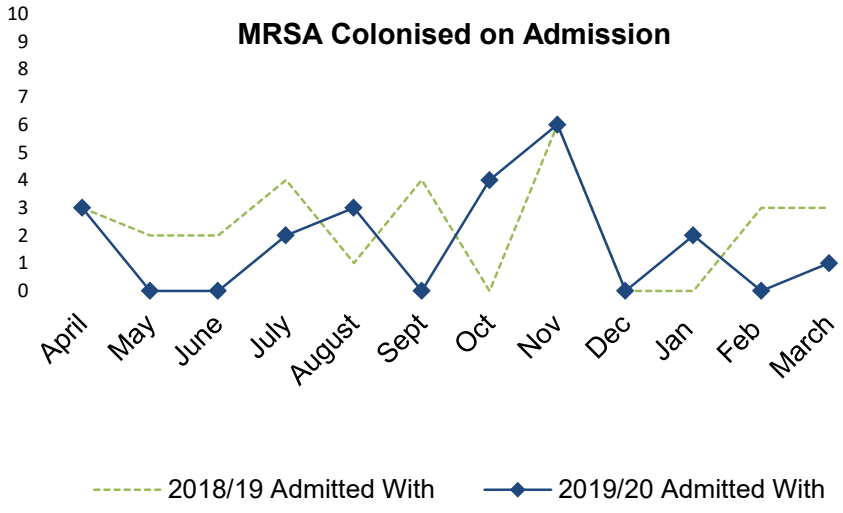


There were no patients who acquired an MRSA bloodstream infection during 2019-2020. The last MRSA bloodstream infection was in November 2017. We continue to strive for zero avoidable infections.

During 2019 - 2020 there were 8 patients admitted to the Trust who became colonised with MRSA during their inpatient stay compared to 6 patients for the period April 2018 to March 2019.

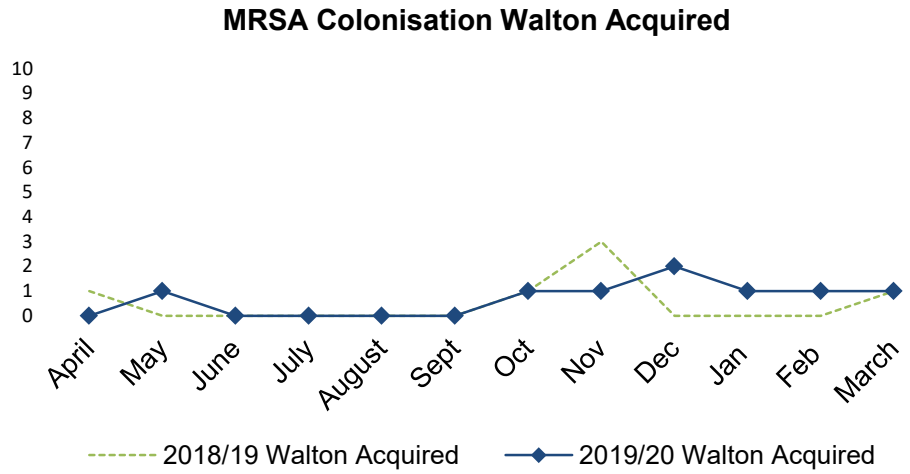
The graph below shows comparative data from April 2019 to March 2020 of the number of patients were colonised with MRSA on admission to the Trust.

Graph 2 - Patients colonised on admission April 2018 – March 2020

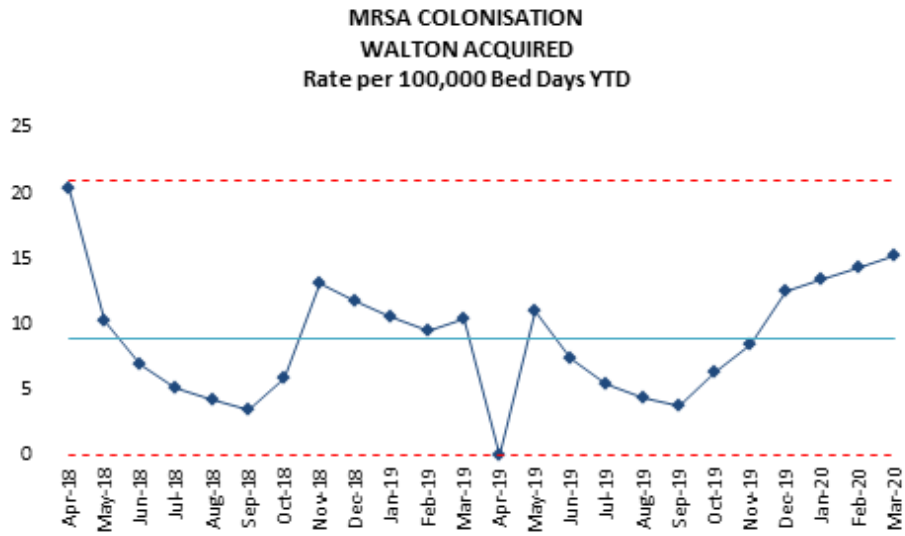


The graph over the page shows comparative data from April 2018 to March 2020 for the number of patients who have acquired MRSA whilst an inpatient at the Walton Centre.

Graph 3 - MRSA colonisation Walton acquired April 2019 – March 2020



Graph 4 - MRSA colonisation Walton acquired rate per 100,000 bed days April 2019 – March 2020



3.2 MRSA Screening

Neurological conditions are classified as high risk patients therefore routine admission screening for all patients admitted to the Trust continues in line with national guidance.

MRSA screening of patients within 6 hours of admission was on average 98.88% for the period 2019-2020.

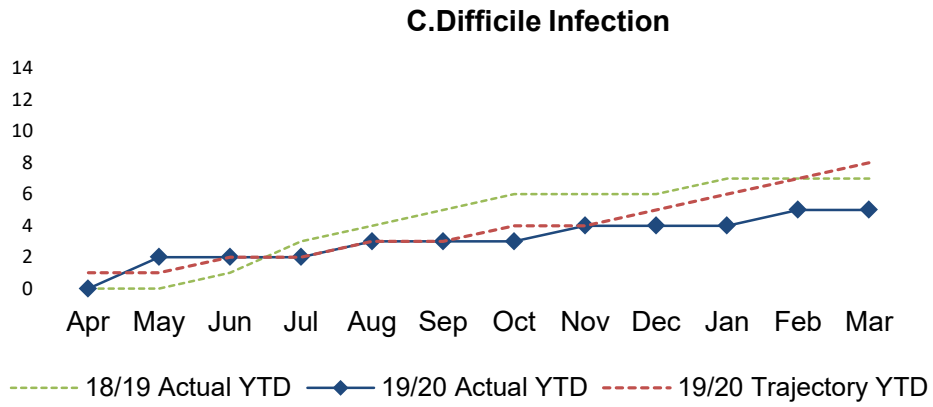
All There is a programme of additional screening which includes patients who are admitted to Critical Care, Lipton, CRU and those that have been an inpatient for >30 days are routinely screened for MRSA. Inpatients requiring 30 day screening are reviewed on a daily basis.

All patients who have a positive MRSA result are commenced onto the eP2 MRSA care pathway that is audited quarterly and the results are reviewed at the IPCC.

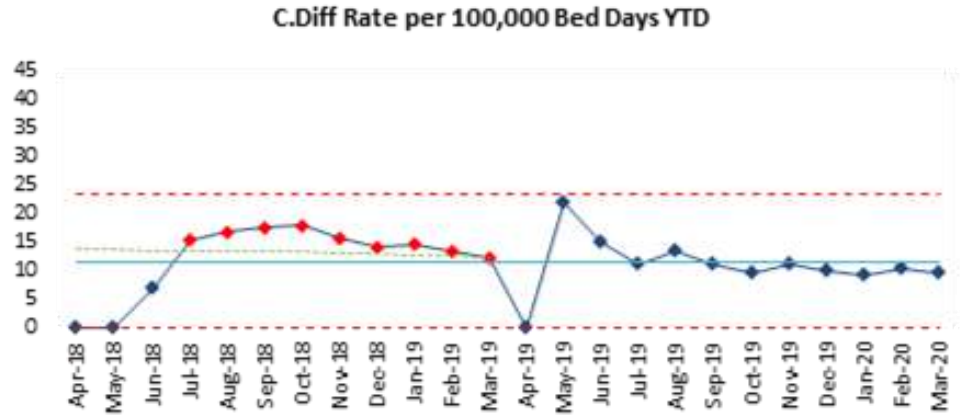
3.3 Clostridium Difficile

Achieving the Clostridium difficile NHSI reduction threshold of eight cases and rate 9.5% per 100,000 bed days continued to be a challenge for the Trust. However, at year end we have had five patients who have acquired a Clostridium difficile infection (CDI) therefore ending the financial year below the NHSI objective of eight cases.

Graph 5 - Walton Centre CDI rates April 2019 to March 2020



Graph 6 - Walton Centre CDI rates per 100,000 beds April 2018 to March 2020



The treatment of neurological infections is complex, both in the reduced antibiotic selection that can be used to penetrate the blood brain barrier, and the extended length of time that antibiotic treatment is required. Both of these factors are risks associated with the development of a Clostridium difficile infection. Despite this complexity the Trust has reduced Clostridium difficile infections annually the past three years.

Patients are commenced on the Clostridium difficile care pathway to ensure optimal care and treatment and the pathway is audited quarterly and the results are reviewed at the IPCC.

Preventative measures include; emphasising the importance of environmental cleanliness, use of HPV and UV technology are all key measures to reduce the risks of transmission of infection.

The reporting of Clostridium difficile changed from April 1st 2019. Cases attributed to the Trust are now those that occur within 48 hours of admission (previously 72 hours) with additional requirements to the definitions of healthcare and community cases, meaning a total number of five incidents has demonstrated a significant improvement.

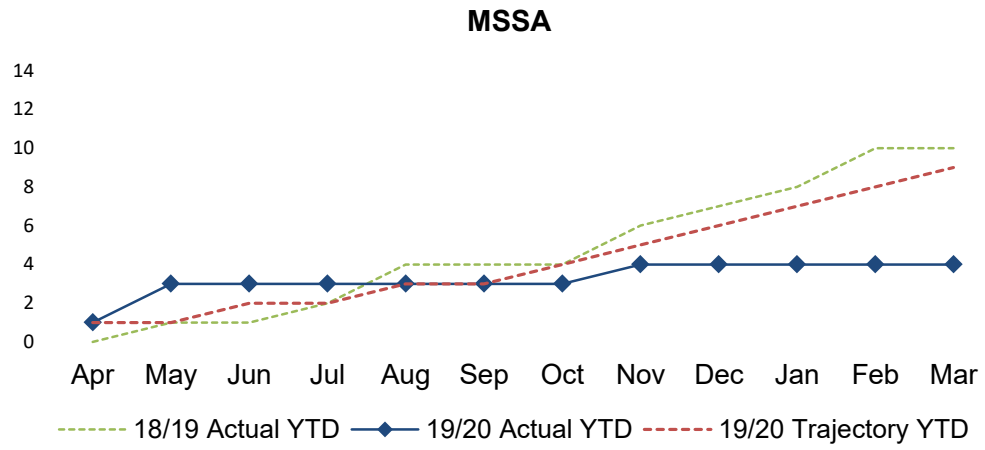
Although there were initial concerns that the revised reporting requirement had the potential to increase cases attributed to the Trust, this did not occur and the Trust achieved a reduction in the number of infections. Under the new reporting criteria there was one infection that was agreed with NHSE/I as a community onset clostridium difficile infection, although this remains in the Trusts 2019-2020 year end performance.

3.4 Meticillin Sensitive Staphylococcus Aureus (MSSA) Bacteraemia

There are no external reduction objectives; however, the Trust set an internal reduction threshold of nine. There have been a total of five patients who have acquired an MSSA bacteraemia at year-end. This is a reduction of six cases compared to 2018-2019 demonstrating a 60% reduction in cases and for the first time since the financial year 2017-2018 and did not exceed its internal target of nine cases.

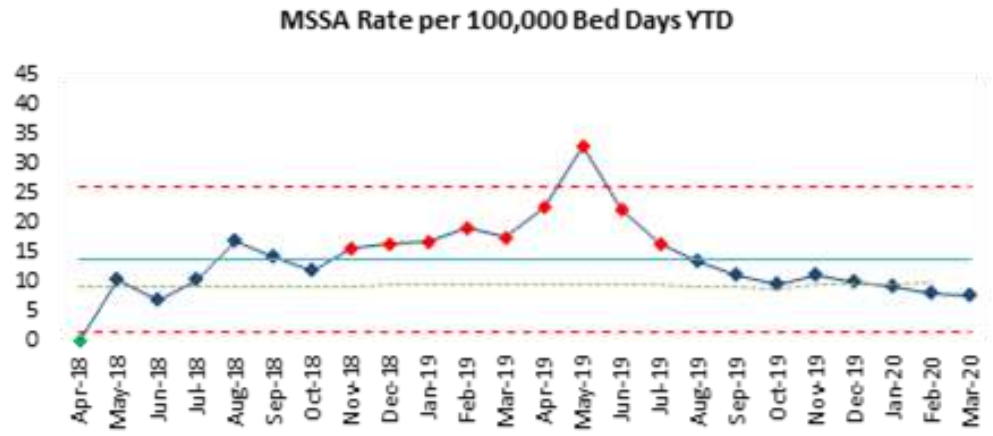
The following graph compares Walton Centre MSSA rates year on year from April 2018 to March 2020.

Graph 7 - MSSA rates from April 2018 to March 2020



The graph compares Walton Centre MSSA rates per 100,000 beds day from April 2018 to March 2020.

Graph 8 - MSSA rate per 100,000 bed days April 2018 – March 2020



The reduction of MSSA bloodstream infections within the Trust is thought to be the result of the implementation of an antiseptic body wash (Octenisan/Chlorhexidine) for all patients on HITU. In view of this all inpatients will be provided with an antiseptic wash for the duration of their hospital stay. This is a cost effective method to improve patient safety whilst reducing costs associated with extended inpatient admissions e.g. antibiotic treatment, critical care capacity.

Blood culture contaminants continue to be a cause for concern as this indicates suboptimal clinical practice when the obtaining blood cultures. To address these concerns a retrospective blood culture audit was undertaken which identified areas of improvement, particularly in relation to staff competency; a robust plan is in place and this will be embedded during 2020-2021 and progress reported to the Infection Prevention and Control Committee.

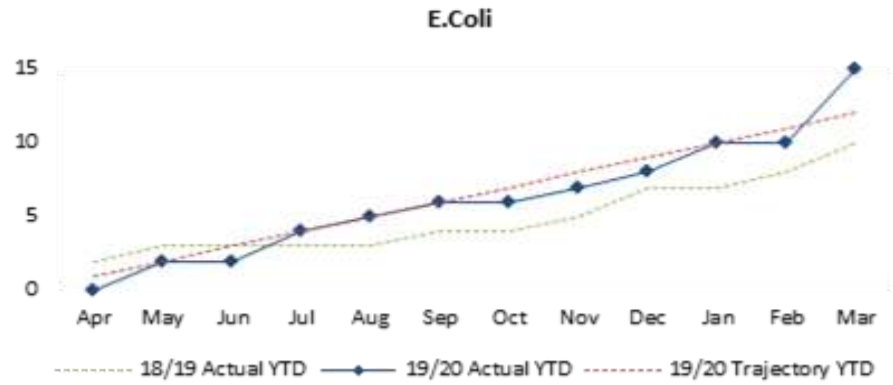
3.5 Escherichia coli (E-coli) Bacteraemia

The Trust set an internal reduction threshold of 12 cases. There have been fifteen patients who acquired an E.coli bacteraemia at year end. This is above the Trust internal annual reduction threshold of 12. Although the Trust has remained in line with the national average per 100,000 bed days, it is disappointing as there has been a sustained reduction in cases in previous years.

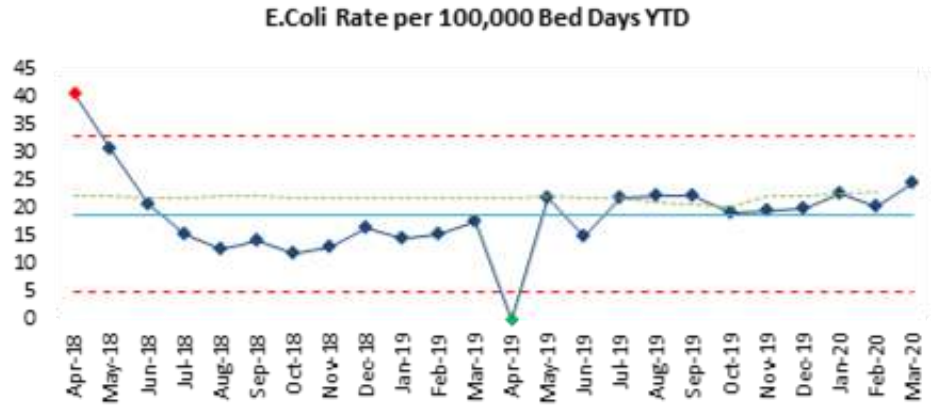
To address this reduction of E.coli will be a key area of work as part of the HCAI reduction plan which will include a review of the gram negative action plan and a task and finish group that will review training needs, management of continence and themes from RCA's.

The graph over the page compares Walton Centre E.coli rates year on year from April 2018 to March 2020.

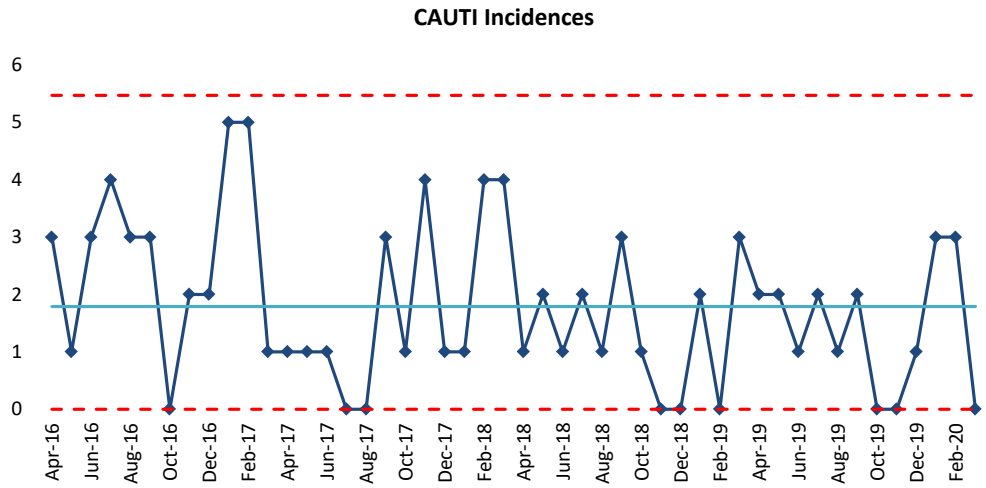
Graph 9 - E-coli bacteraemia April 2018 – March 2020



Graph 10 - E.coli bacteraemia rate per 100,000 bed days April 2018 - March 2020



Graph 11 - Number of CAUTI's 2016 – 2020



The Trust had 17 catheter associated infections (CAUTI's) during 2019 - 2020 against an internal threshold of 22. Out of the 17 cases E.coli was cultured in 11 cases, with urosepsis identified as the main cause of E.coli blood stream infections (catheter and non-catheter related infections)

There was no mandatory or Trust annual reduction thresholds for gram negative bloodstream infection during 2019-2020. However, it is expected that a reduction threshold will be set externally for 2020-2021.

There were four patients who acquired a Klebsiella bloodstream infection during 2019 – 2020 compared to two in 2018 – 2019.

4. Multi-drug Resistant Organisms (MDRO) including Carbapenemase Producing Enterobacteriaceae (CPE)

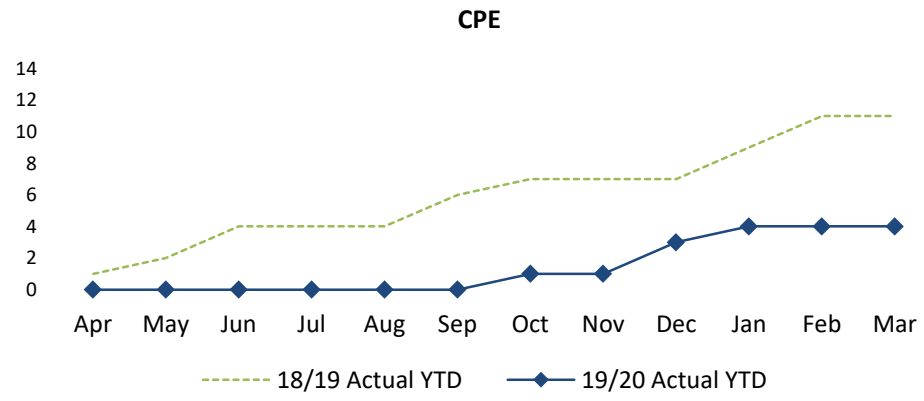
MDROs are defined as microorganisms, predominantly bacteria, that are resistant to one or more classes of antimicrobial agents. MDRO including, meticillin-resistant *Staphylococcus aureus* (MRSA), vancomycin-resistant enterococci (VRE) and certain gram-negative bacilli (GNB), have important infection control implications. These pathogens are frequently resistant to most available antimicrobial agents, making them difficult to treat and are a transmission risk to other patients.

The Infection Prevention and Control Team undertake surveillance of all alert organisms including all MDRO. There has been an increasing number of patients identified as "at risk" of CPE who require isolating and screening on admission.

During 2019-2020 there were four patients who acquired CPE during their inpatient stay compared to 11 in 2018-2019. Three patients became colonised with CPE and one patient developed a CPE infection. This shows a significant reduction in the transmission of a multi drug resistant organism and demonstrates the effectiveness of the trusts infection prevention strategies.

The graphs below show the number of patients admitted with CPE and patients who acquired CPE during their inpatient episode.

Graph 12 - Number of patients who acquired CPE



On identification of a CPE positive patient the IPC Team will implement prevention strategies e.g. the use of personal protective equipment, limiting patient and staff movement across the Trust whilst ensuring the patient continues to receive the appropriate clinical care, and minimising the

use of shared patient equipment. Universal screening for all patients' would facilitate early identification of colonised patients and would reduce the risk of transmission and the need to identify and screen contact patients. However this has significant resource implications; in view of this, screening and the associated costs are to be reviewed and recommendations submitted to the Executive Team for consideration.

Compliance with the CPE Care Pathway is audited on a quarterly basis to gain assurance of compliance with the Trust policies to promote patient safety.

All patients admitted to Critical Care and patients who have been inpatients for 30 days are also routinely screened for CPE; this is reviewed on a daily basis.

5. Antimicrobial Stewardship

The increased incidence of multi drug resistance and the subsequent consequences e.g. increased treatment failure for common infections and decreased treatment options for serious infections; therefore a robust antibiotic stewardship programme is key to combating resistance.

- During 2019-2020 the Trust appointed an antimicrobial pharmacist to support the stewardship programme.
- The Outpatient Antimicrobial Therapy (OPAT) service was extended and embedded into the Trust. The OPAT service is a multi-disciplinary team who will discuss patients who would benefit from having their antibiotics given at home. The OPAT service ensures that patients receive an ongoing appropriate review of their treatment plan when discharge from the Trust. Patient feedback of the service has been very positive.
- The Antimicrobial Stewardship Group met four times during 2019-2020. The minutes from meetings are submitted to the Drugs and Therapeutics Committee. The purpose of the group is to identify areas of suboptimal antimicrobial use through prospective audits, antimicrobial prescriptions or surveillance and recommend appropriate intervention strategies.
- Daily antibiotic ward rounds are undertaken Monday to Friday in critical care and weekly on the acute wards.
- Medical staff training is focused on antimicrobial resistance and weekly antibiotic ward rounds continue to monitor antibiotic use and ensure appropriate treatment plans are in place.
- Quarterly audits were undertaken to review stewardship and were presented to Infection Prevention and Control Committee.

6. Trust Alert Organism/Condition Surveillance

Surveillance is an essential element of infection prevention and control. High quality information on infectious diseases, healthcare associated infections and antimicrobial resistant organisms is essential for monitoring progress, identifying concerns, investigating underlying causes and applying prevention and control measures. Surveillance also assists in reducing the frequency of adverse events such as infection or injury.

Alert organisms are identified via microbiology laboratory. The Microbiologist also notifies any urgent results to the Infection Prevention and Control Team. Alert organisms include:

- New cases of MRSA
- New cases of Clostridium difficile associated diarrhoea
- Extended spectrum Beta lactamase (ESBL) gram negative bacilli

- Gastro intestinal organisms e.g. rotavirus, norovirus
- mumps
- Measles
- Group A streptococcus
- Chicken pox
- Shingles
- Tuberculosis
- Carbapenemase Producing Enterobacteriaceae (CPE)
- Multi-drug Resistant organisms
- All blood stream infections
- Covid-19

The IPC Team advise on preventative measures and will also investigate any clusters of infection in addition to the provision of a comprehensive range of policies.

Alert conditions are identified from clinical diagnosis, not laboratory results and therefore the IPCT remain reliant on the clinical staff to inform them of any confirmed or suspected cases To ensure appropriate management to reduce the risks of spread and the potential risks of an outbreak of infection prompt identification of cases is essential to reducing the spread and ensure, where necessary, reporting to PHE.

7. Surgical Site Surveillance

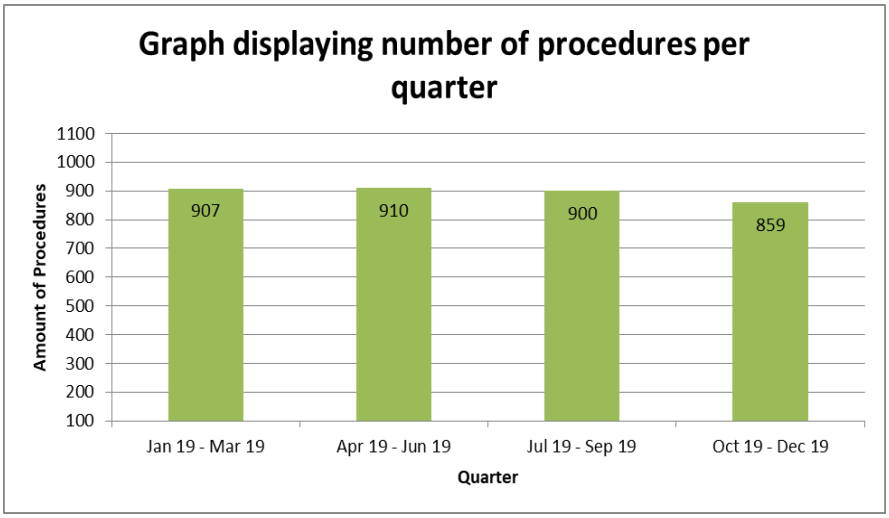
Surgical site infection (SSI) is a post-operative complication occurring within 30 days following a surgical procedure and up to 12 months if a prosthetic device has been implanted. The majority of surgical site infections are preventable and there are a range of interventions that can be undertaken in the pre-, intra- and postoperative phases of care to reduce the risk of infection.

The total percentage rate of surgical site infections for the period April 2019 – December 2019 is 2.57% below the 5% internal threshold set by the Trust.

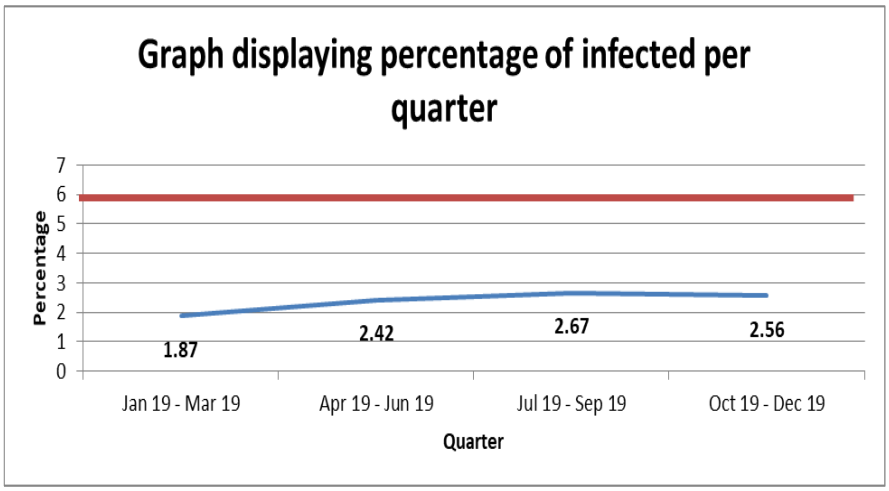
There has been a significant amount of work undertaken during 2019-2020 to reduce surgical site infection, including:

- The surgical site data collection tool has moved to a digital format. Although in the early stages with further development work planned this will improve the quality of the data, reduce duplication and release a significant amount of time across a number of departments.
- A plan was developed in response to an increase in extra ventricular drain (EVD) infections to look for trends or themes; an SBAR is undertaken for all infection cases. The plan also includes a review of the process for sampling EVD's, audit of dressings. All medical and nursing staff were competency assessed and a different colour/marked pillow case implemented for patients undergoing cranial surgery/procedures to ensure that they are used solely to support the patients head.
- EVD infections have been reported monthly to the IPCC from April 2019.
- Participation in GIRFT programme.
- A pilot of 30 day post discharge SSI surveillance.

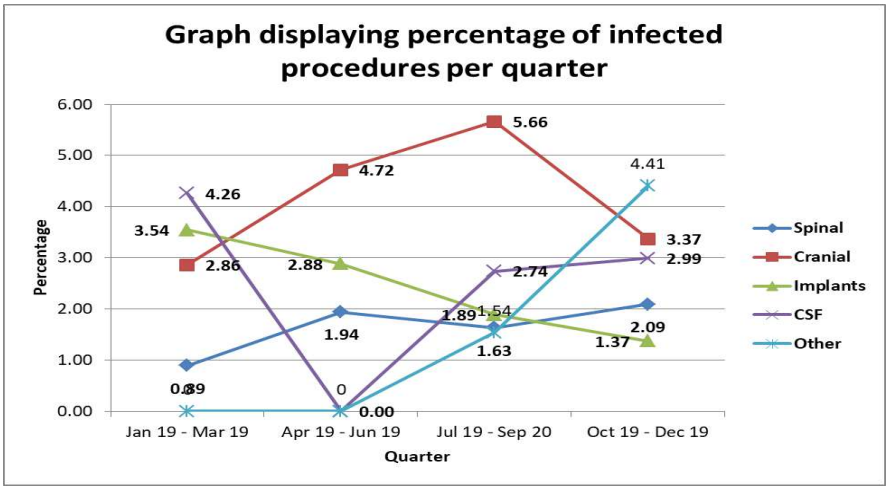
Graph 13 - Number of procedures April 2019 – December 2019



Graph 14 - Percentage of SSI April 2019 – December 2019



Graph 15 - Percentage of infected procedures per quarter



8. Serious Untoward Incidents involving Infection and Outbreaks

8.1 Rotavirus

Complex Rehabilitation Unit (CRU) June 2019

During June 2019 an outbreak of diarrhoea and vomiting was identified within the Complex Rehabilitation Unit (CRU). The outbreak was over a period of 11 days. During this time there were 9 staff and 9 patients affected. A total of 23 patients were in the CRU at this time. The unit was closed to admissions from 5 June 2019 – 17 June 2019. All symptomatic patients were initially tested for CDT and Norovirus, all of which were negative. Following advice from PHE full viral screens were undertaken of which 4 patients were identified as Rotavirus positive.

The following actions were implemented on closing the ward to admissions:

- Enhanced environmental cleaning
- Enhanced hand hygiene and PPE including observations
- All patients to remain in their rooms for therapy and meals
- Any symptomatic patients to have a stool sample sent
- Visitors informed and advised not to visit unless needed
- No movement of staff from CRU were reasonably possible
- Ensure there are 2 x domestic cover on the ward

8.2 Caton and Theatres June 2019

A patient developed Invasive Group A Streptococcus infection (IGAS). An incident meeting was convened with PHE and a number of staff in Theatre and Caton staff were reviewed and screened. No source of the infection could be identified and there were no further cases reported.

8.3 CPE

Sherrington Ward December 2019

There were two cases of New Delhi metallo-β-lactamase (NDM)-1 CPE identified on Sherrington ward. NDM-1 is not a strain endemic in the Trust and the last case of NDM-1 was May 2018.

The first case was identified on admission screening when a patient was transferred to another Trust. An Outbreak Control Group was convened and screening of immediate bay contacts was commenced and it was during this screening that the second case was found; in view of this screening was extended to include all ward contacts and all patients on the adjoining ward. No further cases were identified.

Extended screening (including patients who had been discharged before the initial screening and readmitted) did not identify any further cases.

8.4 Creutzfeldt Jakob Disease (CJD)

In March 2019 the Trust was notified by PHE that a patient who had undergone surgery at The Walton Centre had been diagnosed with probable sporadic CJD. An incident meeting was convened and a look back exercise was undertaken.

There is a very low risk of sporadic CJD being transmitted by surgical instruments. A review of decontamination processes were undertaken and the Trust was fully compliant with national standards and could identify all instruments that had been used during the patient's surgery and subsequent surgery's via the Trusts track and trace system.

All patients who were identified as contacts were contacted and offered the choice of a clinic or telephone consultation with the Neurosurgical Clinical Director and Consultant Medical Microbiologist. The consultations were to provide advice and support to the affected patients. The IPC Team liaised with PHE, primary care and the National CJD Surveillance and Research Centre over an extended period of time to ensure data and follow up requirements were met.

8.6 Gastrointestinal infections

There were sporadic cases of patients and staff with diarrhoea and vomiting. This resulted in the initial closure of some bays for a short period.

9. Facilities/Environmental Cleaning

There is a comprehensive audit programme undertaken by the senior facilities manager and the IPCT continue to monitor the standards of environmental cleanliness throughout the Trust in collaboration with ISS Mediclean and the estates department.

The hydrogen peroxide (HPV) and ultra violet light systems continue to be used to enhance the cleaning process of infected isolation rooms. The effectiveness of the cleaning is monitored via the 3M Clean Trace cleaning monitoring. An additional HPV machine has been provided by ISS which has increased the turnaround time for cleaning and improved patient flow.

PLACE (Patient Led Assessment of the Care Environment) is a system for assessing the quality of the patient environment and involves local people (patient assessors) coming into the Trust to assess how the environment supports the provision of clinical care. Results of PLACE assessments are reported nationally and are accessible to patients and their families.

The formal PLACE inspection was carried out November 2019 and the Trust scored higher than the national average across the six domains that were assessed; achieving 100% for cleanliness.

10. Water Safety

The function of the Water Safety Group is to provide a multi-disciplinary approach to assess and manage risks from water systems in the context of clinical risk to patients. The Water Safety Group meets bimonthly however during 2019 – 2020 there were a series of extraordinary meetings due to the detection of legionella at some water outlets.

During October 2019 water testing identified the presence of legionella in the water supply on Lipton ward. Filters were immediately applied to affected water outlets and remedial work identified/commenced. This was presented at the Water Safety Group on 15th October 2019 and a management plan to agree and monitor progress of the remedial measures to mitigate the potential risks to patients and staff. Ongoing water sampling has demonstrated a reduction in colony count and the remedial work continues.

The Trust has worked collaboratively with Public Health England (PHE) and had the opportunity to work with Dr Fox PHE Lead Public Health Microbiologist to ensure effective management.

During 2019-2020 comprehensive remedial work has been undertaken due to manage Pseudomonas aeruginosa (PA) in Horsley ITU and HDU and filters remain in use were required.

The Trust has purchased the Hydrops water management system which can provide a detailed Defect/Non-Compliance Log, risk assessments, planned preventative maintenance task management and provide an overview of adherence to water flushing across the Trust. The strategies that have been implemented have ensured that there has been no impact to patients or staff.

11. Theatre Ventilation

As documented in previous reports the air flows in theatres 1 to 5 do not meet HTM regulations. To mitigate the risks and provide reassurance that patient safety is not compromised a number of interventions e.g. microbiological monitoring/testing and surgical site surveillance.

There has been a programme of testing undertaken to confirm the air changes and ongoing solutions continue to be considered.

12. Audit Programme 2019-2020

12.1 Hand Hygiene

Continuous improvement in hand hygiene practices continues to be a priority for the Trust. Observational Hand hygiene audits are undertaken monthly and compliance is monitored using the World Health Organisations (WHO) 5 moments for hand hygiene audit tool and reported at IPCC and via the balanced score cards.

In line with many Trusts compliance rates range between 98% and 100% although this is not reflected in independent audit scores in line with many other trusts differing rates ranging from 60% to 95%. Repeated non-compliance to policy is reported to Mrs Salter, Director of Nursing and Governance/DIPC, for nursing and allied health professionals, medical staff non-compliance is reported to Dr Nicolson, Medical Director.

Compliance with hand hygiene has been continually monitored during the COVID-19 Pandemic as it is recognised as a key control measure in preventing transmission.

12.2 Saving Lives High Impact Interventions

The Saving Lives High Impact interventions are an evidenced based approach to the delivery key clinical procedures that can reduce the risks of infection if performed appropriately. The interventions include:

- Management of central venous lines
- Management of peripheral lines
- Management of urinary catheters
- Management of ventilated patient/tracheal suctioning
- Decontamination of infected and non-infected areas
- Preventing surgical site infection

Monthly observations of practice are undertaken across all clinical areas and reported quarterly via the IPCC. Any areas where there are non-compliance themes will be identified and any training issues will be addressed.

High impact interventions were temporarily suspended during the COVID-19 pandemic and a small task and finish group is to be convened to review the current tools and the needs of the Trust.

12.3 Mattress Audit

Mattress audits, to assess the integrity and cleanliness of mattresses continue to be undertaken quarterly. There is a rolling programme for mattress replacement to ensure patients are nursed on an appropriate surface. These audits are additional to the mattress checks that are required following every patient discharge.

13. Seasonal Influenza

Frontline staff are more likely to be exposed to the influenza virus, particularly during the winter months when there is a high risk of patients being infected. It has been estimated that one in four healthcare workers may become infected with influenza during a mild influenza season, a much higher incidence than expected in the general population.

The national flu' CQUIN associated with 2019/20 staff flu' campaign was increased to 80% vaccination uptake by frontline staff (70% 2018/19).

The IPCT led the flu campaign again this year along with peer vaccinators (which included the Director of Nursing and Governance/Director of IPC) across the Trust. As a result of their hard work and commitment 80.3% of staff were vaccinated, resulting in the Trust meeting the CQUIN target.

14. Education and Training

A comprehensive programme of education and training has been provided to all relevant disciplines of staff on the principles of infection prevention and control, as part of:

The IPCT participated in the following education activities to support effective infection prevention and control practice;

- Infection Prevention Week. This included ward based educational sessions, a display stand quiz and a number of educational activities
- Glove awareness week
- Hand hygiene day
- Provision of spoke placement for Student Nurses.
- IPCT undertaking clinical sessions to maximise learning opportunities and support staff
- Programme of "bite sized" education sessions
- Antimicrobial stewardship/sepsis
- There was a successful day delivered by ANTT UK to prepare for the trust wide implementation of ANTT (Aseptic Non Touch Technique)
- Vaccinator training to support the seasonal staff flu campaign
- Use of PPE during Covid-19 pandemic
- Showcased work at the World First patient safety event

Aseptic Non Touch Technique (ANTT)

ANTT was introduced across the Trust and will be embedded further across all discipline during 2020-2021. A pre-implementation audit was carried out which will be repeated quarterly

to monitor the effectiveness of the programme.

The introduction of ANTT is a key component in the work that is to commence regarding blood culture collection and competency. Progress will be reported to IPCC.

15. Policies

Infection prevention and control policies due for renewal or required review following department or NICE guidance have been updated and ratified at IPCC up until quarter three. The COVID-19 pandemic which developed during quarter four has delayed some policy review; however, there have been a number of standard operating procedures and policies that have been developed to manage the ongoing COVID-19 pandemic. This work stream will continue into 2020-2021.

16. HCAI Reduction Plan 2019 – 2020 (Appendix 1)

The achievement of all objectives within the plan was impacted by staffing within the IPCT and Tissue Viability and the COVID-19 pandemic during quarter four; staffing was placed on the Trust register and actions are in place to mitigate risks.

There has been some progress in plan to improve the quality of HCAI data and reduce duplication. This has been discussed with the Head of Informatics and a plan agreed; this objective has transferred to the 2020-2021 work plan.

The audit programme was reduced in response to staffing within the team but all key clinical areas and interventions were completed.

Despite these challenges there has been a significant reduction in the numbers of Clostridium difficile, MSSA and CPE which is down to the hard work of both the IPCT and staff in the Trust.

17. COVID-19 Pandemic

COVID-19 is an infectious disease caused by a newly discovered coronavirus that was first identified in China during December 2019. In January 2020 it became apparent that human transmission was occurring and the World Health Organisation (WHO) a global public health emergency 30th January. The rate of transmission increased and WHO declared the Covid-19 outbreak a pandemic on 12th March 2019.

The majority of people infected with the COVID-19 virus experience mild to moderate respiratory illness and recover without requiring treatment. However, older people and those with underlying medical problems like cardiovascular disease, diabetes, chronic respiratory disease, and cancer are at a higher risk of developing a serious illness. As the pandemic evolved it became apparent that there was significant mortality associated with the virus.

The effect of the COVID-19 has been unprecedented and the NHS has never had to manage a pandemic of this scale.

The COVID-19 virus spreads primarily through droplets of saliva or discharge from the nose when an infected person coughs or sneezes. It is therefore imperative that exemplarily infection prevention and control strategies are fully implemented and adhered to.

To ensure patient and staff safety the IPCT has undertaken/supported the following interventions:

- In collaboration with procurement planning commenced in January 2020 to ensure that in the event that the outbreak escalated there would be sufficient personal protective equipment (PPE) to ensure staff and patient safety. This has been an ongoing work stream and is under constant review.
- Extensive training programme to support infection prevention strategies and safe working practice e.g. PPE, COVID-19 testing, supported ISS domestic services.
- Review and implantation of patient pathways with clinical services/departments.
- Development of an extensive library of standard operating procedures.
- Patient placement strategy
- Development of COVID-19 policy.
- Development of fit testing database.
- Staff COVID-19 testing.
- Collaborative working with the estates department to redesign HITU and Chavasse ward to allow safe patient placement.
- Ongoing advice and support to staff.
- Accredited fit testing training day to increase the number of trainers.
- Participated in local, regional and national teleconferences.
- Collaboration with external infection prevention and control colleagues.
  Due to the unprecedented nature of the pandemic there were challenges.
- Rapidly changing guidance especially in relation to PPE.

Sufficient stock of PPE and consumables were maintained. However, due to national procurement arrangements, on a number of occasions FFP3 respirators were delivered that were a different type of respirators to those that staff had been fit tested and severe shortages of fit testing solution. The provision of soap and alcohol hand rub also became challenging.

These ongoing challenges caused significant staff anxiety and the IPCT have provided ongoing support.

The Trust will continue to feel the impact of the COVID-19 pandemic for the foreseeable future and will need to adapt to continue to deliver its services. To support the following have been developed.

- Development of the COVID-19 dashboard. This provides both an overview of COVID-19 activity in the trust, identifies patients who require review, stepdown, staff sickness absence, tracking of COVID-19 contacts and patient listed for scheduled surgery to ensure that surgical activity can be maintained safely. This dashboard will be further developed to encompass HCAI reporting which will improve the quality of the data and identify potential infection hotspots in the Trust
- Pathways for patient who require surgical interventions to maintain patient and staff safety and improve patient flow.
- To provide effective cohort/isolate areas doors will be installed to the bays in the ward areas were not currently in place. This will allow appropriate management of COVID-19 and other infectious organisms going forward.

18. Conclusion

The biggest challenge to infection prevention and control in the Trust has been the COVID-19 pandemic. There is national and international acknowledgement that the ongoing pandemic will impact on the delivery of services for the foreseeable future and that COVID-19 will become endemic within trusts. In view of this, proactive infection prevention will be essential

especially when considered in the context of increasing patient dependence, complexity of treatments, and in the continued emergence of new resistant organisms.

The Walton Centre is committed to continuous, quality improvement in infection prevention and control and supports zero tolerance of avoidable infections and harm to our patients. To support this Trust remains committed to supporting a collaborative approach across the health economy.

Although 2019 – 2020 proved challenging with increased pressures evident throughout the Trust in addition to the ongoing COVID 19 pandemic. There has been significant staff engagement and collaboration across all disciplines.

Quality Committee and Trust Board are asked to note the content of this report and approve the 2020-2021 HCAI reduction plan.

Lisa Salter
Director of Nursing and Governance/Director of Infection Prevention and Control

Helen Oulton
Lead Nurse Infection Prevention and Control/Tissue Viability

APPENDIX 1

Infection Prevention and Control; Healthcare Associated Infection (HCAI) Reduction Plan 2019-20

1. Introduction

This proposed Plan outlines the core activities which will be undertaken by the Infection Prevention and Control Team (IPCPT) during 2019 to 2020. The plan will be amended as required to reflect any new statutory regulations or other infection control issues that are identified as a priority by the Infection Prevention and Control Team and/or the Infection Prevention and Control Committee.

The plan reflects the requirement of the Code of Practice and Care Quality Commission Fundamental Standards.

The plan will be monitored by the Infection Prevention and Control Committee and progress reports submitted quarterly to Quality Committee.

The Walton Centre has a comprehensive education, surveillance and audit programme which includes the development, implementation and review of policies and guidance. These components are integrated into this reduction plan as part of the proactive approach to infection prevention and control within the Trust.

Staff contributing to the implementation of the annual HCAI reduction plan include:

- The Director Nursing and Governance/Infection Prevention and Control
- The Deputy Director of Infection Prevention and Control/Consultant Microbiologist
- Lead Nurse Infection Prevention and Control/Tissue Viability
- The Infection Prevention and Control Nurse Specialists
- The Infection Prevention and Control Infection Prevention and Control Ambassador's
- Medicines Management Team
- ISS Mediclean
- Estates and Facilities Department
- Matron/Ward Managers

HEALTHCARE ASSOCIATED INFECTION REDUCTION PLAN 2019 -2020

COMPLETED		IN PROGRESS		NO PROGRESS TO REPORT	

Objective 1 • **The organisation has systems in place to manage and monitor the prevention and control of infection**								
Action	**Target /Timescale**	**Lead**	**Q 1**	**Q 2**	**Q 3**	**Q 4**	**Progress**
Review compliance with CQC standards	April 19, July 19 , Nov 19, Feb 20	Lead Nurse IPC					Complete
Review and submit HCAI Assurance Framework and submit to NHSE Specialist Commissioning	15th each month	Senior IPC Nurse					Complete
Submit quarterly reports to Quality Committee Submit 2019-20 IPC Annual IPC Report to Quality Committee/Trust Board	May 19, July 19, November 19, February 19 May 19	DIPC Lead Nurse IPC					 Complete
Maintain support to Divisional Risk and Governance Groups	Monthly	Lead Nurse IPC/Senior IPC Nurse					Complete
To undertake a retrospective thematic review of 10 cases of MSSA (trust apportioned) and develop reduction plan	December 19	Senior IPC Nurse					Review of laboratory data highlighted high numbers of contaminants. Blood culture audit and implementation of universal decolonisation has reduced cases >50% and therefore review not required

Objective 2 • **Mandatory and internal surveillance/reporting requirements**							
Continue alert organism surveillance and generate monthly reports as to progress against trajectories	Monthly	IPC Team					Mandatory and internal reporting maintained
	Target /Timescale	**Lead**	**Q 1**	**Q 2**	**Q 3**	**Q 4**	**Progress**
To report mandatory surveillance data in line with national requirements	15th each month	DIPC IPC Team					Complete
Continue surgical site surveillance	Monthly	IPC Team					Complete
Support Root Cause Analysis for all bacteraemia, CD infection and any untoward incidents related to infection prevention to identify source of infection, any lapses of care, shared learning and monitor themes	April 19 – March 20	IPC Team					Complete
Undertake review of HCAI reporting in the Trust to reduce duplication and increase efficiency • Integrated Performance Report • Surveillance • Hand hygiene • Saving lives	May 19 September 19 October 19 January 20	Business Intelligence					SSI surveillance pilot of electronic forms underway. Further review of progress 18th May 2020 Delay due to COVID-19
Undertake surveillance and monitor • Cranial infections • EVD infections	Monthly	IPCT/ Hydrocephalous Nurse Specialist					Complete
Objective 3 • **Ensure the provision of evidence based, relevant policies procedures and guidance**							
Implement plan to ensure all polices/guidelines are reviewed and revised in line with review dates and amended in the event of new guidance Provide specialist support to services to develop policies, procedures and guidance within the Trust	March 2020	Lead Nurse IPC					4 policies lapsed their review date during Q.4, this has been actioned and reviews are in progress

Objective 4 • **Monitor compliance with IPC policies through the Infection Prevention Audit Programme**							
Action	**Target /Timescale**	**Lead**	**Q 1**	**Q 2**	**Q 3**	**Q 4**	**Progress**
Review and plan annual audit programme	April 19	Lead Nurse IPC					Complete
Implement IPC audit programme and monitor outcomes/progress	July 19 , Nov 19, Feb 20	Senior IPC Nurse					Limited progress Q.2 due to staffing levels in IPCT and TVN vacancy Audits reduced during Q4 due to increased workload in relation to COVID-19 pandemic.
Objective 5 • **All staff will receive appropriate education and training in infection prevention polices and practice** **Clinical Procedures/interventions are undertaken appropriately**							
Annually review content of infection prevention and control training package	April 2019	IPC Team					Complete
Prepare core training plan and deliver formal and informal education to all grades and disciplines of staff	April 19 - ongoing	IPC Team					Training plan agreed Mandatory training delivered
Maintain IPC Ambassador education programme	June 19 September 19 December 19 March 20	IPC Team					Unable to deliver an education day due to COVID 19 and the need for social distancing
Improve awareness of hand hygiene during WHO Hand Hygiene day	May19	IPC Team					Complete
Introduce ANTT across the Trust	October 19	IPC Team					ANTT has been introduced across the Trust but requires further work to embed effectively and across all disciplines.

Continue to support spoke placements for student nurses, Trainee Nurse Associates and *adhoc* placements for students and ward staff	April 19– March 20	IPC Team					Placement accepted as requested
Objective 6 • **There will be a skilled IPC workforce that is flexible and resilient**							
Action	**Target /Timescale**	**Lead**	**Q 1**	**Q 2**	**Q 3**	**Q 4**	**Progress**
Ensure that all IPC team are skilled evidence based practitioners	April 19 - March 20	Lead Nurse IPC					Complete
Support attendance at regional forums and attend relevant local and national study days and conferences	April 19 – March 20	IPC Team					Cancelled in Q4 due to COVID -19
Ensure clear objectives and development needs are identified by the appraisal process	June 19	Lead Nurse IPC					Complete
Objective 7 • **Support staff health and well-being by promotion and delivery of the Staff seasonal flu campaign**							
Review 18-19 campaign	May 19	IPC Team					Complete
Undertake TNA for immuniser training	July 19	IPC Team					Complete
Objective 8 • **Reduce the risks of spread of Multi-drug Resistant organisms (MDRO) including carbapenemase producing enterobacteriaceae (CPE)**							
Audit compliance with CPE admission and 30 day screening	June 19 September 19 December 19 March 20	IPC Team					Retrospective look back of Q4 planned
Monitor MRSA admission and 30 day screening	Monthly	IPC Team					Admission screening reviewed as part of MRSA pathway, to review 30 day screening
Audit compliance with MDRO policy	January 20	IPC Team					Components reviewed as part of pathway

							audit and will be extended to cover all components in 2020-2021
Objective 9 • **To comply with national guidance on cleanliness and provide patients, visitors and staff with a clean safe environment**							
Action	**Target /Timescale**	**Lead**	**Q 1**	**Q 2**	**Q 3**	**Q 4**	**Progress**
PLACE and mini PLACE assessments will be undertaken and action plans formulated to address any concerns	June 19, Sept 19 Dec 19, March 19	IPCT, Estates ISS					PLACE assessment November 2019 Q2. Postponed due to staffing Q4. Postponed due to COVID-19
Further develop Clean Trace programme reporting	Monthly	IPCT/Ward Managers					Awaiting software update from 3M
Undertake walk arounds with ISS	Weekly	IPCT/ISS					Senior Facilities Manager has implement robust audit programme, therefore the IPCT have adjusted their audit proforma accordingly to undertake independent walk arounds
Provide expertise and specialist IPC input into Estates and Facilities meetings	Quarterly	IPCT					Complete
Objective 10 • **Appropriate antimicrobial prescribing in in line with "Start Smart and Focus" to ensure compliance Antimicrobial Stewardship will be embedded and monitored across the Trust**							

Antibiotic ward rounds for acute wards and CRU	Weekly	Consultant Microbiologist					Ward rounds were suspended during Q4 due to COVID -19. Telephone support available
Daily antibiotic ward rounds Critical Care	Daily	Consultant Microbiologist					Complete
Antibiotic audits/prevalence studies	Quarterly	Pharmacist					Complete
Antimicrobial Stewardship Group	Quarterly	Mr Lawson Pharmacist					Complete
Review and report outcomes of OPAT service	July 19, October 19, Jan 20, April 20	Consultant Microbiologist					Agreed at IPCC to provide annual update now that service is established
Objective 11 • **Undertake enhanced surveillance to reduce variation and ensure best practice in pre/peri/post-operative practice to support a sustainable reduction in surgical site infection (SSI)**							
Action	**Target /Timescale**	**Lead**	**Q 1**	**Q 2**	**Q 3**	**Q 4**	**Progress**
Improve quality of SSI data • Review/amend current data collection Tool • Transfer input of data into digital format	May 19	IPCT/Theatre R & G Lead					Digital data collection pilot November 2019 Digital collection from April 2020
Develop SSI project plan	May 19	IPCT/Theatre R&G Lead					Delayed due to capacity in IPCT/COVID-19 pandemic
Develop SSI dashboard	January 20	Lead Nurse IPC/A Sharrock (BI)					Delayed due to capacity in IPCT/COVID-19 pandemic. Implementation planned 2020-2021
Participate in GIRFT audit programme	October 19	Mr Carter					Complete

Provide support to Theatre User Group	Monthly	IPCT					Complete Actioned outside of group
Objective 12 • **To reduce avoidable deaths from sepsis we must ensure early recognition of sepsis, ensure treatment is initiated in an appropriate time scale and appropriate escalation and monitoring occurs**							
Action	**Target /Timescale**	**Lead**	**Q 1**	**Q 2**	**Q 3**	**Q 4**	**Progress**
Continuous Audit of sepsis management to be presented quarterly at ICP committee the month proceeding each quarter	July 10 October 19 January 2020 April 2020	Alex Nuttal/Elenna Talbot					Complete
Improve recognition and identification of those patients at risk of Sepsis through the use of NEWS2 compliance	Daily	SMART					Complete
Mandatory education and yearly update for all clinical staff surrounding sepsis	ongoing	SMART					Complete
Commence deteriorating patient audit – monitor ongoing compliance to NEWS 2 sepsis screening and escalation	To commence July 19	SMART					Complete

APPENDIX 2

Infection Prevention and Control; Healthcare Associated Infection (HCAI) Reduction Plan 2020 - 21

2. Introduction

This proposed Plan outlines the core activities which will be undertaken by the Infection Prevention and Control Team (IPCPT) during 2020 to 2021. The plan will be amended as required to reflect any new statutory regulations or other infection control issues that are identified as a priority by the Infection Prevention and Control Team and/or the Infection Prevention and Control Committee.

The plan reflects the requirement of the Code of Practice and Care Quality Commission Fundamental Standards.

The plan will be monitored by the Infection Prevention and Control Committee and progress reports submitted quarterly to Quality Committee.

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- Lead Nurse Infection Prevention and Control/Tissue Viability
- The Infection Prevention and Control Nurse Specialists
- The Infection Prevention and Control Infection Prevention and Control Ambassador's
- Medicines Management Team
- ISS Mediclean
- Estates and Facilities Department
- Matron/Ward Managers
- SMART

HEALTHCARE ASSOCIATED INFECTION REDUCTION PLAN 2020 -2021

COMPLETED		IN PROGRESS		NO PROGRESS TO REPORT	

Objective 1 • **The organisation has systems in place to manage and monitor the prevention and control of infection**								
Action	**Target /Timescale**	**Lead**	**Q 1**	**Q 2**	**Q 3**	**Q 4**	**Progress**
Review compliance with CQC standards	April 20, July 20 , Nov 20, Feb 21	Lead Nurse IPC					
Review and submit HCAI Assurance Framework and submit to NHSE Specialist Commissioning	15th each month	Senior IPC Nurse					
Submit quarterly reports to Quality Committee Submit 2020-21 IPC Annual IPC Report to Quality Committee/Trust Board	May 20, July 20, November 20, February 20 May 21	DIPC Lead Nurse IPC					
Maintain support to Divisional Risk and Governance Groups	Monthly	Lead Nurse IPC/Senior IPC Nurse					
Objective 2 • **Mandatory and internal surveillance/reporting requirements**								
	Target /Timescale	**Lead**	**Q 1**	**Q 2**	**Q 3**	**Q 4**	**Progress**
Continue alert organism surveillance and generate monthly reports as to progress against trajectories	Monthly	IPC Team					

To report mandatory surveillance data in line with national requirements	15th each month	DIPC IPC Team					
Continue surgical site surveillance	Monthly	IPC Team					
Support Root Cause Analysis for all bacteraemia, CD infection and any untoward incidents related to infection prevention to identify source of infection, any lapses of care, shared learning and monitor themes	April 19 – March 20	IPC Team					
Undertake review of HCAI reporting in the Trust to reduce duplication and increase efficiency • Integrated Performance Report • Surveillance • Hand hygiene • Saving lives	May 20 September 20 October 20 January 21	Informatics					
Undertake surveillance and monitor • Cranial infections • EVD infections • Implant infections	Monthly	IPCT/ Hydrocephalous Nurse Specialist					
Reduce the number of Ecoli blood stream infections by 10%/ as required by NHSE/I • Task and finish group to review catheter care, management of continence • Training plan • Competencies	April 20 – March 2021	IPCT DIPC					
Objective 3 • **Ensure the provision of evidence based, relevant policies procedures and guidance**							
Implement plan to ensure all polices/guidelines are reviewed and revised in line with review dates and amended in the event of new guidance Provide specialist support to services to develop policies, procedures and guidance within the Trust	March 2021	Lead Nurse IPC					

Objective 4 • **Monitor compliance with IPC policies through the Infection Prevention Audit Programme**							
Action	**Target /Timescale**	**Lead**	**Q 1**	**Q 2**	**Q 3**	**Q 4**	**Progress**
Review and plan annual audit programme	May 2020	Senior Nurse IPC					
Implement IPC audit programme and monitor outcomes/progress	July 20 , Nov 20, Feb 21	Senior IPC Nurse					
Objective 5 • **All staff will receive appropriate education and training in infection prevention polices and practice Clinical Procedures/interventions are undertaken appropriately**							
Annually review content of infection prevention and control training package	June 2021	IPC Team					
Prepare core training plan and deliver formal and informal education to all grades and disciplines of staff	April 20 - ongoing	IPC Team					
Maintain IPC Ambassador education programme	June 20 September 20 December 20 March 21	IPC Team					
Embed ANTT across the Trust	August 20	IPC Team					
Undertake blood culture competencies and audit of practice	September 20	IPC Team/PEF's					
Continue to support spoke placements for student nurses, Trainee Nurse Associates and *adhoc* placements for students and ward staff	April 20– March 21	IPC Team					

Objective 6 • **There will be a skilled IPC workforce that is flexible and resilient**							
Action	**Target /Timescale**	**Lead**	**Q 1**	**Q 2**	**Q 3**	**Q 4**	**Progress**
Ensure that all IPC team are skilled evidence based practitioners	April 20 - March 21	Lead Nurse IPC					
Support attendance at regional forums and attend relevant local and national study days and conferences	April 20 – March 21	IPC Team					
Ensure clear objectives and development needs are identified by the appraisal process	August 20	Lead Nurse IPC Senior Nurse IPC					
Objective 7 • **Support staff health and well-being by promotion and delivery of the Staff seasonal flu campaign**							
Review 19-20 campaign	May 20	IPC Team					
Undertake TNA for immuniser training	July 20	IPC Team					
Objective 8 • **Reduce the risks of spread of Multi-drug Resistant organisms (MDRO) including carbapenemase producing enterobacteriaceae (CPE)**							
Audit compliance with CPE admission and 30 day screening	October 20	IPC Team					
Monitor MRSA admission and 30 day screening	November 20	IPC Team					
Objective 9 • **To comply with national guidance on cleanliness and provide patients, visitors and staff with a clean safe environment**							
Action	**Target /Timescale**	**Lead**	**Q 1**	**Q 2**	**Q 3**	**Q 4**	**Progress**
PLACE and mini PLACE assessments will be undertaken and action plans formulated to address any concerns	TBC	IPCT, Estates ISS					

Undertake environmental audits within clinical areas	Weekly	IPCT					
Provide expertise and specialist IPC input into Estates and Facilities meetings/works	Quarterly	IPCT					
Objective 10 • **Appropriate antimicrobial prescribing in in line with "Start Smart and Focus" to ensure compliance Antimicrobial Stewardship will be embedded and monitored across the Trust**							
Antibiotic ward rounds for acute wards and CRU	Weekly	Consultant Microbiologist					
Daily antibiotic ward rounds Critical Care	Daily	Consultant Microbiologist					
Antibiotic audits/prevalence studies	Quarterly	Pharmacist					
Antimicrobial Stewardship Group	Quarterly	Mr Lawson Pharmacist					
Review and report outcomes of OPAT service	March 21	Consultant Microbiologist					
Objective 11 • **Undertake enhanced surveillance to reduce variation and ensure best practice in pre/peri/post-operative practice to support a sustainable reduction in surgical site infection (SSI)**							
Action	**Target /Timescale**	**Lead**	**Q 1**	**Q 2**	**Q 3**	**Q 4**	**Progress**
Improve quality of SSI data • Transfer input of data into digital format • Commence digital recording	June 20	IPCT/Theatre R & G Lead					
Develop SSI dashboard	March 21	Lead Nurse IPC/Informatics					
Provide support to Theatre User Group	Monthly	IPCT					

Objective 12 • **To reduce avoidable deaths from sepsis we must ensure early recognition of sepsis, ensure treatment is initiated in an appropriate time scale and appropriate escalation and monitoring occurs**							
Action	**Target /Timescale**	**Lead**	**Q 1**	**Q 2**	**Q 3**	**Q 4**	**Progress**
Continuous Audit of sepsis management to be presented quarterly at ICP committee the month proceeding each quarter	July 20 October 20 January 20 April 21	Alex Nuttal/Elenna Talbot					
Improve recognition and identification of those patients at risk of Sepsis through the use of NEWS2 compliance	Daily	SMART					
Mandatory education and yearly update for all clinical staff surrounding sepsis	ongoing	SMART					
Monitor ongoing compliance to NEWS 2 sepsis screening and escalation	Ongoing	SMART					
Objective 13 • **To reduce transmission and effectively manage COVID-19**							
Action	Target/Timescale	Lead	**Q 1**	**Q 2**	**Q 3**	**Q 4**	
Review COVID-19 Assurance Framework	May 20 August 20	Lead Nurse IPC					
Develop COVID-19 action plan	June 20	Lead Nurse IPC					
Maintain PPE education programme	Ongoing	IPCT					
Continue to develop COVID-19 dashboard	July 2020	IPCT					

7. IPCC Annual Report

Publications approval reference: 001559

Infection prevention and control board assurance framework

4 May 2020, Version 1

Foreword

NHS staff should be proud of the care being provided to patients and the way in which services have been rapidly adapted in response to the COVID-19 pandemic.

Effective infection prevention and control is fundamental to our efforts. We have developed this board assurance framework to support all healthcare providers to effectively self-assess their compliance with PHE and other COVID-19 related infection prevention and control guidance and to identify risks. The general principles can be applied across all settings; acute and specialist hospitals, community hospitals, mental health and learning disability, and locally adapted.

The framework can be used to assure directors of infection prevention and control, medical directors and directors of nursing by assessing the measures taken in line with current guidance. It can be used to provide evidence and also as an improvement tool to optimise actions and interventions. The framework can also be used to assure trust boards.

Using this framework is not compulsory, however its use as a source of internal assurance will help support organisations to maintain quality standards.

Ruth May
Chief Nursing Officer for England

1. Introduction

As our understanding of COVID-19 has developed, PHE and related guidance on required infection prevention and control measures has been published, updated and refined to reflect the learning. This continuous process will ensure organisations can respond in an evidence-based way to maintain the safety of patients, services users and staff.

We have developed this framework to help providers assess themselves against the guidance as a source of internal assurance that quality standards are being maintained. It will also help them identify any areas of risk and show the corrective actions taken in response. The tool therefore can also provide assurance to trust boards that organisational compliance has been systematically reviewed.

The framework is intended to be useful for directors of infection prevention and control, medical directors and directors of nursing rather than imposing an additional burden. This is a decision that will be taken locally although organisations must ensure they have alternative appropriate internal assurance mechanisms in place.

2. Legislative framework

The legislative framework is in place to protect service users and staff from avoidable harm in a healthcare setting. We have structured the framework around the existing 10 criteria set out in the Code of Practice on the prevention and control of infection which links directly to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The Health and Safety at Work Act 1974 places wide-ranging duties on employers, who are required to protect the 'health, safety and welfare' at work of all their employees, as well as others on their premises, including temporary staff, casual workers, the self-employed, clients, visitors and the general public. The legislation also imposes a duty on staff to take reasonable care of health and safety at work for themselves and for others, and to co-operate with employers to ensure compliance with health and safety requirements.

Robust risk assessment processes are central to protecting the health, safety and welfare of patients, service users and staff under both pieces of legislation. Where it is not possible to eliminate risk, organisations must assess and mitigate risk and provide safe systems of work. In the context of COVID-19, there is an inherent level of risk for NHS staff who are

treating and caring for patients and service users and for the patients and service users themselves in a healthcare setting. All organisations must therefore ensure that risks are identified, managed and mitigated effectively.

Infection Prevention and Control board assurance framework

1. Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks posed by their environment and other service users

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions
Systems and processes are in place to ensure:			
• infection risk is assessed at the front door and this is documented in patient notes	Admission risk assessment form Positive results stored on PAS system	Not filed in patients case notes Decisions being made outside of the IPC Ward RAG rating (weekends)	Discussion with Divisional Directors to ensure documentation is filed in patient notes. Request for ep2 version
• patients with possible or confirmed COVID-19 are not moved unless this is essential to their care or reduces the risk of transmission	Trust RAG rating system for the placement of patients. Movement of patients goes through command and control, bed managers and IPCT	Non-compliance with PHE guidance	Dashboard to be updated in real time Escalation to bronze or silver on call if needed
• compliance with the national guidance around discharge or transfer of COVID-19 positive patients	Trust COVID -19 policy De escalation protocol	Ad hoc communication to staff groups	Continue staff support and education
• patients and staff are protected with PPE, as per the PHE	Trust COVID -19 policy in line with PHE	Ad hoc communication to	IPCT staff support and

national guidance	guidance Register of staff training for fit testing and donning and doffing Visual aids of PPE guidance	staff groups	continued education Daily discussions regarding PPE at Trust wide safety huddle
• national IPC guidance is regularly checked for updates and any changes are effectively communicated to staff in a timely way	IPC team communicates any changes noted within national guidance in a timely manner. This is managed through command and control and communications Twice daily emails circulated from Command and Control Trust wide	Ad hoc communication to staff groups	Continue staff support and education
• changes to guidance are brought to the attention of boards and any risks and mitigating actions are highlighted	Organizational risk assessments for e.g BAME and high risk staff Letters / emails sent to staff Trust wide stating a risk assessment is available so this can be completed with their manager. BAME staff have been advised this should be undertaken. Daily Executive meetings to highlight changes in Covid 19 guidance and this is shared with Command and Control.	Staff may not engage	Education and support to be offered
• risks are reflected in risk registers and the Board Assurance Framework where appropriate	Operational risk on Datix which informs the Trust BAF specific to Covid 19.	Inaccuracies in the document as and when guidance changes	Daily updates provided via Execs to Command & Control
• robust IPC risk assessment processes and practices are in	Ep2 IPC risk assessment completed on admission.	None identified	

place for non COVID-19 infections and pathogens	The IPC team continue to undertake in depth surveillance of all HCAI within the Trust and report accordingly via the Trust datix system.		
2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure:			
• designated teams with appropriate training are assigned to care for and treat patients in COVID-19 isolation or cohort areas	Each clinical area has allocated domestic teams. Register of staff training and monitored by Divisional Managers and reported through to Command and Control	Movement of staff due to sickness/holidays	Staff only to be moved when absolutely necessary.
• designated cleaning teams with appropriate training in required techniques and use of PPE, are assigned to COVID-19 isolation or cohort areas.	As above Fit testing for FFP3 masks where needed, logged on database (as above) ISS domestic services guidance from their management which also follows PHE guidance. COVID 19 policy Cleaning policy	Poor communication Staff anxieties	Continued staff support and education / visual aids.
• decontamination and terminal decontamination of isolation rooms or cohort areas is carried out in line with PHE and other national guidance	COVID -19 Policy Decontamination Policy Isolation Policy Monitoring and discussion at Trust safety huddle Facilities Manager audits	Non adherence to policy	Refer to appropriate policy during education sessions, signpost to intranet page

• increased frequency of cleaning in areas that have higher environmental contamination rates as set out in the PHE and other national guidance	COVID 19 Policy Isolation Policy Decontamination Policy Cleaning schedules altered during Covid 19	Non adherence to policy / schedule	Refer to appropriate policy during education sessions, signpost to intranet page Audit process of cleaning schedule completion
• linen from possible and confirmed COVID-19 patients is managed in line with PHE and other national guidance and the appropriate precautions are taken	Infection Prevention and Control Policy COVID-19 Policy	Non adherence to policy	Refer to appropriate policy during education sessions, signpost to intranet page. Risks identified and discussed at safety huddle.
• single use items are used where possible and according to Single Use Policy	Infection Prevention and Control Policy	The Trust does not have a single use policy	Mandatory Health and Safety and induction training addresses single use items. The policy incorporates some elements of single use guidance
• reusable equipment is appropriately decontaminated in line with local and PHE and other national policy	SOP for cleaning of visors/goggles and hoods COVID -19 policy	Poor communication	Staff support and education Re circulation of the SOP Process required for monitoring re-usable equipment

3. Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and process are in place to ensure: • arrangements around antimicrobial stewardship are maintained	Virtual antimicrobial ward rounds continue. Microbiology advice available 24/7 IPC surveillance Minutes available from Antimicrobial stewardship meetings	Inconsistency in ward rounds Medical input poor	Communication improved , looking at different ways of delivering the service SOP for how this is delivered
• mandatory reporting requirements are adhered to and boards continue to maintain oversight	HCAI surveillance reporting through PHE monitoring system. IPC quarterly and annual report taken through quality committee and Trust board. Serious incidents managed via SI meeting and report to Quality Committee and Trust Board	None identified	
4. Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure: • implementation of national guidance on visiting patients in a care setting	Trust guidance on the visiting of patients, as per national guidance	None identified	

• areas in which suspected or confirmed COVID-19 patients are where possible being treated in areas clearly marked with appropriate signage and have restricted access	Ward RAG rating for patient placement COVID 19 policy	There is no visible signage on the wards marking the appropriate colour coding.	Request for appropriate signage to be made from communications team
• information and guidance on COVID-19 is available on all Trust websites with easy read versions	Intranet COVID site Log is maintained within command and control of any changes to documents and reports decisions made.	Some staff many not be able to access information	Managers have been asked to appraise their teams regarding updates from Command & Control
• infection status is communicated to the receiving organisation or department when a possible or confirmed COVID-19 patient needs to be moved	Protocol for admission and discharge. Nursing transfer letter COVID 19 dashboard	Transfer letter not being completed	Discussions with receiving organisation prior to patient leaving the ward
5. Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure:			
• front door areas have appropriate triaging arrangements in place to cohort patients with possible or confirmed COVID-19 symptoms	Assessment undertaken via telephone pre visit. Clinics currently reduced Signage clear at the entrance / reception area and on the Trust website	Information taken during assessment not being highlighted clearly in the documentation or on PAS.	Improve communication of patient status following assessment to be updated into the system.

to minimise the risk of cross-infection			
• patients with suspected COVID-19 are tested promptly	Liverpool Clinical Laboratories SOP for patient testing. COVID 19 policy Protocol for rapid COVID 19 testing Testing available 24/7 7 days a week	Samples not being processed due to poor labelling	Labelling of samples discussed at Trust safety huddle
• patients that test negative but display or go on to develop symptoms of COVID-19 are segregated and promptly re-tested	Ward RAG rating for patient placement De-escalation protocol Dashboard	Dashboard not currently real time	Command and control has regular updates re patients screened, bed moves and patients for step down and will maintain accurate state
• patients that attend for routine appointments who display symptoms of COVID-19 are managed appropriately	Patients attending with symptoms will be assessed and confirmed whether they need to go home to self isolate or be admitted, depending on their condition.	None identified	

6. Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions
Systems and processes are in place to ensure: • all staff (clinical and non- clinical) have appropriate training, in line with latest PHE and other guidance, to ensure their	IPC policies and SOPs Attendance register for fit testing and donning and doffing COVID bulletins Fit test training register and database	Poor communication	Continued education and staff support

personal safety and working environment is safe	Equipment risk assessments		
• all staff providing patient care are trained in the selection and use of PPE appropriate for the clinical situation and on how to safely don and doff it	PPE posters specific to each clinical area and procedure are available and regularly reviewed and updated	Staff noncompliance, poor communication.	Continued education, visual aids including mannequins
• a record of staff training is maintained	IPCT has a record of staff training dates and attendance and is provided regularly to Command and Control	Clinical areas deviating from national guidance	Any staff attending training sessions will sign a register
• appropriate arrangements are in place that any reuse of PPE in line with the CAS alert is properly monitored and managed	CAS policy is managed by Risk and Governance and coordinated via Command and Control	Some sessions ad hoc, therefore attendance not recorded. Small numbers on occasions due to workload.	Non-compliance is challenged in real time
• any incidents relating to the re-use of PPE are monitored and appropriate action taken	Divisions monitor and action Datix reporting which is then managed by Risk and Governance / command and control	Staff don't follow guidance	Noncompliance is challenged in real time
• adherence to PHE national guidance on the use of PPE is regularly audited	Observations in practice undertaken	Not all incidents reported	Audit to be arranged on a cyclical timescale

• staff regularly undertake hand hygiene and observe standard infection control precautions	Observations in practice undertaken and reported to IPC	No formal audits undertaken	Monthly hand hygiene audits to be re commenced including independent observations
• staff understand the requirements for uniform laundering where this is not provided for on site	COVID 19 policy Discussed at Trust safety huddle	Staff may not adhere to guidance	Noncompliance is challenged in real time
• all staff understand the symptoms of COVID-19 and take appropriate action in line with PHE and other national guidance if they or a member of their household display any of the symptoms.	SOP for staff testing COVID – 19 policy	Staff may be unclear re symptoms as they are variable	Managers to reinforce health and wellbeing messages to staff
7. Provide or secure adequate isolation facilities			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure: • patients with suspected or confirmed COVID-19 are isolated in appropriate facilities or designated areas where appropriate	Ward RAG rating for placement of patients All side rooms have en-suite facilities All positive patients nursed within the same area Dashboard	None identified	
• areas used to cohort patients with suspected or confirmed	Minutes of divisional group meetings Command and control log	None identified	

COVID-19 are compliant with the environmental requirements set out in the current PHE national guidance	IPC walkabouts		
• patients with resistant/alert organisms are managed according to local IPC guidance, including ensuring appropriate patient placement	Management of multi drug resistant organism policy Isolation policy SOP for side room allocation IPC daily escalation email / ward visits	Limited side rooms	IPCT have daily communication with bed managers
8. Secure adequate access to laboratory support as appropriate			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
There are systems and processes in place to ensure:			
• testing is undertaken by competent and trained individuals	SOP for testing LCL guidance on testing and packaging of samples	None identified	
• patient and staff COVID-19 testing is undertaken promptly and in line with PHE and other national guidance	SOP for staff testing COVID -19 policy	None identified	
• screening for other potential infections takes place	MDRO policy undertaken MRSA policy CDT policy CPE policy Quarterly audits BSC HCAI surveillance	Q4 care pathway audits not completed	Q1 audits to be commenced

9. Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure that: • staff are supported in adhering to all IPC policies, including those for other alert organisms	Mandatory health and safety training Induction training Ward manager meetings / IPC Committee / PNF	Non adherence to policy	Refer to appropriate policy during education sessions, signpost to intranet page
• any changes to the PHE national guidance on PPE are quickly identified and effectively communicated to staff	COVID -19 policy PPE posters COVID 19 intranet page Twice daily Communications from Command and Control	Non adherence to policy	Discussion at Trust safety huddle Staff support and education Mandatory Health and Safety
• all clinical waste related to confirmed or suspected COVID-19 cases is handled, stored and managed in accordance with current national guidance	COVID -19 policy Waste audits Health and safety committee minutes	Noncompliance to correct waste segregation	Discussion at Trust safety huddle Staff support and education Mandatory Health and Safety
• PPE stock is appropriately stored and accessible to staff who require it	Fallow storage space, stock levels managed by procurement / Command and Control	Command and Control oversee daily	

10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Appropriate systems and processes are in place to ensure: • staff in 'at-risk' groups are identified and managed appropriately including ensuring their physical and psychological wellbeing is supported	Staff COVID risk assessment COVID – 19 staff support helpline Shiny minds Numerous emails sent to staff highlighting health and wellbeing initiatives Occupational health	Staff do not wish to engage with support	Managers advised to support staff and encourage interaction
• staff required to wear FFP reusable respirators undergo training that is compliant with PHE national guidance and a record of this training is maintained	Fit testing is being delivered as per protocol and recorded centrally in Command and Control	None identified	
• staff absence and well-being are monitored and staff who are self-isolating are supported and able to access testing	Inputted on ESR SOP for staff testing COVID -19 staff support helpline	Ad hoc communication	Managers to ensure communication is shared with all members of their teams
• staff that test positive have adequate information and support to aid their recovery and return to work.	Return to work assessment Occupational health Manager support	Staff don't interact with their manager	Managers and teams and occupational health available to support staff. FTSUG in place

Infection Prevention and Control COVID-19 Management Checklist

Refer to COVID-19: infection prevention and control (IPC) - GOV.UK

This tool is designed to be an "aide memoire" that COVID-19 Guidance is being implemented appropriately within the healthcare setting	
Standard Infection Control Precautions Apply to all staff, in all care settings, for all patients when blood, body fluids or recognised/unrecognised source of infection are present. Patients, staff and visitors are encouraged to minimise COVID-19 transmission through; • Good hand hygiene and respiratory hygiene; and • Social distancing wherever possible	
Patient Placement/Assessment of risk/Cohort area	**Comments/Notes**
Emergency Department • Patients are triaged rapidly to maintain separation in space and/or time between possible and confirmed COVID-19 patients **Admission** • Possible cases (awaiting lab confirmation) and confirmed cases are isolated in a single room with clinical wash hand basin and en-suite facilities. • If single rooms are in short supply, priority is given to patients who have excessive cough and sputum production • Single rooms in non-COVID-19 areas are reserved for patients requiring isolation for other (non-influenza-like illness) reasons • Prioritising of patients for isolation other than suspected or confirmed COVID-19 patients is decided locally, based on patient need and local resources.	N/A
• Cohort areas are established for multiple cases of confirmed COVID-19, ideally in a designated self -contained area • Possible cases (awaiting lab confirmation) should be cohorted separately (ideally in single rooms) until confirmed • Patients should be separated by at least 2 metre and privacy curtains/screens used between bed spaces to minimise opportunities for close contact • The segregated area is not being used as a thoroughfare by other patients, visitors or staff • Doors to isolation/cohort rooms/areas are closed and signage is clear • Patient placement is reviewed daily as the care pathway changes	✓ ✓ X beds not 2m ✓ ✓ ✓
Staff Cohorting: • Dedicated teams of staff are assigned to care for patients in isolation/cohort rooms/areas	✓
Ensure all patient placement decisions and assessment of infection risk (including isolation requirements) is clearly documented in the patient notes and reviewed throughout inpatient stay	X not documented in case notes

Personal Protective Equipment (PPE)	
General ward: Staff providing direct care within 2 metres of a possible/confirmed case are wearing disposable aprons, gloves, fluid-resistant facemask (FRSM) and eye/face protection, when in the patients' immediate care environment. Link to PPE table	✓
High risk areas: An FFP respirator and need for gown/coveralls risk assessed Link to PPE tables and AGP's list	✓
Where an AGP is a single procedure, PPE is single use	✓
PPE must be :	
• Available at point of use and stored in a clean dry area	✓
Staff:	
• are trained on putting on and removing PPE.	✓
• know what PPE they should wear for each setting and context	✓
• have access to the PPE that protects them for the appropriate setting and context	✓
Single use Sessional use	✓
• Gloves and aprons are single use as per SICP's with disposal after each patient contact, task or procedure	✓
• FRSM and eye protection may be used for a session of work	✓
• Gowns or coveralls may be worn for a session of work in high risk areas	
Safe Management of Care Equipment	
• Single-use items are in use where possible	✓
• Dedicated, reusable, non-invasive care equipment is in use and decontaminated between each use and prior to use on another patient. See Routine decontamination of reusable non-invasive patient care equipment flowchart	✓
• Fans that re-circulate the air are not in use	✓
Decontamination of the Care Environment	
• Domestic teams are assigned to COVID-19 cohort area/wards	✓
• All areas are free from non-essential items and equipment	x
• Isolation room/Cohort area (Cleaning of isolation areas is undertaken separately to the cleaning of other clinical areas.)	✓ last area
• There is at least, daily decontamination of the patient isolation room/cohort area using for example, a combined detergent/disinfectant solution at a dilution of 1,000 parts per million (ppm) available chlorine (av.cl.)	✓
• There is an increased frequency (at least twice daily) of environmental decontamination schedules for 'frequently touched' surfaces such as door/toilet handles, locker tops, over bed tables, bed rails, desktops and electronic equipment e.g. mobile phones, desk phones and other communication devices , tablets, keyboards particularly where these are used by used by many people.	✓
• 'Terminal' decontamination is undertaken following transfer, discharge, or once the patient(s) is no longer considered infectious	✓
• Communal cleaning trollies are not taken into patient rooms	✓
Hand Hygiene	
• Staff undertake hand hygiene as per WHO 5 moments, using either ABHR or soap and water	✓
• Staff are aware of the importance of skin care	✓

Movement Restrictions/Transfer/Discharge	
Moving Patients within Hospital Patients with possible/confirmed COVID are not moved to other wards/departments unless for essential care. If necessary:	✓
• Staff at the receiving destination are informed that the patient has possible or confirmed COVID-19	
• Patient is wearing a surgical face mask during transportation	✓
• Patients are taken straight to and returned from clinical departments	✓
• If possible, patients are placed at the end of clinical lists	✓
Waste	
• Disposal and transport of all waste related to possible/confirmed cases is classified as Category B clinical waste (orange bag)	✓
Linen	
• All linen is managed as 'infectious' linen	✓
• Disposable gloves and apron are worn when handling infectious linen	✓
• All linen is handled inside the patient room/cohort area. A laundry receptacle is available as close as possible to the point of use for immediate linen deposit	✓
• All linen bags/receptacles are tagged with ward/care area and date	X
• All used/infectious linen is stored in a designated area whilst awaiting collection	✓
Respiratory Hygiene	
• Patients are supported with hand hygiene and provided with disposable tissues and a waste bag	✓
• Symptomatic patients may wear a surgical face mask if tolerated:	✓
◦ In common waiting areas	✓
◦ During transportation	✓
◦ In clinical areas.	✓
A surgical face mask should not be worn by patients if there is potential for their clinical care to be compromised	

The Walton Centre
NHS Foundation Trust

Safeguarding Annual Report

May 2020

Contents

Introduction

All staff within the Walton Centre NHS Trust (WCFT) are committed to ensuring that safeguarding and the assessment of mental capacity of patients is given the highest priority in all that the Trust does. All safeguarding work is underpinned by the Trust values and is embedded throughout the Walton Way.

The Walton Centre remains committed to ensuring safeguarding is part of its core business and recognises that safeguarding children, young people and adults is a shared responsibility with the need for effective joint working between partner agencies and professionals, so that vulnerable groups in society are protected from harm.

In order to do this the Trust undertakes collaborative working to ensure that all of the services provided have regard to the duty to protect individual human rights, treat individuals with dignity and respect and safeguard them against abuse, neglect, discrimination, embarrassment or poor treatment. The balance between an individual's rights and choices and the need to protect those at risk, is acknowledged.

Our teams work in an increasingly complex safeguarding environment. It is a challenging time for NHS Trusts but by using existing resources to effectively safeguard those for whom we care, we can work to improve psychological wellbeing, mental health and improve the future of our society as a whole.

Purpose

The purpose of this annual report is to inform the Walton Centre NHS Foundation Trust Board, the Quality Committee and the Local Safeguarding Children and Adults Boards with an annual update on adult and children safeguarding activity across the Trust in the last year (April 2019 - March 2020).

This report summarises the safeguarding work undertaken across the Trust and demonstrates to the Trust Board and external agencies how WCFT discharges its statutory duties in relation to:

- ✓ Safeguarding children under section 11 of the Children Act (1989, 2004). All staff has a statutory responsibility to safeguard and protect the children and families who access our care.
- ✓ Safeguarding Vulnerable Adults in line with the Care Act 2014 and Department of Health Care and Support Statutory Guidance issues under the Care Act 2014.
- ✓ The Mental Capacity Act (2005) and Deprivation of Liberty Safeguards amendment in 2007.
- ✓ CQC Regulation 13: Safeguarding service users from abuse and improper treatment
- ✓ Working Together to Safeguard Children (2018).

Definition

Safeguarding adults' responsibilities as set out in the Care Act 2014 are to safeguard an individual over the age of 18 whom:

- Has needs for care and support;
- Is experiencing, or is at risk of, abuse or neglect;
- As a result of those needs is unable to protect him or herself against the abuse or neglect or the risk of it.

Safeguarding and promoting the welfare of children is now defined as:

- Protecting children from maltreatment
- Preventing impairment of children's health and development;
- Ensuring children grow up in circumstances consistent with the provision of safe and effective care;
- Taking action to enable all children to have the best outcomes.

Working Together to Safeguard Children (2018)

The Working Together to Safeguard Children was revised in April 2018. This guidance covers the legislative requirements and expectations on individual services to safeguard and promote the welfare of children, and a clear framework for action.

Trust Safeguarding Responsibilities

The Trust in its capacity as a specialist Trust has been identified in the role of an alerter organisation and as such has specific responsibilities and duties in respect of safeguarding children and adults.

As an alerter organisation, the role of the Trust is to ensure that staff are aware of what they are accountable for in terms of escalating and reporting any safeguarding concerns within the Trust.

All staff at the Trust have a responsibility to raise concerns with regards to safeguarding to their line manager or appropriate person. This information for staff is contained within the Trust Safeguarding policies.

All staff receive safeguarding training by attending a one off corporate induction session and 3 yearly mandatory safeguarding training via e-learning or face to face sessions, which is dependent upon job role and responsibilities, in line with the Intercollegiate Document 2018 for Adult Safeguarding and Intercollegiate Document 2019 for Children and Young People

Safeguarding Leadership and Accountability

The Executive Lead for Safeguarding is the Director of Nursing and Governance. This person has the responsibility of ensuring the appropriate resources are available to enable the Trust to discharge its safeguarding responsibilities fully. Operational responsibility is delegated to the Deputy Director of Nursing and the Matron for Safeguarding as the Operational Lead.

The Trust has a quarterly Safeguarding Group which is chaired by the Director of Nursing and Governance. The role of the Safeguarding Group is to ensure processes within the Trust are in line with the current legal framework and national guidance, promoting the well-being and safeguarding of vulnerable patients whilst in the care of the Trust.

There is also representation from external partners from the CCG designated safeguarding professionals and learning disability primary care facilitators within the local area. This Group seeks to provide assurance on all matters relating to safeguarding and reports to the Board of Directors via the Quality Group.

The Matron for Safeguarding is the Operational Lead and is a proactive member of the local external Safeguarding Board sub health groups, ensuring the Trust is linked in at all levels to multiagency developments and assurance. A briefing report from attendance at such groups regarding key points is submitted to the quarterly Safeguarding Group to share information and to provide transparency and collaborative working and learning.

Quality Assurance

Safeguarding Vulnerable People in the NHS – Accountability Framework was refreshed in July 2015 by NHS England. It states that all health providers are required to have effective arrangements in place to safeguard children and adults at risk of abuse or neglect and to assure themselves, regulators and their commissioners that these are working. These arrangements include:

- ✓ Safe recruitment practices and arrangements for dealing with allegations against people who work with children or adults at risk as appropriate.
- ✓ A suite of safeguarding policies including a chaperoning policy.
- ✓ Effective training of all staff commensurate with their role and in accordance with the Intercollegiate Competences 2018 (Adults) and 2019 (Children and Young People).
- ✓ Effective supervision arrangements for staff working with children /families or adults at risk of abuse or neglect.
- ✓ Effective arrangements for engaging and working in partnership with other agencies.
- ✓ Identification of a named doctor and a named nurse.
- ✓ Identification of a named lead for adult safeguarding and an MCA lead – this must include the statutory role for managing adult safeguarding allegations against staff.

- ✓ Developing an organisational culture where all staff are aware of their personal responsibility to report concerns and to ensure that poor practice is identified and tackled.
- ✓ Policies, arrangements and records to ensure consent to care and treatment are obtained in line with legislation and guidance including the MCA 2005 and the Children Act 1989 and 2004.

The Trust has the required full complement of safeguarding personnel.

A safeguarding adult and children team structure chart is given in Appendix 1 and Appendix 2.

Statutory Framework and National Policy Drivers

Safeguarding is a statutory responsibility of all NHS organisations, as detailed under the Care Act (2014), Children's Act (1989 and 2004). Legislation and guidance is built upon the principle that the welfare of the most vulnerable in our society is paramount and that all statutory services consider and promote the needs of children and vulnerable adults.

Working Together to Safeguard Children 2018

This statutory guidance has been revised in April 2018 and the revisions are reflective of the legislative changes introduced through the Children and Social work Act 2017.

- ✓ Replacement of Local Safeguarding Boards (LSCB) with local safeguarding partners
- ✓ Learning from serious cases and new regulations on local and national reviews
- ✓ Transfer of responsibility for child death reviews from LSCB to new Child Death Review Partners

The Children and Social Work Act 2017

The bill received Royal Assent in April 2017. The main purpose of the legislation is to:

- ✓ Improve decision making and support for looked after children in England and Wales
- ✓ Improve joint work at the local level to safeguard children and enable better learning at the local and national levels to improve practice in child protection
- ✓ Promote the safeguarding of children by providing for relationships and sex education in schools
- ✓ Enable the establishment of a new regulatory regime specifically for the social work profession in England.

Lampard Report 2015

The Trust continues to provide updates on recommendation 7 of the Lampard report to NHS England and these actions are monitored through the Trust Safeguarding Group.

`All NHS hospital trusts should undertake DBS checks (including, where applicable, enhanced DBS and barring list checks) on their staff and volunteers every three years. The implementation of this recommendation should be supported by NHS Employers`.

The Trust continues to undertake DBS checks for new starters and continues to require existing staff to complete an annual self-declaration regarding convictions. The DBS update service is currently offered for staff to sign up to at the point of entry to the Trust.

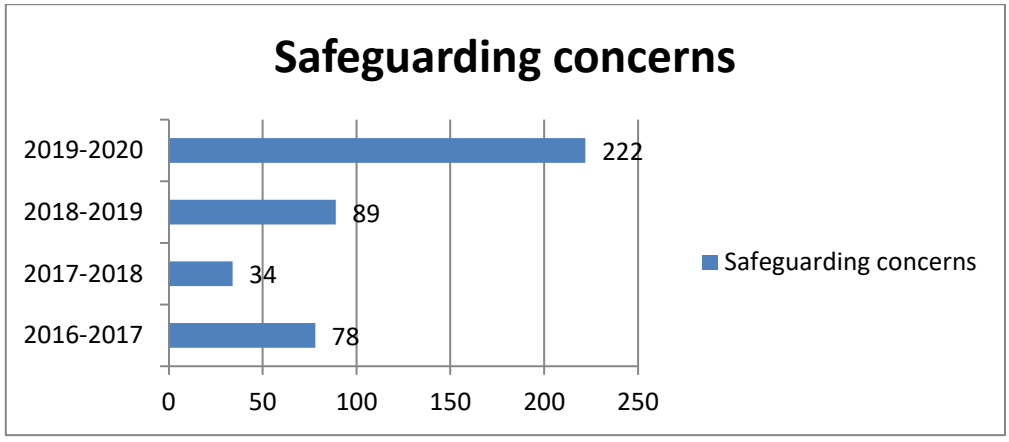
Adult Safeguarding Activity

Prevention, early identification/intervention and promoting the welfare of adults accessing our services are fundamental factors in safeguarding. The Trust's ultimate goal is to ensure that all patients receive care that reflects and responds to their specific needs and wishes, which includes keeping them safe from harm at all times, particularly when they may not be able to make decisions for themselves.

From April 2019 to March 2020, a total of 222 reported safeguarding adult incidents were noted on Datix of which the majority were categorised as minor harm.

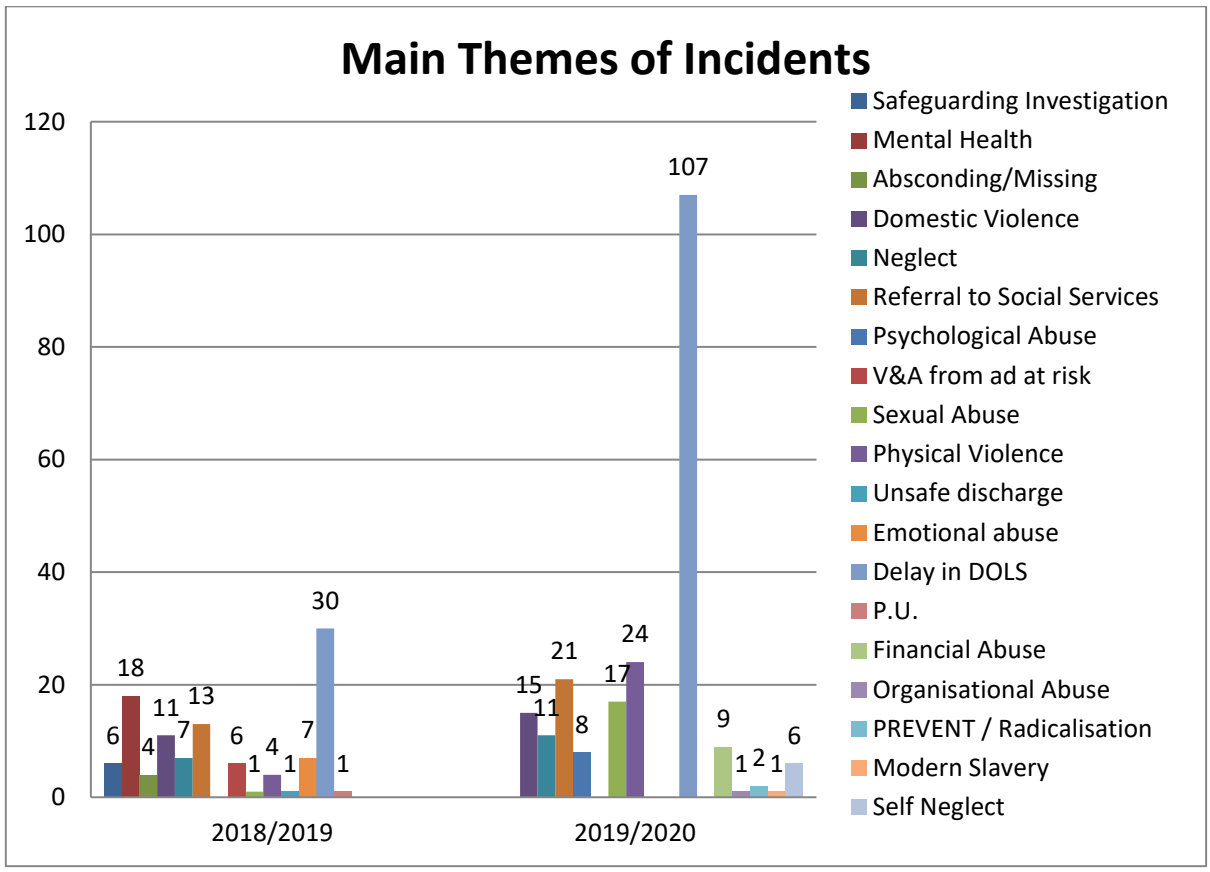
The Trust has seen an increase in Datix reporting of safeguarding concerns in 2019/2020. The increase is believed to be a result of the L3 face to face safeguarding training which was introduced in January 2019. These figures demonstrate that staff have a greater understanding of the full context of safeguarding and recognise when they need to escalate concerns.

Table 1 -Yearly summary of adult safeguarding alerts recorded on DATIX



The table below highlights the key themes/ trends which have been reported in 2019/2020 in comparison to 2018/2019.

Table 2 - Key Adult – Main Themes of Incidents 2018/2019 and 2019/2020



*Please note: some themes have changed over the reported 2 years, due to review of safeguarding reporting which will affect some specific comparisons.

Safeguarding Adult Reviews (SAR)

A Safeguarding Adult Review, formerly Serious Case Review, takes place when an adult at risk dies, or suffers serious abuse or neglect, and there are concerns about the multi-agency system. Safeguarding Adult Reviews are statutory under section 44, Care Act 2014.

The Trust has participates in Safeguarding Adult Reviews when requested.

Key Achievements for 2019 – 2020

- Training: 90% compliance for level 3 adult safeguarding, reached for Q4 reporting following the introduction of face-to-face training in January 2019.
- Significant increase in safeguarding themed Datix reporting – demonstrating staff's increased awareness of safeguarding responsibilities.

- Staff have initiated escalation and had positive involvement in a range of complex cases (various themes) resulting in MDT and multi-agency engagement. Safeguarding supervision has been provided for Trust staff during this work – thus enhancing and developing bespoke knowledge and skills across various staff disciplines within the Trust.
- The development of secure records/systems for Trust safeguarding activity and documentation, which is linked to a robust flagging/alert system for individuals at risk.
- Datix reporting system has been continuously reviewed and refined to enable more specific reporting in order to provide accuracy with external reporting and identifying safeguarding themes and trends.
- Involvement/management of an extremely complex safeguarding case with a number of external agencies (2 Local Authorities, 2 Police Forces, specialist agencies, multiple internal teams, multiple legal teams, Safeguarding Matron provided evidence in the Court of Protection). Consequently, the Safeguarding Matron has been invited to engage with local CCG's Harmful Practices Group to share the Trust's rare experience through a case review presentation.
- Successful recruitment of a Safeguarding & Mental Capacity Specialist Nurse and a Safeguarding Administrator.

Key Priorities for 2020 - 2021

- Improve overall compliance figures and staff's understanding for all areas of safeguarding training.
- Did Not Attend policy is currently under review – to finalise and have policy ratified.
- Full review of staff training needs analysis for all safeguarding related training – to align with Intercollegiate documents 2018 (Adults) and 2019 (Children).
- Full review of all safeguarding related training packages / training provision.
- Further develop safeguarding supervision provision within the Trust.
- Workstream to review safeguarding page on intranet.
- Safeguarding adult audit.

<u>Dementia</u>

Dementia is a significant challenge for the NHS with an estimated 25% of acute beds occupied by people with dementia. Their length of stay is longer than people without dementia and they are often subject to delays on leaving hospital.

Whilst work is underway to improve the nature of outcome data, the process of undertaking dementia risk assessment will set an effective foundation for appropriate management of patients.

In 2019/2020 as part of the Quality Indicator, the Trust was required to screen all emergencies over 75 years of age with a single question, there were 136 patients who met the criteria for dementia screening and 92 patients were screened. The Trust achieved 67.65% compliance for 11 months. March 2020 data submission

was suspended due to COVID outbreak. The low compliance for screening was due to the process being ineffective. This issue has been addressed and is currently being monitored.

Key Achievements in 2019-2020

- Quality Indicator – screening all emergencies over 75 years of age with a single question.
- Continue to signpost Liverpool patients with a diagnosis of Dementia to access post diagnostic support service via Mersey Care NHS Trust through our memory clinics in Outpatients.
- We continue to be signed up to Johns Campaign and welcome carers of patients with dementia in all areas of the hospital.
- The Trust became a member of the National Dementia Action Alliance (NDAA) in December 2019.

Key Priorities for 2020-2021

- Dementia awareness training continued as part of mandatory training and reached 89%. To push for and maintain compliance level (90%) with Dementia training.
- Trust Dementia Strategy to be revised and embedded throughout the Trust.
- To extend dementia screening to all patients over 75 years of age who are admitted as in-patients.
- To continue to offer and further develop the opportunity for staff and volunteers to become dementia friends / champions within the Trust.
- We will commit to become a dementia friendly organisation as highlighted in the Prime Minister's Challenge on Dementia 2020.
- We will promote the Dementia Friendly Hospital Charter within the Trust.
- We will self-assess our current position against the framework of dementia friendly principles developed by the NDAA and develop/update an action plan to submit on the NDAA website.

<u>Deprivation of Liberty Safeguards (DOLS)</u>

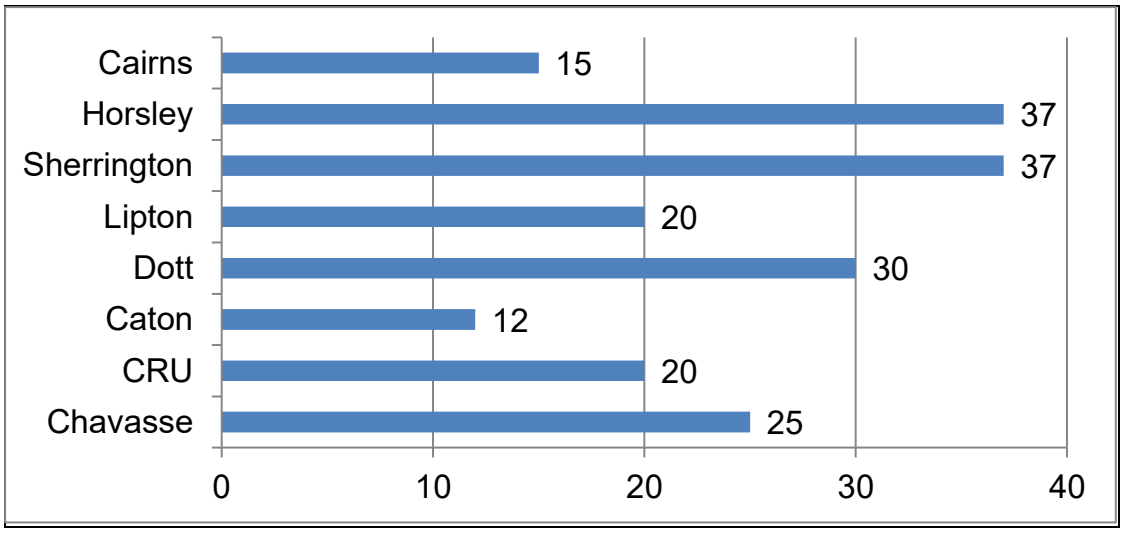
The Mental Capacity (Amendment) Bill: Liberty Protection Safeguards (LiPS), was given Royal Assent on May 16 2019 and was expected to be implemented by October 2020. However, due to COVID-19 outbreak, implementation planning is on hold.

Table 3 - Yearly summary of Deprivation of Liberty Safeguards Applications

2017 – 2018	2018 – 2019	2019-2020

160	**187**	**196**

Table 4- DoLS Applications within Wards in 2019/2020.



The table above highlights the ward areas submitting DoLS applications during the period from April 2019 – March 2020. Overall there were 196 DOLS applications submitted.

DoLS applications data is submitted quarterly as part of the Trust safeguarding KPI schedule. The following information was submitted over the last 4 quarters in 2019/2020

- 55 applications were urgent only and not assessed before transfer / discharge of the patient
- 112 patients were not assessed but remained an in-patient at time of the quarterly KPI submission
- 10 applications were authorised
- 6 were declined as patient had capacity
- 2 withdrawn as patient did not meet the criteria for DOLS
- 6 patients died before being assessed
- 6 patients were assessed by a Best Interests Assessor but paperwork not received at time of KPI submission.

Sherrington ward and Horsley unit both had the most DoLS applications with 37 each in total and Caton had the least with 12 in total. The reduction in applications from Caton ward may be attributed to the rise in applications from Horsely. This would indicate that the applications were being made at an earlier point during the patient admission which would be a positive shift, indicating that all ward/units were engaging with the DoLS process and the application was being made in a more timely manner.

It is expected that the implementation of the LiPS process will enable timely assessments and authorisations, in order to better protect the rights of the

patients involved with the process, thus avoiding legal breaches of the Mental Capacity Act. The high numbers of breaches currently observed at WCFT is a national problem. The Trust recently employed a Specialist Safeguarding and Mental Capacity Specialist Nurse, who will support with the implementation of LiPS.

Key Achievements in 2019-2020

- Additional to E-learning, supplementary face-to-face MCA/DoLS training sessions have continued since December 2018, to facilitate discussion in order to enable a better understanding of the subject.
- DoLS OLM (E-learning) training compliance has fallen to 84%, however an additional hour supplementary training (MCA and DoLS) has been provided along with the safeguarding adult L3 face to face training (Safeguarding Adult training is at 90% compliance). There is a need to look at the capture/merge of the additional face to face training figures to support compliance for DoLS training.
- DoLS database and a live working document is now well established. MIAA auditor commended the Trust on the robust DoLS process in place, during the audit. All outstanding actions were completed and signed off.
- The final MIAA action plan review took place in June 2019 and subsequent documentation for sign off was received by WCFT in December 2019.
- Internal audit on CRU (June 2019) – demonstrated an improvement in compliance with the DoLS process and a positive improvement with timely capacity assessments for patients.

Key Priorities for 2020-2021

- Implementation of Liberty Protection Safeguards (LiPS).
- Continue to drive compliance with DoLS training (90%).
- To audit compliance of correct documentation of DoLS applications, ensuring correct processes are adhered to.
- The Trust's Matron for Safeguarding will continue to support the Trust's compliance with DoLS legislation, by keeping abreast of changes as they occur and translating the legislative developments into practical guidance for frontline staff.

Mental Capacity Act (MCA)

The Mental Capacity Act (2005) is supported by the MCA Code of practice. It is imperative that clinicians adhere to the MCA code of practice when treating and caring for patients. This includes completing a comprehensive assessment of capacity and adhering to the five principles at all times. We must make every effort support our patients who have capacity issues in their decision making.

Key Achievements in 2019-2020

- Mental Capacity Act audit completed and was presented to Trust Safeguarding Group in July 2019. Recommendations from this audit are being monitored through the Safeguarding Group: positive results from the MCA audit.
- MCA OLM (E-learning) training compliance has fallen to 84%, however an additional hour supplementary training (MCA and DoLS) has been provided along with the safeguarding adult L3 face to face training (Safeguarding Adult training is at 90% compliance). There is a need to look at the capture/merge of the additional face to face training figures to support compliance for MCA training.
- MCA lead is a member of regional MCA forum which meets on a quarterly basis to network and share good practice.
- Positive engagement from Consultants and Specialist Nurses during outpatient clinics, regarding MCA and best interest decision making: requesting input from MCA Lead (Safeguarding Matron) to ensure robust compliance and use of the MCA and Best Interests framework with complex cases.
- Excellent progress with timely mental capacity assessments, utilising the electronic documentation on EP2.

Key Priorities for 2020-2021

- Review current training on Mental Capacity Act and ensure it is providing relevant information to staff.
- Continue to drive training compliance to >90% for MCA.
- Re-launch the Mental Capacity Act/DoLS Champions initiative.
- Re-audit to ascertain if recommendations of previous audit have improved practice.
- Review and update resources regarding the Mental Capacity Act on the Intranet and ensure that staff are aware of available resources via Walton Weekly and Team Brief.
- Continue work towards there being one process where all mental capacity assessments are recorded electronically (Outpatients system – EP2).

Domestic Violence and Abuse.

In the Domestic Violence, Crime and Victims Act 2004, it defines domestic violence as ‘any incident of threatening behaviour, violence or abuse (psychological, physical, sexual, financial or emotional) between adults who are, or have been intimate partners or family members, regardless of gender or sexual orientation’. The landmark Domestic Abuse Bill was published on 21 January 2019 and is aimed at supporting victims and their families and pursuing offenders.

To help tackle the crime, legislation:

- ✓ Provides statutory government definition of domestic abuse to specifically include economic abuse and controlling and manipulative non-physical

abuse - this will enable everyone, including victims themselves, to understand what constitutes abuse and will encourage more victims to come forward.

- ✓ Establishes a Domestic Abuse Commissioner to drive the response to domestic abuse issues
- ✓ Provides Domestic Abuse Protection Notices and Domestic Abuse Protection Orders to further protect victims and place restrictions on the actions of offenders.
- ✓ Prohibits the cross-examination of victims by their abusers in the family courts
- ✓ Provides automatic eligibility for special measures to support more victims to give evidence in the criminal courts

Serious Crime Act (2015) section 75

Controlling or coercive behavior may be present in an intimate or family relationship. The law classes' coercive controlling behaviour as a form of domestic abuse and it became a criminal offence in December 2015 under section 76 of the Serious Crime Act, which can be punishable with up to five years custodial sentence.

Key Achievements in 2019-2020

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- Safeguarding Matron has provided support and supervision when staff have raised domestic abuse/violence issues relating to patients and families; support was provided to complete the MeRIT (Merseyside Risk Identification Tool) checklist and if required to complete a referral to multiagency risk assessment conference MARAC (Multi-Agency Risk Assessment Conference) process, therefore supporting knowledge and confidence for staff dealing with this difficult and complex issue.
- The level 3 face to face Adult Safeguarding training session incorporates domestic abuse, including assessment, MARAC process, Clare's Law and harmful practices. Again this is providing staff with improved knowledge and confidence to enable staff to appropriately address this difficult and complex issue.

Key Priorities for 2020-2021

- Revise and update the Domestic Violence and Abuse Policy.
- To explore how to add `Routine Enquiry` questions to Trust documentation to prompt staff to ask if patient feels safe.
- To continue with face to face training and providing ad-hoc support and supervision for front line staff.

<u>Domestic Homicide Reviews (DHRs)</u>

The Statutory requirement related to domestic homicide reviews came into force in April 2011.The focus is a multi-agency approach with the purpose of identifying learning.

There has been no Trust involvement with DHRs in the 2019/20 period. The Trust engages with DHRs when requested.

Learning Disability Update

It is recognised that people with learning disabilities are more vulnerable in acute hospitals than the general population due to their additional complex needs. The goal is to continue to improve the safety and quality of healthcare for people with learning disability in The Walton Centre.

Key Achievements in 2019-2020

- Safeguarding Matron supports/co-ordinates support for patients with learning disabilities, families and carers, for in patients and outpatients, when required.
- Trust Learning Disability Steering Group has met on a quarterly basis with primary care learning disability facilitators as part of the membership.
- The Trust facilitated adjustments for a complex patient with a severe LD, to enable dual Trust engagement, in order to provide multiple specialist input under a single anaesthetic to avoid the stress of multiple appointments.
- Good attendance by WCFT representative at the bi monthly Liverpool and Sefton Learning Disabilities Liaison Network meetings
- Signed up to Mencap campaign `Treat me Well` in transforming how the NHS treats people with a learning disability.
- Developed an easy read patient admission booklet and it is placed on Trust Internet.
- Development underway of an easy read appointment/ admission letter for patients with a learning disability.

Key Priorities for 2020-2021

- Continue with development of an easy read appointment/ admission letter for patients with a learning disability.
- Learning disability training compliance is at 87% at year end. To drive and maintain compliance to >90%.
- The Trust to embed Mencap campaign `Treat me Well `.
- Embed the revised Learning Disability Policy within the Trust and ensure staff are aware of the support required for patients with a learning disability pre- admission and on arrival.
- Offer further opportunities for staff to become Learning Disability Champions within the Trust.
- To re-launch STOMP: the Trust has signed up to ‘Stopping over medication of people with a learning disability’, autism or both (STOMP). This is about all health care providers improving the use of psychotropic medicine, offering non-drug therapies and making sure that people, families and staff are fully informed and involved.

Prevent

Prevent is part of the UK's Counter Terrorism Strategy known as CONTEST. Prevent works to stop individuals from getting involved or supporting terrorism or extremist activity. Radicalisation is a psychological process where vulnerable and/or susceptible individuals are groomed to engage into criminal, terrorist activity.

Within health, NHS Trusts and Foundation Trusts are specifically mentioned in the Duty. However, Prevent is part of mainstream safeguarding and therefore all health care staff must ensure vulnerable people are safeguarded.

The Trust has submitted 2 external Prevent referrals over the last 12 months.

The Prevent Lead for the Walton Centre is the Matron for Safeguarding and represents the Trust at the city wide and regional Prevent meetings. There are two accredited Prevent WRAP 3 trainers for the Trust who are the Matron for Safeguarding and Practice Educator. Training figures are submitted as part of the safeguarding KPIs on a quarterly basis.

Key Achievements in 2019-2020

- Prevent training has reached compliance for Prevent Awareness training and Prevent WRAP training at 92% and 91% respectively.
- Prevent Lead continues to attended the regional Prevent forums and feedback of significant information to the Safeguarding Group.
- The Trust continues with the Unify data submission for Prevent on a quarterly basis.

Key Priorities for 2020-2021

- Review and continue to provide Health WRAP (Workshop for Raising Awareness of Prevent) level 3 training as an e-learning module to patient facing staff.
- Add Prevent guidance to the Safeguarding page of the Intranet so allow staff easier access to relevant information.
- Raise the profile of Prevent to encourage staff to report concerns regarding Prevent, as the Trust has low reporting activity on this issue.
- For the Prevent Lead to attend at least 2 forums in 2020/21 which is a requirement in the Prevent Training and Competencies Framework.

Safeguarding Children Activity

The Datix system records the number of safeguarding children incidents made in the various departments across the Trust. The system has been updated to allow for identification of how many of those alerts are subsequently generated into formal safeguarding referrals or early help referrals.

During 2019/2020 the Trust has continued to see an increase of activity in safeguarding children in comparison with previous years (as shown in table

below), demonstrating increased knowledge and confidence in escalating and reporting issues.

Table 5 - Yearly summary of safeguarding children alerts recorded on DATIX

2017 – 2018	2018 - 2019	2019 - 2020
3	13	24

Child Exploitation

The issue of CE has continued to receive high media coverage over the last few years and the Department of Education released new guidance for practitioners, 'Child sexual exploitation: definition and guide for practitioners' (February, 2017). The new definition now includes the irrelevance of perceived consent.

However, there is a commitment within Merseyside to safeguarding children and young people from being sexually exploited or criminally exploited, whilst disrupting and prosecuting individuals who have exploited them.

An overarching term of Child Exploitation is used to encompass both criminal and sexual exploitation of children. A protocol has been developed which provides a set of multi-agency principles for tackling Child Exploitation across Merseyside.

Key Achievements in 2019-2020

- Significant increase of Datix reporting for Safeguarding Children and referrals. Further information from the Datix report confirms submission the following referrals – safeguarding / MARF (Multi-Agency Referral Form) / EHAT (Early Help Assessment Tool). The multiple types of referrals that have been made, evidences that staff are identifying the need for early intervention/support rather than crisis/at risk intervention only. This is an excellent development in staff engagement with Safeguarding Children.
- There is a designated SPOC (Single Point Of Contact) within the Trust which is the Matron for Safeguarding.
- Safeguarding training includes information about how to identify the signs of sexual exploitation.
- The Trust is part of Liverpool CE (Child Exploitation) Health Forum which is in place to lead on the issue of sexual exploitation, driving work forward and ensuring effective cooperation between agencies and professionals.

Key Priorities for 2020-2021

- Continue to drive training compliance for 'Safeguarding Children'.
- Full review of all training packages to ensure up to date legislation, policy and procedures, in particular child exploitation (CE) and Children in Care (CiC).

- Full review and update of all relevant Safeguarding Children guidance on safeguarding page on Trust Intranet.
- Ensure relevant staff (level 3 safeguarding children) attend LSCB training on Child Exploitation.
- To further develop supervision processes within the Trust.

Did Not Attend under 18

Missing appointments for some children may be an indicator that they are at an increased risk of abuse. There are many innocent reasons why children miss appointments, but numerous studies have shown that missing healthcare appointments is a feature in many Serious Case Reviews, including those into child deaths.

Within Health there is now a move towards the concept of Was Not Brought (WNB) rather than Did Not Attend (DNA) for children and young people. It is rarely the child's fault that they miss appointments.

Our Trust cares for 16-17-year-old patients in the clinical wards and outpatient's department and in satellite clinics and we have an escalation pathway in place for under 18-year olds who do not attend (DNA) clinic.

In 2019/20 there were 121 DNA's for patients under the age of 18 who did not attend outpatient clinics. This is a year on year increase: 112 DNAs for 2018/19 and 100 DNAs for 2017/18 (under the age of 18).

Key Priorities for 2020-2021

- Trust 'Was Not Brought' pathway and guidance is currently under review.
- Safeguarding Matron is part of CCG 'Was Not Brought' review group, currently reviewing local policy and procedures.
- Was Not Brought pathway to be included in pending DNA Policy.

Female Genital Mutilation (FGM)

Female Genital Mutilation (FGM) is child abuse and illegal.

Healthcare professionals must report to the police any cases of female genital mutilation (FGM) in girls under 18 that they come across in their work. This duty came into force on 31 October 2015.

Staff have been notified of the need for mandatory reporting and there has been an increased focus on FGM in all levels of safeguarding children training.

During 2019/20 the Trust reported 0 cases to NHS England.

Education and Training

The Trust continues to show an on-going commitment in ensuring that all staff receives appropriate safeguarding training. A Safeguarding Training Needs Analysis (TNA) has been developed which sets out the requirements and arrangements for safeguarding training provision for all WCFT employees including those on bank, honorary contracts or volunteers.

Table 7 – Safeguarding Adult Training Compliance for 2019-2020.

Trajectory to reach 90% at year end. Year End compliance			
Safeguarding Adult Training	Safeguarding Training Compliance at end of March 2020.	Number of staff compliant	Total number of staff
Adults Level 1	91%	1304	1436
Adults Level 2	88%	989	1118
Adult Level 3	90%	222	246
Adult Level 4	66.66%	2	3
Dementia Awareness	89%	1275	1436
Prevent Awareness	92%	1326	1436
Prevent WRAP	91%	1018	1118
MCA/DOLS	84%	857	1017
Learning Disability Awareness	87%	1246	1436

Table 8 – Safeguarding Children Training Compliance for 2019-2020.

Trajectory to reach 90% at year end. Year End compliance			
Safeguarding Children Training	Safeguarding Training Compliance at end of March 2020.	Number of staff compliant	Total number of staff
Children Level 1	91%	1308	1436
Children Level 2	91%	1013	1118
Children Level 3	100%	40	40
Children Level 4	50%	2	4

Key Achievements for 2019-2020

- Training compliance target of 90% was reached for the first reporting of Safeguarding Adults L3 face-to-face training (commenced January 2019).
- Overall PREVENT training compliance has been reached at year end.

Key Priorities for 2020-2021

- For appropriate staff to attend planned L4 safeguarding children training sessions from NHSE when suspension of training is ceased, post COVID.
- Continue to provide consistency in reporting all aspects of safeguarding training to effectively monitor the delivery of training and identify gaps in training and address as it occurs in year.
- Continue to report training compliance both at clinical and non-clinical level at Committee and Trust Board.
- Monthly monitoring of the level of compliance with safeguarding training to meet and exceed target of 90%.
- To continue to provide a monthly Trust Safeguarding training report.
- Address medical staff low compliance with safeguarding training as a priority and ensure plans to accredit prior learning are in place by training and development team. To set monthly trajectories and link with clinical leads for each division and the Medical Director and present to the Trust Safeguarding Group.

<u>Policies and Procedures</u>

Safeguarding is a rapidly changing and growing area of work. As such it is essential that policies and procedures are revisited and updated accordingly. The Trust has a range of policies that support staff in safeguarding children and young people and adults at risk. Liverpool Safeguarding Adults Board Inter-agency safeguarding adult's policy and procedures is the overarching policy that supports local safeguarding policies.

Over the past 12 months the following policies have been reviewed and refreshed:

- Deprivation of Liberty Safeguards (DoLS) – July 2019
- Mental Capacity Act (MCA) – July 2019

All safeguarding related policies were reviewed when the Safeguarding Matron started in post (December 2018), hence they require review again now.

Responsibilities of all staff employed by The Walton Centre Foundation Trust for safeguarding children and adults are documented in WCFT Safeguarding Policies

<u>Monitoring</u>

External

Adult and Children Safeguarding are required to satisfy the requirements of Key Performance Indicators (KPI) as set by the Clinical Commissioning Group. These include offering assurance on safeguarding activity throughout the Trust. The KPI

for Safeguarding requires a quarterly submission to the CCG Safeguarding Service.

Internal

To ensure the Trust has processes in place to discuss and learn from the raising of concerns and to keep up to date with national policy and literature, the Safeguarding Group receives quarterly performance and annual reports.

The membership of the committee includes external representation from the Safeguarding commissioning leads, departmental heads, risk leads, named doctors and named nurses. This group is chaired by the Director of Nursing and Governance.

Safeguarding Audit

The Trust has undertaken the following safeguarding audit in 2019/2020:

- Mental Capacity Act (MCA)
- Deprivation of Liberty Safeguards (DoLS)
- Learning Disability

The Trust audit plan is to be reviewed by CCG in Q1 of 2020/21.

Safeguarding Supervision

Safeguarding group supervision within the Trust continues as a standard agenda item on the quarterly Safeguarding Group. The Matron for Safeguarding is accredited to offer safeguarding supervision to Trust staff if required. It is recognised that staff will often require advice or support in relation to safeguarding adults outside of formal supervision sessions.

The Trust has a Safeguarding Supervision Policy which provides the framework for safeguarding supervision to be provided within the Trust.

Key Priority for 2020-2021

- To review and further develop the Safeguarding Supervision Policy and framework.
- To look at ways to capture data for the different modes of safeguarding supervision currently provided to staff.
- To develop the intranet safeguarding page to disseminate 7 minute briefings for staff, to receive the learning from Serious Case Reviews / Safeguarding Adult Reviews / Domestic Homicide Reviews etc.

Overall Key Priorities for 2020/2021

- Draft an organisational safeguarding strategy with nominated staff as part of a task and finish group.
- Continue to progress work required to achieve KPI requirements for safeguarding.
- Continue to complete actions identified on safeguarding work plan.
- Continue to ensure that safeguarding mandatory training meets 90% compliance by end of 2020-2021.
- Revise and develop Trust safeguarding policies to reflect statutory requirements.
- Continue to develop the use of electronic systems to further improve and develop robust governance around safeguarding data and information sharing and storage in view of GDPR (General Data Protection Regulation).
- It is recognised that the point of transition from child to adult services is a time of risk for vulnerable young people and we will ensure that the team work involved in transition is robust.
- The Trust is committed to having robust safeguarding processes in place and once a safeguarding concern is escalated, the person is protected, and information is shared appropriately. The Trust will continue to review it's processes considering case reviews and guidance from Liverpool and Sefton Safeguarding Boards.

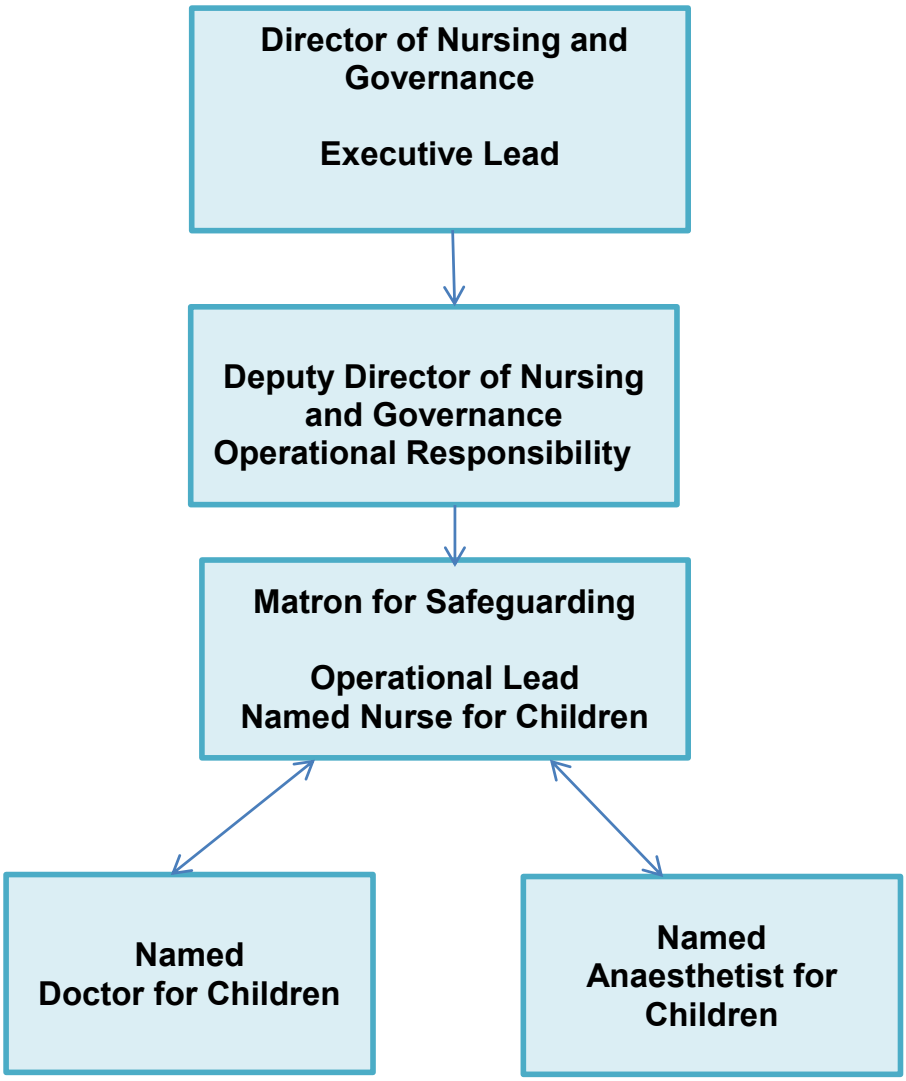
Conclusion

Our Safeguarding work plan demonstrates the progress made however we recognise there is further work required. The underpinning message remains the same in that safeguarding is everyone's business, irrespective of role or position. The safeguarding team will continue to strive to embed the mind-set that safeguarding is not an 'add-on', it is core business. It is everyone's responsibility to safeguard and protect the most vulnerable adults and children in our society. The child and adult at risk must remain at the centre and motivation of all our actions.

The Annual Report has provided an insight into the complex areas of safeguarding and progress made over the last 12 months. In doing so it aims to provide assurance to the Trust Board that we remain fully committed to ensuring we meet and exceed our statutory responsibilities in relation to safeguarding all our service users.

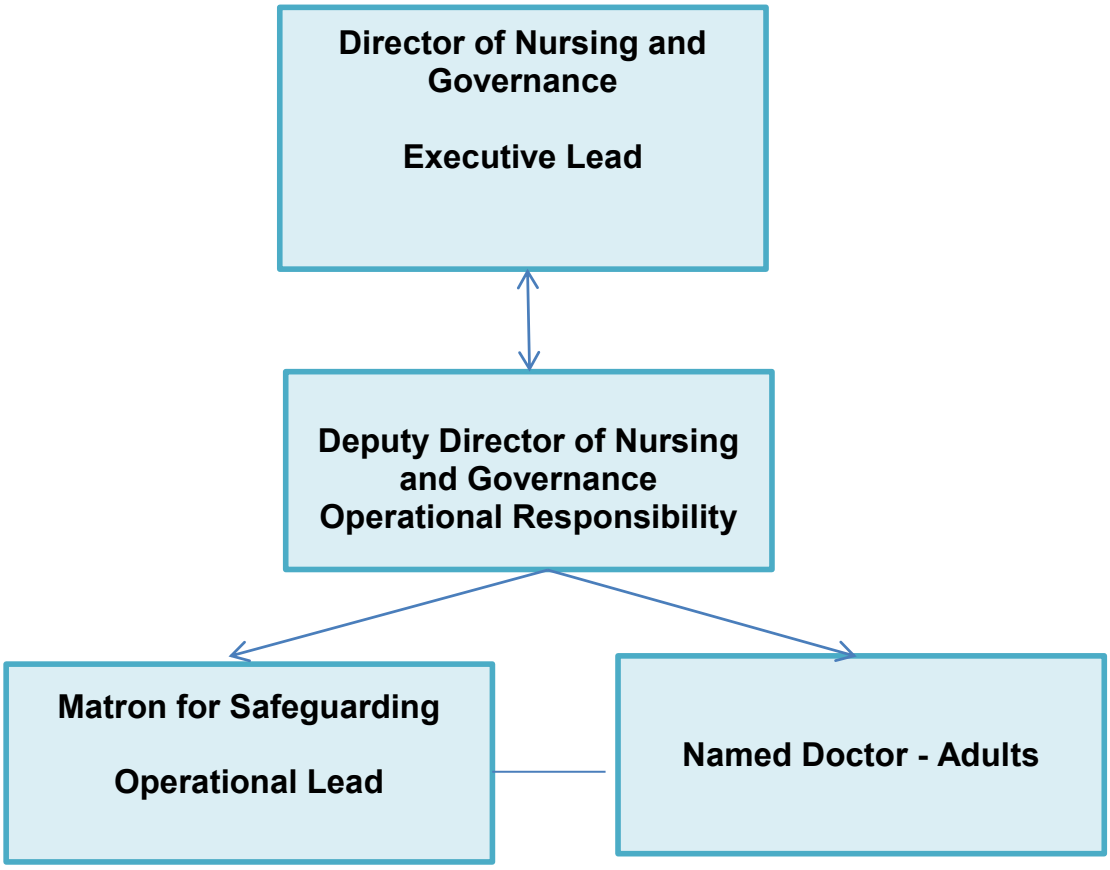
Appendix 1

Safeguarding Structure for Children



Appendix 2

Safeguarding Structure for Adults



The Walton Centre
NHS Foundation Trust

Respect Caring Openness Pride Dignity

Governance, Risk and Patient Experience

Annual Report for 2019/20

"Governance is a framework to receive, assess and act upon information we know about the services that we provide. Good governance provides assurance about the key issues and themes relating to the safety and experience of patients and staff. Governance is the backbone of the organisation."

1. Introduction

This annual report has been compiled during the COVID-19 outbreak. Due to the impact of COVID-19, some elements of process have had to be adapted due to the operational constraints on services. This includes:

- Duty of Candour written notification - although verbal notification is still taking place as per Specialist Commissioners written agreement
- Volunteering - due to the impact of COVID, volunteering was suspended, although activity prior to suspension has been included
- Reporting data (Q4) - may be altered due to a significant change in bed occupancy

1.1. The purpose of this report is to provide:

- a summary of Governance activity across the Trust in 2019/20, comparing results of data with those of 2018/19 (variance shown relates to a comparison with the previous financial year)
- an update on patient safety, incident management, patient experience, concerns, complaints, claims, volunteering, risk management, resilience and health and safety
- assurance to the Trust Board that issues are being managed effectively, that robust actions are taken to mitigate risk and reduce harm and that we learn lessons from incidents, complaints, concerns, claims and deaths

NB: This data is accurate from the date the reports were generated for each financial year. There are occasions when incidents are retrospectively reported or complaints or claims withdrawn and those amended figures may appear in subsequent reports. Unless otherwise specified, text, tables and charts refer to 2018/19 and 2019/20.

2. Executive Summary

2.1. Incident reporting

There has been a slight reduction in overall incident reporting from 3184 in 2018/19 to 3134 in 2019/20. On review, the category with the main decrease relates to “communication incidents.” See section 1 on page 14.

2.2. Serious Incidents (SI)

There was a notable decrease as 11 serious incidents were reported to the Commissioner in the year 2019/20, compared to 18 the previous year 2018/19. See section 1 on page 15.

2.3. Moderate & above incidents (including Duty of Candour)

Moderate harm incidents have increased slightly by 3 incidents, increasing from 61 2018/19 to 64 2019/20.

62 of those incidents reported in 2019/20 required verbal and written notification to the patient/relative/next of kin, under the statutory requirements of Duty of Candour.

NB: 2 of these incidents involved staff members.

3. Annual Incident Themes

3.1. Communication

Communication incidents decreased from 565 in 2018/19 to 439 in 2019/20. "Communication failure outside the team" had the greatest decrease, from 211 in 2018/19 to 99 in 2019/20.

NB Although a decrease in incidents relating to communication can be seen on review of annual statistics, communication will be continued to be monitored via the Governance Assurance Framework Ref 304, following:

- a steady increase in complaints and concerns received in 2019/20
- the results from the Trusts annual staff survey, that have also identified concerns with "communications issues"

3.2. Safeguarding concerns & Deprivation of Liberty (DoLs) applications

Safeguarding concerns (historical) have increased significantly from 2 in 2018/19 to 246 in 2019/20, with the main area of increase relating to an increase in the "delay in Deprivation of Liberty (DOLs) applications." NB: this category was only introduced in the latter stage of Quarter 4 2018/19.

3.3. Violence & Aggression

There has been a slight reduction in incidents from 285 in 2018/19 to 272 in 2019/20.See section 2 on page 19.

3.4. Learning from Deaths

There was an increase in reported deaths from 78 in 2018/19 to 92 in 2019/20. See section 4 on page 22.

3.5. Information Governance incidents

Information Governance incidents have remained constant from 214 in 2018/19 to 213 in 2019/20.

3.6. Fire safety incidents

Fire safety incidents have decreased from 45 in 2018/19 to 25 in 2019/20. See section 9 on page 35.

4. RIDDOR

RIDDOR reportable incidents have increased from 10 in 2018/19 to 12 in 2019/20. See section 9 on page 34.

5. Risks

There was an increase in risks reported on the Trust wide Risk Register from 67 in 2018/19 compared with 73 in 2019/20. See section 8 on page 33.

6. External audit

6.1. Risk Management arrangements

An MIAA review of the Trusts Risk Management Arrangements, received a score of Significant Assurances in 2019/20. A number of minor recommendations are being progressed and monitored by the Patient Safety & Quality Group.

7. Complaints/Concerns/Claims

7.1. Complaints

There was an increase in the number of formal complaints received with 129 in 2019/20 compared to 95 in 2018/19. The increases in numbers are reflected in the current themes, with formal complaints mainly relating to “appointment arrangements” and “communication.” See section 5 on page 25.

7.2. Concerns

There was an increase in the number of concerns received with 486 in 2019/20 compared to 382 in 2018/19, the increase in numbers are reflected in the recurrent themes of “appointment arrangements” and “communication” as with formal complaints.

7.3. Compliments

The total number of compliments received via the Patient Experience Team was 287 in 2019/20, a decrease from 520 in 2018/19. See section 7 on page 29.

7.4. Lessons Learned from closed claims and coronial reviews

Lessons Learned from closed claims and coronial reviews are detailed within the report.

8. Patient Experience

8.1. Volunteers

Volunteers have donated >7,500 hours from 79 volunteers currently working across the Trust. See section 5 on page 27.

8.2. Friends and Family Test (FFT)

The Trust results for FFT remained very positive for 2019/20 both in terms of recommended rate and response rate and consistent across all wards. The Inpatient Response Rate was consistent between 97-98% each month which demonstrates the positive experience received by both patients and their families. See section 6 on page 28.

8.3. Claims

There are 48 open CNST claims at the end of 2019/20. Of these, 4 are periodic payment claims, 3 have agreed Damages out of Court, 6 are being defended, 9 have repudiated Letters of Response served, 8 Letters of Response have agreed admissions, for 4 Letters of Response, the Trust have challenged the claim, 1 claim has been discontinued with costs to be agreed. The remaining claims are at various stages and are currently on-going.

There are 6 Employer/Public Liability open claims. Of these 2 have repudiated Letters of Response served, for 1 claim the Trust have challenged the claim in the Letter of Response, 1 claim has settled, 1 claim has exited the claims portal and 1 claim is on-going. See section 8 on page 30.

Governance Assurance Framework (GAF) Log

Theme	Context	Analysis	Action	Recommendation
REF287 Violence & Aggression (V&A) 09.10.2017	Feedback from incidents continues to highlight the issue of violence/ aggression against staff. This has also been highlighted in the 2018/19 staff survey. Issues of V&A are also discussed at the Safety Huddle meeting. **Lead:** LSMS (Health Safety & Security Group).	There has been a reduction in incidents from 285 in 2018/19 to 272 in 2019/20.	Personal Safety Trainer or security management specialist attending wards following incidents of V&A, supporting staff following incidents and supporting the development of risk assessments, solutions and to ensure most appropriate techniques are being used to manage the patient. In addition, there has been the development of bespoke training packages including new training package developed between Personal Safety Trainer and the Moving and Handling advisor to further enhance the training being provided to staff. Daily escalation of V&A issues are now included at the Safety Huddle. All ISS security staff has now attended the Trust's personal safety training. Collaborative working between the Safeguarding matron and personal safety trainer to ensure safeguarding/DOLS issues are all included within the relevant training programme.	Continue with the Violence and Aggression working group to identify further work streams to help support staff and manage challenges. The trust is currently in the process of recruiting a replacement for the Personal Safety Trainer in Q1. **Recommendation - Continue to monitor.**

Theme	Context	Analysis	Action	Recommendation
REF 286 Appointments Cancellations/Delays 16.01.2018	Poor patient and staff experience due to cancelled or delayed appointments. Problems with appointment letters and patients not being able to get through to PAC to book/cancel appointments. It is anticipated that there will be a significant increase in DNAs, complaints and this will affect staff/patient experience going forward **Lead:** Neurology Operations Services Manager (Governance and Risk)	There has been a noted increase in concerns received in 2019/20, regarding appointment issues. Increase in issues in 2019/20, relating to patients unable to get through or cancel appointments with PAC due to insufficient IT/Telephony infrastructure.	Service improvement work continues regarding outpatients/appointments. Data regarding increase in concerns and complaints relating to appointments is provided to the divisions to support service improvement work. MITEL installation and training to be completed by 30/05/2020.	It is recommended that this remain on the Governance Assurance Framework to monitor whether improvements in patient and staff experience are sustained. **Recommendation - Continue to monitor**
REF 294 Patient Case Notes 04.01.2018	An increase in the number of incidents involving the misfiling of patients notes, which could have the potential to cause major harm to a patient. **Lead:** Digital Health Records & IG Manager (IGSF)	A slight decrease can be noted on review of the Quarter statistics.	Health records incidents continue to be reviewed at IGSF monthly. All incidents being reviewed and fed back to departments at the time. All user email, Walton Weekly, Team Brief, Trust Safety Huddle and clerk team meetings have communicated this issue to all staff. Code of conduct for employees in respect of confidentiality has also been amended to ensure staff know to check three demographics when performing a task involving personal identifiable information.	Slight improvement again has been noted in figures in Q4 of patient case notes being incorrectly filed. **Recommendation - To be closed** (as incidents seem to be improving over the year and brought back as an exception if incidents increase).

Theme	Context	Analysis	Action	Recommendation
REF 293 Patient Falls 04.01.2018	An increase in the number of falls is evident when reviewing quarterly and annual statistics. **Lead:** Practice Educator (Falls Steering group).	Patient falls decreased from 252 in 2018/19 to 225 in 2019/20. Fall - Not witnessed / found on floor has the highest decrease in incidents, decreasing from 115 in 2018/19 to 92 in 2019/20.	Incidents are reviewed at the Safety Huddle and monitored through the Monthly assurance reports. Falls incidents are discussed at Falls Prevention Steering group (FPSG). Monthly analysis is sent to ward managers for sharing with staff. The Trust are looking at different falls equipment and falls sensors in bathrooms; our high risk area for falls. Real time questionnaire are continued post fall. Share ownership of falls with patients who have capacity and who choose to ignore advice. Fall leaflets for inpatients has been reviewed and updated. New falls leaflet for outpatients with long term conditions being developed. This is waiting external printing, estimated completion in June 2020. Annual health and safety is an opportunity to discuss with staff, falls incidents, RCA findings and falls prevention work plan. The Trust have been collecting data for the National Falls CQUIN. Monitoring compliance against mobility assessments, drugs known to cause issues with balance and lying and standing blood pressure.	It is recommended that this remain on the Governance Assurance Framework to monitor whether improvements in patient experience are sustained. **Recommendation - Continue to monitor**

Theme	Context	Analysis	Action	Recommendation
REF 296 Delayed clinic letters 08.01.2018	Increase in concerns and complaints relating to delayed clinic letters. Concerns raised that this has led to delayed scan results and medication changes. **Lead:** Neurology Operations Services Manager (Governance and Risk)	There was an increase in complaints regarding issues with clinic letters which could lead to patients not receiving changes to their medications in a timely manner.	Improvement work has been taking place, which may be linked to the decrease in concerns and complaints. However, we may wish to monitor this further to see sustained improvement. Full action plan in place since August 2019 to address the ongoing issues within the Neurology secretariat such as: communication, processes and system wide concerns. This action plan is monitored monthly with HR and the division. Neurology secretariat agreed to ad-hoc outsource typing when department is experiencing unforeseen workforce pressures e.g. sickness/absence, spikes in activity and peak holiday periods. Significant improvements identified staff morale improving and genuine engagement with action plan.	It is recommended that this remain on the Governance Assurance Framework to monitor whether improvements in patient experience are sustained. The overdue delayed clinic letters have reduced significantly over the last 3-6 months due to changes in working practices and methods and the utilisation of outsourced typing. The current backlog is minimal and we predict the KPI will continue to improve monthly and that we will meet KPI typing targets. Clinicians are being reminded weekly to verify documents in a timely manner; however, there are still some significant delays which will continue to be addressed. **Continue to monitor**

Theme	Context	Analysis	Action	Recommendation
REF 300 Rejection Of Pathology samples by LCL 02.10.2018	Pathology samples may be rejected by Liverpool Clinical Laboratories (LCL) if request forms are incomplete and do not meet the acceptance criteria set out in both the Neuroscience Laboratories Specimen Acceptance Policy and LCL Minimum Data Standard Policy for Laboratory Investigations. This will lead to a delay in results and potential re-sampling requirements. **Lead:** Labs Quality & Governance Manager (Neurosurgery Division Governance Meeting).	Rejection data now received monthly from LCL. In total, approx. 60 samples per month are rejected across the Trust. It is not possible to determine the number of tests this equates to or the percentage of requests affected. OPD and HITU highest affected locations. Rejections may increase in the near future when samples will be rejected if time of collection is not included following a SUI.	Monthly rejection data now sent to Matrons and OPD, HITU and Ward Managers. OPD now preparing samples from late clinics and retaining at WCFT until the following day. OPD staffs have received training on laboratory processes and specimen requirements. Addressograph labels to be used on microbiology samples. When applicable, communications to be given about rejections associated with lack of time on request. IT has prepared a prioritisation document for an order communications systems within pathology. This would ensure requests would be completed correctly and reduce number of rejections. Discussed regularly by Division.	Incidents to be monitored through Datix. **Recommendation - Continue to monitor**

Theme	Context	Analysis	Action	Recommendation
REF 301 Fire Safety Compliance 17.01.2018	Following the OPD/NRC fire, and subsequent Merseyside Fire Service investigation, in addition to the inspection of the Walton Centre, the following legislative breaches were identified: - maintenance of fire compartmentation lines - access to records of maintenance information provided by Aintree Estates Department **Lead:** Estates Manager (BPC).	The Fire Service identified serious breaches in the OPD/NRC fire compartment lines post fire. These gaps were as a result of the original building works not being inspected and signed off as compliant as part of the schemes governance arrangements. These gaps were not fully identified in a subsequent survey by a competent contractor in 2015 post a DH Estates Alert.	A registered fire compartmentation contractor is currently on site undertaking reinstatement works. An action plan is monitored by the Head of Risk. The works are ongoing throughout the main site. Sid Watkins Building has been surveyed and no remedial action is required.	Continue to monitor until remedial compartmentation works are complete. Due to COVID 19, the remedial works in ITU cannot be progressed and is under constant review to seek a window to mitigate existing breaches in compartmentation **Recommendation - Continue to monitor.**

Theme	Context	Analysis	Action	Recommendation
REF 302 Safeguarding 09.07.2019	Increase in safeguarding incidents reported to the commissioner in 2019/20 as a result of the implementation of new safeguarding section in DATIX. It is anticipated that there will be a significant increase in incidents going forward as staff receive further education. **Lead:** Safeguarding Matron (Quality Committee)	Following the implementation of enhanced training for staff, there has been a significant increase in the identification of incidents of abuse/neglect. This increase in DATIX reporting in the financial year 2019/20 is a positive indicator regarding staff knowledge and appropriate action in response to safeguarding concerns. There is also an increase in the reporting of DATIX breaches due to untimely Local Authority assessment of the applications. This is in line with the revised Trust policy and processes for Deprivation of Liberty Safeguards (DoLS) applications. The increase in safeguarding themed Datix has continued throughout the year.	The DATIX reports will continue to be monitored with oversight from the Safeguarding Matron and Executive Safeguarding Lead to ensure that appropriate escalation/actions/referrals are addressed.	To continue to monitor to ensure appropriate reporting of safeguarding incidents. Reporting is now split into 2 groups: safeguarding concerns and safeguarding incidents. **Recommendation - Continue to monitor.**

Theme	Context	Analysis	Action	Recommendation
REF 304 – Communication 19.12.2019	Communication issues have been identified via number of sources, including the staff survey (2019/20), incidents, concerns and complaints. **Lead:** Divisional Governance and Risk meeting	Communication incidents have had the biggest decrease in incidents from 565 2018/19 to 439. It was identified from the 2019/20 staff survey results that issues have been identified with Communication.	• Introduction of Divisional KPIs to monitor, measure and reduce complaints and concerns • Divisions to review current processes for escalation of concerns and complaints • Divisions to identify how learning can be embedded to prevent concerns occurring	Monitor via Incidents, complaints and concerns. **Continue to monitor in Q1 20/21 once actions underway.**

Theme	Context	Analysis	Action	Recommendation
REF 305 – Legionella 19.12.2019	Legionella positive samples found in water outlets in Walton Centre. **Lead:** Estates Manager (BPC).	Following an identified problem on Lipton Ward, raising a risk, which led to the testing for legionella bacteria. The samples returned identified a number of positive outlets for Legionella pneumophila serogroup 1. Further extended sampling across the following wards has shown the existence of the same in Dott, Cairns, Chavasse, Horsley and Sherrington.	An exercise was undertaken to pasteurise the system by raising the hot water temperature to circa 80°c followed by further re-sampling. Additional measures undertaken include the implementation of a thorough flushing regime to all areas and the installation of an additional hot water return shunt pump to try and get the water circulating better. Re-sampling results have shown that, although not eradicated, the readings obtained are showing a downward trend which suggests the measures being taken is having a positive impact. In order to protect the patients further, Point of Use filters (POU) have been fitted to all outlets where it is possible for them to be fitted. Recent samples of cold water in Jefferson Ward brought one area back as positive. Upon investigation, there appears to be possible reasons why this may have occurred and these have been rectified. Additional sampling is underway to establish if this has improved the water quality. Works associated to eliminating legionella from the water systems are widespread and lengthy; therefore, there will be no “quick-fix” to the problems being experienced.	Continue with remedial, re-sampling regime and flushing. Continue to work through Water Safety Action Plan (from Hydrop). Due to the complexity of remedial works, filtration of outlets, it is difficult to estimate a completion date. **Recommendation – Continue to monitor.**

Section 1 - Incident Management

This section provides a detailed report of the number and type of incidents reported during 2019/20 compared with 2018/19. The Walton Centre NHS Foundation Trust (WCFT) is committed to the Health, Safety and Welfare of patients, visitors, contractors and staff. Accurate reporting of incidents and near misses is essential in order to reduce risks, avoid untoward incidents and subsequent harm.

TRUST WIDE	Trend 18/19	Q1 18/19	Q2 18/19	Q3 18/19	Q4 18/19	18/19	Trend 19/20	Q1 19/20	Q2 19/20	Q3 19/20	Q4 19/20	19/20
Incident												
Total number of Incidents		775	729	806	874	**3184**		740	819	840	735	**3134**
Neurosurgery		506	455	506	519	**1986**		468	499	498	435	**1900**
Neurology		235	236	256	307	**1034**		230	281	299	267	**1077**
Corporate		34	37	45	48	**164**		42	39	43	33	**157**
StEIS reported SUI's		5	1	5	7	**18**		6	1	3	1	**11**
Patient Safety Incidents reported to the NRLS		180	251	246	298	**975**		281	281	284	250	**1096**
Accident		86	93	105	131	**415**		113	110	98	98	**419**
Communication		146	120	142	157	**565**		106	123	113	97	**439**
Death		22	21	22	13	**78**		17	13	37	25	**92**
Digital Systems		14	18	19	16	**67**		15	12	24	23	**74**
Environmental		38	26	38	37	**139**		31	38	31	19	**119**
Infection Control		23	31	33	33	**120**		22	21	30	38	**111**
Information Governance		44	49	53	68	**214**		55	58	49	51	**213**
Investigations, Images & Diagnosis		21	25	30	32	**108**		32	29	35	19	**115**
Medical Devices, Systems & Equipment		56	24	31	46	**157**		36	43	42	40	**161**
Medication		53	78	102	96	**329**		76	68	75	66	**285**
Nutritional and Hydration		15	13	12	9	**49**		10	9	8	11	**38**
Patient Care		130	117	96	128	**471**		109	91	83	76	**359**
Safeguarding					2	**2**		15	70	87	74	**246**
Security		26	33	14	15	**88**		11	20	13	11	**55**
Treatment and procedure		28	18	27	28	**101**		31	33	47	25	**136**
Violence and aggression		75	63	82	65	**285**		61	81	68	62	**272**
RIDDOR		4	2	2	2	**10**		3	3	3	3	**12**
Percentage reported within 12 hours (as per Policy)		88%	89%	90%	91%	**89%**		88%	88%	88%	89%	**88%**
% of level 2&3 incidents acknowledged in 24 hours (as per Policy)		83%	92%	90%	89%	**88%**		85%	75%	86%	68%	**74%**
% of level 1 incidents acknowledged in 48 hours (as per Policy)		91%	89%	90%	91%	**89%**		94%	89%	87%	89%	**88%**
% of level 0 incidents acknowledged in 48 hours (as per Policy)		95%	91%	91%	90%	**89%**		100%	87%	89%	92%	**92%**
Rate of incidents per 100 admissions (excl Jef & OPD)		14.52%	13.46%	13.67%	15.87%	**14.38%**		13.87%	16.35%	16.06%	13.31%	**14.05%**
Number where DOC (Duty of Candour) where patient/relative have been notified?		17	11	17	18	**63**		12	12	17	21	**62**

Serious Incident (High level incidents) overview – Annual data:

1. Eleven (11) Serious incidents were reported to the Commissioner in the financial year 2019/20, compared to 18 the previous year 2018/19. Duty of Candour reporting was completed for all incidents.

Incident date	Reported	Incident Type	Incident Summary
1st May 2019	1st May 2019	Safeguarding Incident	External multiagency investigation on-going.
20th May 2019	22nd May 2019	Medical Devices Systems and equipment	When carrying out a cranioplasty, the patient had been anaesthetised and surgery commenced when the implant date was checked. The implant was out of date. Following discussion with the senior medical and nursing teams, the operation proceeded.
13th June 2019	14th June 2019	Operation or procedure wrongly sited	Wrong level spinal procedure.
17th June 2019	19th June 2019	Operation or procedure wrongly sited	Wrong level spinal procedure.
21st June 2019	21st June 2019	Safeguarding concern	External multiagency investigation on-going.
21st June 2019	21st June 2019	Patient Care	Patient developed facial palsy following being admitted to the Trust with category 3 pressure ulcer.
8th August 2019	21st August 2019	Category 4 Pressure Damage	Patient with complex neurological condition developed category 4 tissue damage.
4th November 2019	12th November 2019	Never Event - retained foreign object post operation	A guidewire was left in place following emergency insertion of a femoral central line.
8th November 2019	13th December 2019	Category 3 Pressure ulcer	Patient identified as at increased risk of developing tissue damage developed a category 3 pressure ulcer underneath a halo jacket.
5th December 2019	21st August 2019	Operation or procedure wrongly sited	Patient was consented for a L5/S1 revision microdiscectomy. After performing the procedure the surgeon requested a further level check and once this was performed the surgeon found that they had performed the procedure at the wrong level.
19th February 2020	19th February 2020	Category 3 Pressure ulcer	Patient in hyper acute rehabilitation developed category 3 tissue damage.

2. There has been a slight decrease in overall incident reporting from 3184 in 2018/19 to 3134 in 2019/20. On review, the category with the

main decrease relates to “communication incidents” decreasing from 565 in 2018/19 to 439 in 2019/20.

3. Neurology incidents increased from 1034 in 2018/19 to 1077 in 2019/20.
4. Safeguarding concerns & DoLs applications had the highest increase, increasing from 2 in 2018/19 to 114 in 2019/20. NB: Safeguarding concerns & DoLs applications was not captured specifically as a category until the latter stage of Quarter 4 2018/19.
5. Neurosurgery incidents decreased from 1986 in 2018/19 to in 1900 2019/20. Communication incidents saw the main decrease from 385 in 2018/19 to 302 in 2019/20.
6. Corporate incidents decreased from 164 in 2018/19 to 157 in 2019/20. Environmental incidents had the greatest reduction, reducing from 28 in 2018/19 to 16 in 2019/20.

Annual incidents by severity:

Incidents by Severity	**2018/19**	**2019/20**
No obvious harm	2763	2680
Minor harm may require aid/support	355	378
Moderate harm requiring aid/support	61	64
Major permanent harm	4	1
Catastrophic	1	0
To be determined following investigation	0	11
Total	**3184**	**3134**

Duty of Candour:

The table below provides an overview of moderate harm and above patient safety incidents that have required both verbal and written notification to the patient/relative/next of kin, under the statory requirements of Duty of Candour, broken down by subcategory and financial year.

Sub Category	**2018/19**	**2019/20**
Administration - Allergic Reaction	1	0
Administration - Extra dose given	0	1
Appointment failure to follow up	1	0
Burn or Scald	0	1
Cardiac Arrest	1	0
Unexpected cardiac arrest	1	0
CDIF - WCFT acquired	8	5
CPE - WCFT Acquired	10	4
Failure of device / equipment (not user error)	1	0

Device related pressure damage	0	1
DVT	0	2
E-Coli - WCFT acquired	9	14
Extravasation	2	0
FALL - Not witnessed / found on floor	3	0
Klebsiella pneumoniae - WCFT acquired	2	4
Missing needle/swab/instrument	1	0
MSSA - WCFT acquired	9	5
NEVER EVENT - Wrong Implant/Prosthesis	1	0
NEVER EVENT - Retained foreign object post operation	0	1
NEVER EVENT- Wrong site surgery	1	0
Operation or procedure wrongly sited	0	3
Other kind of Accident	1	0
Equipment out of date	0	1
Inpatient Death - Unexpected	1	0
Pseudomonas - WCFT acquired	1	1
Pulmonary Embolism	4	6
Pressure Ulcer - WCFT acquired	4	10
Requested test not performed/result unavailable	0	1
Respiratory problem	0	1
Unplanned return to theatre	1	0
Unintended injury in the course of an operation or clinical task	0	1
Totals:	**63**	**62**

1. Patient safety incidents (requiring written and verbal notification under the staturory requirments of Duty of Candour) decreased from 63 in 2018/19 to 62 in 2019/20.
2. CPE – WCFT acquired incident decreased from 10 in 2018/19 to 4 in 2019/20.
3. Ecoli – WCFT acquired incidents increased from 9 in 2018/19 to 14 in 2019/20.
4. MSSA – WCFT acquired incidents decreased from 9 in 2018/19 to 5 in 2019/20.
5. 'Operation site – wrongly sited,' incidents increased from 0 in 2018/19 to 3 in 2019/20.
6. Pressure Ulcers – WCFT acquired incidents increased from 4 in 2018/19 to 10 2019/20.
7. CDIF incidents decreased from 8 in 2018/19 to 5 in 2019/20.

Annual Themes:
1. Communication incidents decreased from 565 in 2018/19 to 439 in 2019/20. 2. Violence and aggression incidents decreased from 285 in 2018/19 to 272 in 2019/20. 3. Safeguarding incidents increased significantly from 2 in 2018/19 to 246 in 2019/20. NB: safeguarding as a category was only made available on DATIX towards the end of Quarter 4 of 2018/19. 4. Patient falls decreased from 252 in 2018/19 to 225 in 2019/20. a. Fall - Not witnessed / found on floor, decreased from 115 in 2018/19 to 92 2019/20.
Key points to note:
1. In Quarter 3 2019/20 the Clinical Governance Lead & Safeguarding Matron conducted a review of the current safeguarding section on DATIX, splitting notifications relating to incidents and those reported as concerns. Safeguarding concern notifications sent from DATIX, now has a limited audience. This was discussed and agreed at the Safeguarding Meeting. 2. 24 DATIX refresher training sessions have been delivered in 2019/20. 3. In Quarter 2 2019/20, Divisional Specialities were added to the incident reporting form to support the Divisions with better incident analysis and investigation. 4. An audit of the Duty of Candour process,which identified 100% of moderate harm patient safety incidents were verbally communicated to the patient/relative within 10 working days of the incident occurring. 5. Duty of Candour continues to be reviewed, with a further audit planned in 2020/21. 6. Improve the DATIX System, including, incidents, risks and patient experience issues.

Section 2 - Violence and Aggression

	Trend 18/19	Q1 18/19	Q2 18/19	Q3 18/19	Q4 18/19	18/19		Trend 19/20	Q1 19/20	Q2 19/20	Q3 19/20	Q4 19/20	19/20
Inappropriate Behaviour		9	10	8	8	**35**			5	5	7	9	**26**
Physical abuse/violence - other on patient		0	1	1	1	**3**			0	0	0	0	**0**
Physical abuse/violence - other on staff		0	0	0	1	**1**			0	0	0	0	**0**
Physical abuse/violence - patient on patient		0	0	0	1	**1**			0	0	0	0	**0**
Physical abuse/violence - patient on staff		45	34	50	18	**147**			27	45	40	29	**141**
Physical abuse/violence - Visitor		1	0	0	2	**3**			0	2	1	1	**4**
Racial abuse/violence - other on staff		1	0	0	0	**1**			0	0	0	0	**0**
Racial abuse/violence - patient on staff		0	0	0	0	**0**			0	3	1	2	**6**
Sexual abuse/violence - patient on staff		0	1	0	3	**4**			0	1	0	0	**1**
Verbal abuse/Violence - other on staff		0	0	0	6	**6**			0	0	0	0	**0**
Verbal abuse/Violence - patient on staff		13	12	16	22	**63**			24	21	18	15	**78**
Verbal abuse/Violence - patient on patient		0	0	0	0	**0**			0	2	0	0	**2**
Verbal abuse/Violence - staff on staff		4	5	0	3	**12**			1	0	1	0	**2**
Verbal abuse/violence - Visitor		2	0	7	0	**9**			4	2	0	6	**12**
Total number of Incidents		75	63	82	65	**285**			61	81	68	62	**272**

Key points to note:

1. There has been a slight reduction in incidents from 285 in 2018/19 to 272 in 2019/20.
2. Physical abuse incidents decreased from 147 incidents in 2018/19 to 141 incidents in 2019/20,134 of these incidents in 2019/20 involved patients who lacked capacity. The location with the highest incidents reported was CRU with 33, followed by Caton Ward with 25 and then Horsley ITU with 24. The lowest reporting wards were Chavasse and Lipton with 7 incidents.
3. Verbal abuse incidents increased from 63 in 2018/19 to 78 in 2019/20.

NB: Inappropriate behaviour include incidents where it does not meet the criteria of verbal or physical abuse but where it still needs to be reported. Incidents include circumstances where a patient, relative or indeed a staff member have acted inappropriately or used inappropriate language but did fit within the verbal or physical abuse categories.

Key actions:

1. Continue to engage clinical managers in the Violence and Agrression Working Group, to help support staff in managing challenging patients. Work streams include development of an alert marker and electronic risk assessment
2. Engagement and close support of ward staff by the Trust's Security Management Specialist following incidents of violence and aggression.

3. Discussion of violent and aggressive incidents at the safety huddle the day following the incident to enable a rapid response.

Section 3 - Information Governance

1. Information Governance incidents have increased slightly from 49 in Q3 to 51 in Q4. This includes all Health Records, Information Governance and Data Quality incidents. All these incidents are reviewed and monitored via the Information Governance and Security Forum on a monthly basis. Of the 51, one was a non-Walton Centre incident.
2. During this timeframe, there was 1 externally reportable incident to the Information Commissioners office (ICO). This has since been closed as no further action by the ICO.
3. Between 1st April 2019 and 31st March 2020 the Trust has reported 12 externally reportable incidents to the ICO compared to 5 in 2018/2019. The ICO has responded to all incidents reported so far to advise that all appropriate remedial action had been taken and the ICO was happy with the responses submitted by the Trust, so no further action was required.
4. The department have implemented a number of actions throughot the year following the incidents which consist of:
   - Increased awareness posters placed across the Trust that were received from NHS Digital highlighting locking computers and not allowing tailgaiting etc.
   - Second version of the Top Tips newsletter devised and implemented in every area of the Trust which is based on the themes of recent incidents.
   - Awareness raised at clinical safety huddle, IGSF, GDPR compliance group to inform managers to speak to staff in their team meetings.
   - Divisional managers have confirmed they have spoken to the clerks and secretaries in their divisions at team meetings.
   - Communications sent through Walton weekly and Team Brief including verbal presentation at team brief from the Digital Health Records and IG Manager.
   - Second check implemented in the Subject Access Department whereby a different staff member to who has processed the request does a final check of demographics on every page prior to the information being sent out.
   - Standard operating procedure and change in printing process implemented in radiology department where a breach occurred.
   - Extra checks implemented in HR when sending out confidential letters to staff.
   - Newsletter detailing recent ICO fines of other NHS trusts implemented around the Trust.
   - Process introduced to ensure HR send over list of locums so they are also monitored on data security awareness e- learning regardless of length of placement.
   - Extra checks implemented in PMP to remind staff to ensure 'W' number is used with patient name at all times after letter being sent to wrong person.
5. During Q4, the Trust has received the following:
   - 134 Freedom of Information Requests compared to 115 (Q3)
   - 361 Subject access requests from patients compared to 100 (Q3)
   - 183 Subject access requests from solicitors compared to 185 (Q3)
   - 120 Subject access requests from other hospitals and agencies compared to 94 (Q3)

6. The Trust has had no breaches of subject access requests this financial year and to date has never had a Freedom of Information Breach. During Q4, 11Data Protection Impact Assessments (DPIA's) were submitted to the Information Governance and Security Forum and approved by the forum and the Data Protection Officer.
7. The Information Asset Register continues to be populated by all areas of the trust with assets increasing. This ensures that a robust reporting mechanism is in place which allows the Information Asset Owners to report any identified risks to the Trusts SIRO. Currently the Asset Register has 210 assets and 616 Dataflows.

Section 4 - Learning from Deaths

1. There were a total of 92 inpatient deaths; all deaths were subject to initial mortality review according to the methodology outlined in the Trust's Mortality Policy. Q1-Q3 deaths have been reviewed at Divisional Mortality meetings; however, in Q4 deaths have been reviewed and are awaiting presentation due to Covid-19 restrictions.
2. There was an increase in deaths in Q3, the mortality reviews highlight several of the emergency admissions due to catastrophic injury or complex medical conditions and the patient's also had multiple co-morbidities, including chronic conditions. These conditions often require treatment with cardiac respiratory and anticoagulant medications, which may have contributed to the neurological event and also to the difficulties of further surgical and medical strategies required as further management of the presenting condition.
3. Following resuscitation and initial assessment at the referring hospital, a number of patients (11) were transferred without delay to the Trust for further investigation, urgent surgery/ or complex medical treatments and subsequent neuro-intensive care. Following discussion with the patients' family, conservative management was the agreed plan of care and referral to the specialist palliative care team was appropriate.
4. Within the Governance team, information regarding mortality is triangulated with incidents and complaints, together with claims to improve opportunities for improvements in quality of care.
5. The clinical teams are keen to improve the support for bereaved families and carers. There have been several family meetings held where although the death was considered unavoidable, and a formal investigation was not required; bereaved relatives have required clarification regarding surgical or medical treatments prior to end of life (EOL) care. These meetings have been facilitated by the Patient Experience Team with the relevant clinical teams.
6. Within the Neurosurgical Division, work is ongoing to design a formal bereavement service across Liverpool University Hospital sites, the Walton Centre and Liverpool Clinical Laboratories. This will include a review of the care of the deceased patient and bereaved relative's policy.
7. Overall in 2019-2020, the mortality meetings have included a wider MDT participation with a concentration on EOL patient and family experience.
8. The Specialist Palliative Care Lead Consultant has attended the surgical mortality review group and incidents related to palliative and EOL care are discussed at the EOL operational group.
9. All patients in critical care were supported by the Specialist Nurse for Organisation Donation (SNOD) and relatives approached for consideration of organ donation. There were 6 patients referred for organ donation, with 3 successful donations.

10. Following the death of a (neurology) patient the admitting Consultant raised concerns with the Neurology Governance Lead in relation to a possible delay in diagnosis at the referring hospital, which possibly contributed to the patient death. In line with the Trust policy and guidance from NHS England, the findings of the Trust's mortality review will be shared with referring hospital, with a recommendation they may wish to carry out further investigation.
11. The Neurology Clinical Governance Lead would be happy to be involved in assisting with any review at the referring hospital; this demonstrates improved compliance with the Learning from Death Guidance in relation to issues outside the Trust's scope for investigation.
12. Further to the discussion at C&M Medical Directors Forum regarding the Medical Examiner's Programme, the National Medical Examiner Team has published an explanatory note on the process in England for Trusts and Foundation Trusts for 2019/20 and 2020/21. The Medical Director has suggested we will link with Liverpool University Hospitals as they are in the process of recruiting to these posts.
13. The Executive team has requested a review of the mortality review process which is being carried out by a Non-Executive Director. The Divisional Governance teams will work closely with the Lead for the review to improve policy and practice if required. This review will include the data presented and format of the reports for Quality Committee and Trust Board.

Thematic review of Moderate and above incidents reported 2019/20

Incident type	Overview
Clostridium Difficile Toxin (CDT) - WCFT acquired	There have been 5 Clostridium Difficile Infections against an external trajectory of 8. This shows a reduction of 62% compared to the previous year. All cases are approved at internal Divisional and Infection Control Committees, and are subject to investigation and review by the commissioners. As part of the investigation, patients had received several courses of antibiotics, all antibiotics and bacteriology results were reviewed by the Consultant Microbiologist according to Trust policy.
Carbapenemase Producing Enterobacteriaceae (CPE) - WCFT Acquired	4 patients were identified as becoming colonised with CPE; again this is a reduction of 60%. 2 of the patients identified were patients on the same ward at the same time indicating a possible cross contamination.
Category 2 - pressure ulcer	An increase of 100%, 8 as opposed to 4, all incidents are subject to investigation.
Category 3 - pressure ulcer	2 instances of Category 3 tissue damage.1 was device related. Device related tissue damage to be reviewed across similar patient groups in referring Trusts
Category 4 - pressure ulcer	1 The development of pressure ulcers in this patients' case was a complicated, multifactorial situation.
Deep Vein Thrombosis (DVT)	2 incidents related to indwelling central venous devices, this has led to a review of practice within critical care.

Incident type	Overview
Pulmonary Embolism (PE)	7 incidents, there was a failure to report two incidents which were identified a result of mortality and morbidity reviews. This issue has been escalated to the appropriate clinical groups, to reinforce that clinicians must report these incidents.
E-Coli - WCFT acquired	There have been 14 identified cases of E Coli bacteraemia in 19-20 against an internal trajectory of 12. The majority of cases are related to Urosepsis. Catheter management will be part of the work plan for 20/21 using the Saving lives, high Impact Intervention methodology.
Klebsiella pneumoniae	There were 4 cases of Klebsiella bacteraemia recorded.
MSSA - WCFT acquired	There were 5 cases against an internal trajectory of 9. It has been noted at Infection Control Committee that the preventive actions put in place over the past year have had a positive effect on the number of cases and teams have been commended for their hard work.
MRSA WCFT Acquired	This gives a yearly total of zero against a tolerance target of zero which has been set for all Trusts. There have been no reported cases of MRSA since November 2017.

Section 5 - Concerns & Complaints

The Patient Experience Team receives a wealth of information surrounding the experience of our patients and their families. We use the positive information to share and promote good practice and this information can be found in below. This section identifies the areas of concern raised by patients and their families and occasionally by our wider community. This information helps us to improve services and learn lessons to improve the care and service we provide. This section analysis the complaints and concerns raised with the Patient Experience Team.

TRUST WIDE	Trend 18/19	Q1 18/19	Q2 18/19	Q3 18/19	Q4 18/19	18/19	Trend 19/20	Q1 19/20	Q2 19/20	Q3 19/20	Q4 19/20	19/20
Complaints												
Coroner statement requests		5	1	2	5	**13**		6	3	1	2	**12**
Police statement requests		4	7	12	12	**35**		5	9	6	9	**29**
Total Number of Concerns		92	83	85	72	**332**		59	118	157	152	**486**
Appointment arrangments		47	41	36	15	**139**		36	66	75	97	**274**
Approach and manner		17	21	7	20	**65**		10	9	14	18	**51**
Patient Care		6	4	9	4	**23**		9	10	10	13	**42**
Communication		8	10	10	12	**40**		19	29	34	45	**127**
Discharge Arrangements		3	3	5	3	**14**		5	5	8	5	**23**
Total Complaints received		21	23	24	27	**95**		31	36	37	25	**129**
Approach and Manner		8	8	10	14	**40**		19	12	11	14	**56**
Treatment		7	9	4	9	**29**		8	10	10	3	**31**
Appointment Arrangements		7	11	8	9	**35**		13	12	14	15	**54**
Patient Care		19	8	11	11	**49**		9	9	4	2	**24**
Communication		2	3	2	6	**13**		12	10	17	8	**47**
% Acknowledged within 3 working days		100%	100%	100%	100%	**100%**		100%	100%	100%	100%	**100%**
% responded to within agreed timescale		100%	100%	100%	100%	**100%**		100%	100%	100%	100%	**100%**
Neurosurgery complaints		16	18	14	14	**62**		19	15	15	12	**61**
Neurology complaints		5	7	11	13	**36**		8	15	19	12	**54**
Neurosurgery/Neurology complaints		0	0	0	0	**0**		3	6	2	1	**12**
Corporate		0	0	0	0	**0**		1	0	1	0	**2**
% signed responses scanned on system		100%	100%	100%	100%	**100%**		100%	100%	100%	100%	**100%**
Complaints to Ombudsman		0	1	0	0	**1**		1	0	2	0	**3**

Concerns and Complaints :

Complaints:

1. There is an increase of 36% in the total numbers of complaints received year-to-date at 129 compared to 95 in 2018/19.

Key 5 themes for complaints include:

- Approach & manner of staff (56)*
- Appointment arrangements (54)*
- Communication (47)
- Treatment (31)*
- Patient care (24)*

*some complaints include more than one key theme

Concerns:

1. There was an increase in the number of concerns received from 486 in 2019/20 compared to 382 in 2018/19. The increase in numbers are reflected in the recurrent themes of "appointment arrangements" and "communication" as with formal complaints.

Annual Summary

1. The increase in complaints was reflected in the current theme mainly relating to appointment arrangements and communication; these subject matters were also noted as a common theme for concerns. The divisions are aware and are taking measures to address this.
2. A decrease in the number of complaints was evident across both divisions in Q4.
3. The overall thematic analysis of complaints were appointment arrangements, approach and manner, patient care and communication.
4. 3 complaints were referred to the Parliamentary Health Service Ombudsman:
   - Complaint was upheld with a recommendation to recompense £500 for the injustice suffered this related to consent to surgery and post-operative treatment. *Closed.*
   - Complaint relates to care and treatment following admission for treatment following brain hemorrhage – *under investigation*
   - Complaint from a relative who felt that patient should not have been discharged without advice to GP – *under investigation*
5. It is a requirement of the NHS Complaints Regulations to report the annual number of complaints that were 'well-founded' or upheld. For complaints concluded in 2019/20 there were:
   - 60 Not upheld (no action, or failures in care/service identified)
   - 37 Partially upheld (failing in some but not all, concerns raised requiring action/learning)
   - 28 Fully upheld (failings in all concerns raised)

Higher Level Learning includes:

- Improvements in standards of basic nursing care

- Improved documentation and record keeping
- Improved documentation implemented specifically relating to bowel management
- Enhanced information relating to safe mobilisation of patients communicated to families
- Improvements in support provided to patients at meal times
- Improvements in communication processes to patients and families
- Implemented new diabetic services arrangements for Trust
- Improved patient advice/information in relation to battery life for device
- Reviewed and improved pathways
- Improved administration and communication processes

Complaint initiatives include:

- In Q4 Patient Experience Rounds were introduced to capture feedback in real time and address any concerns for inpatients and take suggestions for improvement forward.
- Home visit to complainants introduced to share complaint outcomes, including actions and learning.
- Weekly meetings with PET/Divisions to prioritise complaints

Volunteers:

- An annual total of >7,500 dedicated hours.
- All new volunteers have attended the new volunteer induction programme and existing volunteers all completed their mandatory training.

New volunteer intiatives for 2019/20 include:

- Introduction of quartlerly newsletters and quarterly get-togethers including afternoon tea
- Wellbeing feedback questionnaire to measure volunteers wellbeing and progression in roles
- Volunteer handbook developed for all new starters
- New recognition awards for long-standing volunteers and to congratulate those who have achieved 100 & 1,000 hours
- External recognition awards with 5 volunteers being successful
- Development of new volunteering roles

Patient Stories:

The use of patient stories has been developed during 2019/20. Stories are presented at Trust Board, Quality Committee as well as Professional Nurse Forum and Patient & Family Centred Care. This has involved training Trust staff to undertake them as well as the PFET team.

Section 6 - Patient Experience

Friends and Family Test (FFT):

Overall Inpatient FFT

	January	February	March
Recommend rate	97.4%	95.8%	No data due to Covid-19
Response rate	4.5%	6.5%	No data due to Covid-19

Overall Outpatient FFT

	January	February	March
Recommend rate	98.6%	98.3%	No data due to Covid-19
Response rate	39.3%	48.7%	No data due to Covid-19

Recommend rate by Ward (total responses in brackets)

	January	February	March
Cairns	97.0% (33)	100% (56)	No data due to Covid-19
Caton	100% (34)	100% (31)	No data due to Covid-19
Chavasse	97.7% (44)	96.8% (31)	No data due to Covid-19
CRU	100% (6)	100% (1)	No data due to Covid-19
Dott	100% (39)	100% (31)	No data due to Covid-19
Jefferson	98.9% (177)	97.8% (229)	No data due to Covid-19
Lipton	100% (1)	n/a (0)	No data due to Covid-19
Sherrington	97.0% (33)	97.0 (33)	No data due to Covid-19

Annual Summary:

The Trust results remain very positive in 2019/20 and static compared to 2018/19 both in terms of recommended rate and response rate. The inpatient recommended rate was consistent at 97% to 99% which is static compared to 98 to 99% the previous year. The recommended rate remains significantly above the national average.

The FFT recommended rate was consistent throughout the year across all wards. It should be noted that the inpatient FFT is reported nationally, however, there is no requirement for this to be done with outpatients FFT. The outpatient FFT response rate is significantly lower than the inpatient FFT, however, this is consistent with practice across Trusts nationwide. Patients who visit the trust frequently for OPD express they do not wish to complete the survey again.

Section 7 - Compliments

This table represents the numbers of compliments received centrally by the Patient Experience Team. It should be noted, however, that this represents a very small reflection of the positive feedback received directly in wards or departments, and via social media. Below are examples of the compliments received by Wards and Departments during 2019/20.

TRUST WIDE	Trend 18/19	Q1 18/19	Q2 18/19	Q3 18/19	Q4 18/19	18/19	Trend 19/20	Q1 19/20	Q2 19/20	Q3 19/20	Q4 19/20	19/20
Compliments												
Total number of compliments		53	55	75	337	**520**		77	58	82	70	**287**

Examples of compliments received by Patient Experience Team

- When I was an inpatient the nursing staff were all WONDERFUL and I thank you from the bottom of my heart.
- You are all incredible people and you deserve a lot. One thing is a massive Thank you for what you all do!! Stay safe everyone
- I'm a long term patient with you. Yesterday I rang as my regular treatment has been stopped for now due to #COVID2019 and I'm struggling. But within 40mins I had my consultant on the phone with a plan to help me - you are incredible, absolutely amazing.
- Dave received excellent care whilst at The Walton Centre and I would like to offer my sincere thanks to all the staff at the ICU who cared for Dave during his time there, especially his nurse for the last 3 days of his life, Rachel. She was amazing, a great asset to your hospital. In addition my sister and I would like to thank Jen and her staff who manage the families' accommodation at the Sid Watkins Building. They showed great compassion and professionalism during what was an extremely difficult and traumatic time for us.
- My mum was here back in January for an emergency spinal surgery, I couldn't thank the doctors, nurses, HCA's, surgeons and everyone enough for looking after her! The staff are absolutely lovely and so easy to talk to.
- The hospital and wards are so clean and well looked after. By far the most amazing hospital I have ever visited! Thank you Walton Centre and keep up the amazing work you're all doing. Couldn't recommend enough!
- While I'm in a roll can I just say thank you the staff at @Walton Centre Chavasse ward who looked after me on my recent stay they do an AMAZING job every single staff member who steps foot on that ward plays equally as important a role
- Two weeks ago the father in law couldn't walk or move his legs. Trip to A&E and referred to Walton where he found out he had a tumour on his spine. Had it removed 1 week ago and is already on his feet and back home today. He received the best care.

Section 8 - Claims / Legal

The Trust has an agreed process in place for reporting, managing, analysing and learning from claims, in accordance with NHS guidance and Civil Procedure Rules. The Trust is a member of National Health Service Resolution (NHSR) Clinical Negligence Scheme for Trusts (CNST) and Existing Liabilities Scheme (ELS) for clinical claims. The Trust is committed to ensuring that claims are resolved in a professional, efficient and timely manner. The Trust aims to achieve an equitable outcome for all parties concerned, to take appropriate corrective action and to reduce the risk of future litigation. It should be noted that owing to the timeframe to settle a claim there can be a significant period of time to open and close a claim.

TRUST WIDE	Trend 18/19	Q1 18/19	Q2 18/19	Q3 18/19	Q4 18/19	18/19	Trend 19/20	Q1 19/20	Q2 19/20	Q3 19/20	Q4 19/20	19/20
Claims												
Total new claims received		4	9	12	4	**29**		8	4	9	6	**27**
Neurosurgery claims		3	5	8	3	**19**		3	3	4	4	**14**
Neurology claims		0	1	1	1	**3**		3	1	4	1	**9**
Corporate claims		1	3	3	0	**7**		2	0	1	1	**4**
Total number of pre-action protocols in quarter		14	15	13	15	**57**		11	14	10	11	**46**
Number of closed claims in quarter		7	3	7	8	**25**		4	5	7	10	**26**
Value of closed claims - Public liability		£0	£0	£1,286	£0	**£1,286**		£5,427	£0	£0	N/A	**£5,427.00**
Value of closed claims - Employer liability		£0	£0	£0	£0	**£0**		£0	£15,736	£0	N/A	**£15,736.00**
Value of closed claims - Clinical Negligence		£1,433,019	£8,540	£1,414,763	£1,134,580	**£3,990,902**		£12,265	£447,102	£155,194	£485,936.22	**£1,100,497.22**

Re-opened claims

1. Claim Ref 158 (Neurosurgery) - related to the deterioration of an ITU patient in 2016. A muscle relaxant was given to be able to facilitate an emergency bronchoscopy but the patient further deteriorated to the point of cardio respiratory arrest which resulted in the patient's death. It was thought that the patient had had a previous suspected severe allergic reaction to the muscle relaxant given. There was a Coroner's inquest which resulted in a Regulation 28.
   - The Trust initially received confirmation in February 2017 from a solicitor that a claim would be pursued against the Trust. NHSR closed their file in May 2017 as no further correspondence received. Informed relevant staff. Particulars of Claim were later received and we have informed NHSR.
2. Claim Ref 200 (Neurosurgery) - Claimant underwent surgery in 2016 for L1-L3 fixation with decompression and was discharged in 2016. On 2016 claimant became unwell and yellow tissue opening with significant discharge was noted at lower wound site. Surgery was performed to wash out and explore the wound. Operation note confirmed that a wound drain plastic internal section had been left in and this was the cause of the claimant's infection. Claimant has been left with low back pain and psychological injury. NHSR closed their file on this case following the Trust Letter of Response being served in July 2019 and no further correspondence received. Particulars of Claim received in January 2020. Defence served denying allegations.

Lessons Learned

The following lessons have been learned from closed claims. Please note that lessons may have been learned following a RCA at the time of the incident over the last 5 years and not only following receipt of a formal Letter of Claim.

- Falls - The Trust has reviewed and implemented a number of improvements.
- Falls - Extensive education regarding special observation and levels of observation has been completed as a result of this case
- Communication and documentation - Lessons have been learned with changes in practice and documentation.
- Medication – Suspected overdose via PCA. Senior nurses to review education provision to newer staff. Updated patient information leaflet.
- Communication – referral - An electronic ordering system to request MRI scans is now in place. This will avoid MR requests not being received by the Radiology Department. In the new system if an urgent request is made AND the vetting Radiologist agrees with this then it is highlighted for urgent reporting and would be reported the same or next working day (out-patient urgent scans are generally done within 14 days unless specifically discussed).
- Correspondence – A referral from Bridgewater Community Hospital Trust was deemed urgent. However, the triaging consultant did not see any correspondence that the referral was urgent. Following this case all referrals from satellite clinics to be clearly marked urgent.

Coroners Inquests

1. The Trust was directed to attend 3 inquests during 2019/20.
2. Inquest (Ref 1) – Legal representation for both sides. Coroner conclusion meant that no claim was then pursued.
3. Inquest (Ref 2) – No legal representation. Coroner conclusion meant that no claim was then pursued. Following the inquest the PET Manager, Oncology Lead Nurse and Claims Manager met with the family of the deceased to see how we could improve the service that we

provided. Oncology Nurse Lead discussed the family concerns with various departments and improvements made going forward.

4. Inquest (Ref 3) – No legal representation. Following the Inquest the family wanted questions asked of the transferring hospital.

Staff Education and Support

1. The Claims Manager now provides training at junior doctors induction.
2. All staff involved in claims are fully supported regarding the process of clinical negligence claims and Coroner's Inquests.

Section 8 - Risks

Risk:

TRUST WIDE	Trend 18/19	Q1 18/19	Q2 18/19	Q3 18/19	Q4 18/19	18/19	Trend 19/20	Q1 19/20	Q2 19/20	Q3 19/20	Q4 19/20	19/20
Risks												
Current Number of High Risks 15 and above		24	24	24	25	**25**		22	22		27	**27**
Current Number of Medium Risks 6-12		142	142	145	154	**154**		147	150	157	174	**174**
Current Number of Low Risks 1-5		48	48	46	53	**53**		53	43	57	60	**60**
Number of new Risks opened in the Quarter		10	10	23	24	**67**		19	23	12	19	**73**
Number of closed Risks in the Quarter		7	7	16	10	**40**		16	17	10	6	**49**
Number of Risks increased in the Quarter		2	2	0	2	**6**		1	0	0	0	**1**
Number of Risks decreased in the Quarter		6	6	2	7	**21**		4	6	7	6	**23**
Compliments												
Total number of compliments		53	55	75	337	**520**		77	58	82	70	**287**

Key Points to note:

1. Annually there has been an increase in the number of medium risks rating 6-12, increasing from 154 in 2018/19 to 174 in 2019/20.
2. Slight increase in number of risks with a low risk rating increasing from 53 in 2018/19 to 60 in 2019/20.
3. A total of 73 risks were opened in 2019/20.
4. A total of 49 risks were closed in 2019/20.

Top 3 Operation/Divisional Risks:

1. Neurology - There is a financial risk that the division will be unable to meet the Activity Plan 2019/20 (10% of the activity within the plan is based on WLI).This is due to consultants not being willing to undertake WLI clinics because of changes in the government pension annual allowance taper which can lead to personal financial implications – Risk Rating 25.
2. Neurosurgery - risk of CT downtime. Impact on patient care as no CT imaging would be available as only one CT scanner in the Trust – Risk Rating 20.
3. Neurosurgery - achievement of balanced budget – Risk Rating 16.

Key Actions:

1. Continue to ensure the Risk Register process is embedded in the Trust by providing continuous training and scrutiny of the risk registers at various groups and committees. Risk Register Training continues to be provided throughout the year.
2. Risks have now been split by subcommittee of Board following a recent MIAA Audit.

Section 9 - Safety Section

Fire Safety:

Key points to note:

	Toaster	Fault on system	Accidental or Malicious use of fire alarm	Fogging Machine	Air freshener	Smell of external smoke	Cooking fumes	Unknown cause	Actual Fire	Total
2019/20	8	4	3	7	8	1	2	10	2*	45
2018/19	4	1	1	4	7	1	2	4	1	25

* Two entries for 'Actual Fire' were recorded, however this was One incident which affected Two areas therefore DATIX entries were made for each, 'skewing' the figures.

1. There has been a significant reduction in fire incidents from 45 in 2018/19 to 25 in 2019/20.
2. Trinity Fire has been retained as the Trust authorised Fire Alarm maintenance engineer. This will be reviewed prior to next year and a tender process commenced.
3. Following the Fire in OPD (2018) an action plan was produced to monitor a number of areas of concern. The main area of concern being 'breaches' in and/or lack of adequate Fire Compartmentation. A programme of correction has been underway since Jan 2019 with good progress made. It is anticipated the programme will be complete by Q3. NB: With the outbreak of COVID 19, there is some works left to do in ITU and Theatres. With the reduction in occupancy, an opportunity arose to survey the Sid Watkins Building, no significant findings have been identified.
4. Training continues to be well received both mandatory and ward specific with current figures at 88%. On resumption of normal working we will be carrying out more Fire evacuation drill and exercises. Fire responders will be given the opportunity to update during the summer months. Fire Marshalls have been introduced to the pain management department as a result of a request from the department managers.
5. The role of the Marshall will be to manage evacuation, should the need arise, this does not impact on the role of the Fire Response Team.

Key Actions:

1. Develop virtual training utilising MS Teams/Zoom to target staff to increase compliance during COVID restrictions.
2. Fire Risk Assessments continue to be reviewed, findings discussed with all relevant parties.
3. Ensure these findings (works identified/required by the fire risk assessments) are actioned by the Estates dept. and/or Department staff
4. The Fire Safety Advisor continues to work closely with Estates and Facilities Department to ensure suitable and sufficient solutions to problems are dealt with and remedied as early as possible.
5. Continue to work with MFRS to ensure compliance with Fire Safety Legislation and Guidance.

Moving and Handling:

Key Points to note:

1. Education and Training
   - Further development of the Trust programme in relation to safe approaches with Moving and Handling/Movement facilitation for those patients who present or respond negatively, with violence or aggression (BAF 311).
   - Onsite training programme delivered to Liverpool University Hospitals (Aintree) nursing and therapy staff relocating the Stroke Service to Sherrington ward (Covid-19).
   - Upskilling and refresher programme delivered in classroom and on site to Trust staff in preparation for redeployment (Covid-19).
   - On site working and training with individual staff in an area identified with a high proportion of diagnosed musculoskeletal conditions and symptoms.
2. Incident Reports / Risk Management
   - Of the reports received through the DATIX system during 2019-20, 30 contained a Moving and Handling element.
   - Equipment: A cluster related to the spreader bar accessory for the ceiling track provision within the Trust. A thorough investigation with the multidisciplinary team and equipment supplier was undertaken with no conclusive evidence of equipment failure or user error. A decision was taken to replace these units with a different model which is deemed even safer for our patient population. Systems continue to be improved in the use of fabric washable slings (BAF 712).
3. Staff Health and Wellbeing
   - Human Factors Ergonomics (HFE) review completed and contributing factors identified for this area and Trust systems utilised to support this staff cohort.
4. Quality Improvement Initiatives
   - Devising a safe approach for introducing, positioning and removal of X-ray cassette in ITU for intubated patients requiring chest X-ray – to meet Trust protocol which now requires the patient to remain supine during this activity.
   - HFE advice and guidance provided for the setting up of a Complex Needs Clinic within the Outpatient department – in line with CQC fundamental standards and Equality Act (2010).

Health and Safety:

Key points to note:

1. The Trust reported has reported 16 RIDDOR within year (13 staff, 2 patients & 1 public). Each incident was investigated with actions arising where necessary.
2. The Trust reported 2 RIDDOR patient related incidents in Q 1 & Q4 and 1 member of the public in Q3:
   - Q1 - patient on home visit fell whilst exiting a taxi sustaining a fractured pelvis
   - Q4 - patient fell from ceiling hoist causing a laceration to the back of head
   - Q3 - Member of the public tripped over a section of drain cover and fell, causing a fracture to their wrist
3. A full first aid risk based review was undertaken throughout the trust and training arranged for 10 non-clinical staff to complete required training. This has been delayed due to Covid-19 Pandemic.

4. 24 sessions of Datix training been delivered in 2019/20, to ensure sufficient staff are trained in the use and completion of DATIX incident and risk reporting.
5. A review of all health & Safety training sessions has been undertaken incorporating changes in legislation and the Trust's needs.
6. An online risk assessment tool has been jointly developed with the IT Department and tested. The online assessment tool is ready for full role out and training provided has required throughout 2020.

Emergency Planning:

Key points to note:

1. The Trust achieved full compliance in the Emergency Preparedness Resilience & Response (EPRR) Core Standards during 2019/20.
2. Throughout 2019, the Deputy Chief Executive and the Head of Risk implemented the Trusts response to BREXIT No Deal.
3. COVID-19 pandemic - the Trust invoked both its Major and Business Continuity Plans (BCP) on the 19th March 2020, invoking Phase 1 of the BCP Response. This initial phase establishes the Trust's strategic, tactical and operational incident response which is underpinned by a structured command and control model, in line with the NHS England Emergency Preparedness, Resilience and Response (EPRR) Framework.
4. As the first wave of COVID-19 has peaked, this provides the Trust with an opportunity to move into Phase 2 & 3 of the BCP which is Recovery and Restoration, albeit with a number of challenges posed from the requirements of social distancing.
5. The Trust has trained in Q4:
   - 22 fit test trainers to ensure staff have personal protective equipment fitted correctly
   - 4 decision loggists to ensure the incident coordination centre (Command & Control) is effectively staffed and key decisions logged
   - Divisional Operational Managers to act up as Tactical Managers to support the Tactical COVID-19 response to free up senior nursing managers

Appendix 1 - Glossary of Terms

1. Clinical Risk Management - focuses on the risks directly associated with patient care.
2. Emergency Preparedness, Resilience and Response (EPRR) - is the means by which the NHS needs to plan for, and respond to, a wide range of incidents and emergencies that could affect health or patient care. These could be anything from extreme weather conditions to an outbreak of an infectious disease or a major transport or terrorist incident. The Civil Contingencies Act (2004) requires NHS organisations, and providers of NHS-funded care, to show that they can deal with such incidents while maintaining services.
3. Fire Safety - is the means by which all NHS organisations ensure the safety of patients, staff and visitors. For all premises under their control NHS organisations will need to select and effectively implement a series of measures to achieve an acceptable level of fire safety.
4. Formal complaint – is defined as a complaint managed in line with NHS Complaints Procedure 2015 in line with the Department of Health guidance which is known as local resolution.
5. Health and Safety Management - is “the means by which an organisation controls risk through the management process”. The management of occupational health, safety and wellbeing is now central to the effective running of the NHS. There is strong evidence linking patient safety, patient experiences and the quality of care with the safety, health and wellbeing of the workforce.
6. High Risk - is a risk will be deemed high if, the likely impact of the risk would lead to major disability or death of an individual or loss of service or reputation of the organisation or prosecution.
7. Incident reporting - is a fundamental tool of risk management, the aim of which is to collect information about adverse incidents and near misses, ill health and hazards, which will help to facilitate wider organisational learning. If incidents are not properly managed, they may have a negative impact on the patient experience and result in a loss of public confidence in the organisation and a loss of assets.
8. Management of medical devices - is the systematic approach to the acquisition, deployment, maintenance (preventive maintenance and performance assurance), repair and disposal of medical devices and medical device training, to ensure that medical devices are used safely, competently and effectively for the best care of patients and to comply with all relevant legislation and guidance.
9. Moving & Handling - The Manual Handling Operations Regulations 1992/2016 (MHOR) define manual handling as “any transporting or supporting of a load including the lifting, putting down, pushing, pulling, carrying or moving thereof) by hand or bodily force.”
10. Non Clinical Risk Management - is associated with all other Trust activities.
11. Risk Management - is a process of identifying, assessing, controlling and reducing risk across the whole organisation.
12. Risk - is defined as a hazard / exposure to danger which may lead to harm. The consequence of risk can be damaging and consequently steps must be taken to eliminate or minimise risks and / or limit the impact / frequency of occurrence.

REPORT TO TRUST BOARD
Thursday 22nd May 2020

Title	Chairman's Annual Fit and Proper Persons' Declaration
Sponsoring Director	Janet Rosser – Chair
Author (s)	Jane Hindle – Corporate Secretary
Previously considered by:	None
Executive Summary In line with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, the Trust is required to ensure that all individuals appointed to or holding the role of Executive Director (or equivalent) or Non-Executive Director meet the requirements of the Fit and Proper Persons Test (Regulation 5). The attached statement provides an overview of the processes and checks in place which provide assurance on the continuing fitness of Directors.	
Action required by the Board	The Board is requested to: • note the assurance given by the Chairman that all current Executive Directors and Non-Executive Directors meet the Fit & Proper Persons criteria. • confirm that the current Non-Executive Directors remain independent, for inclusion in the Trust's Annual Report 2019/20. • Note the Board Register of Interests
Related Trust Ambitions	Delete as appropriate: • Best practice care • More services closer to patients' homes • Be financially strong • Research, education and innovation • Advanced technology and treatments • Be recognised as excellent in all we do
Related Assurance Framework entries	None

Equality Impact Assessment completed	N/A
Any associated legal implications / regulatory requirements?	It is a requirement of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, to ensure that all individuals appointed to or holding the role of Executive Director (or equivalent) or Non-Executive Director meet the requirements of the Fit and Proper Persons Test (Regulation 5)

FIT AND PROPER PERSONS REQUIREMENTS:
DIRECTORS AND NON-EXECUTIVE DIRECTORS
CHAIRMAN'S ANNUAL DECLARATION

1.0 Background

1.1 In line with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, the Trust is required to ensure that all individuals appointed to or holding the role of Executive Director (or equivalent) or Non-Executive Director meet the requirements of the Fit and Proper Persons Test (Regulation 5).

1.2 The Fit and Proper Persons Test applies to Directors (both executive and non-executive, whether existing, interim or permanent and whether voting or non-voting) and individuals "performing the functions of, or functions equivalent or similar to the functions of a director".

1.3 Regulation 5 states that a provider must not appoint or have in place an individual as a director who:

- is not of good character;
- does not have the necessary qualifications, competence, skills and experience;
- is not physically and mentally fit (after adjustments) to perform their duties.

1.4 Regulation 5 also decrees that directors cannot have been responsible for, been privy to, contributed to or facilitated any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying on a regulated activity.

1.5 These requirements play a major part in ensuring the accountability of Directors of NHS bodies and outline the requirements for robust recruitment and employment processes for Board level appointments. In exceptional circumstances, Trusts may allow an individual to continue as Director without having met the requirements following approval of the Chairman and following an assessment of all elements of risk however this does not apply to any of the existing appointments..

2.0 Declaration for 2020

2.1 As Chair of The Walton Centre NHS Foundation Trust I confirm that all existing Executive and Non-Executive Directors meet the requirements of the Fit & Proper Persons Test.

My declaration has been informed by:

The application of the Board approved Procedure on Fit and Proper Persons Requirements including:

- Pre-employment checks for all new appointments undertaken in line with the NHS Employment Standards and including the following:

- Proof of identity
- Disclosure and Barring Service check undertaken at a level relevant for the post
- Occupational Health clearance
- Evidence of the right to work in the UK
- Proof of qualifications, where appropriate
- Checks with relevant regulators, where appropriate
- Appropriate references, covering at least the last three years of employment, including details of gaps in service.

- Annual Fit & Proper Persons Test self-declarations completed by all Executive and Non-Executive Directors.

- Annual and on-going Declarations of Interest for all Board members

- Additional checks for all Directors on the following appropriate registers:
- Disqualified directors
- Bankruptcy and insolvency

- An audit by HR of the data on personal files, in line with the Fit and Proper Persons Procedure

APPENDIX A

TEST OF INDEPENDENCE
FOR THE CHAIR AND NON-EXECUTIVE DIRECTORS

A major contribution of the Non-Executive Director (including the Chair) is to bring wider experience and a fresh perspective to the boardroom. Although they need to establish close relationships with the Executive Directors and be well-informed, all Non-Executive Directors need to be independent of mind and willing and able to challenge, question and speak up.

Monitor's Code of Governance which regulates NHS Foundation Trusts (provision B.1.2) requires that at least half of the Board of Directors, excluding the Chair, should comprise Non-Executive Directors determined by the Board to be independent.

In addition, this Code (provision A.3.1) requires that the Chair should, on appointment by the Council of Governors, meet the independence criteria set out in B.1.1.

B.1.1. The board of directors should identify in the annual report each non-executive director it considers to be independent. The board should determine whether the director is independent in character and judgement and whether there are relationships or circumstances which are likely to affect, or could appear to affect, the director's judgement. The board of directors should state its reasons if it determines that a director is independent despite the existence of relationships or circumstances which may appear relevant to its determination, including if the director:

- has been an employee of the NHS foundation trust within the last five years;
- has, or has had within the last three years, a material business relationship
- with the NHS foundation trust either directly, or as a partner, shareholder,
- director or senior employee of a body that has such a relationship with the
- NHS foundation trust;
- has received or receives additional remuneration from the NHS foundation
- trust apart from a director's fee, participates in the NHS foundation trust's
- performance-related pay scheme, or is a member of the NHS foundation trust's pension scheme;
- has close family ties with any of the NHS foundation trust's advisers,
- directors or senior employees;
- holds cross-directorships or has significant links with other directors through involvement in other companies or bodies;
- has served on the board of the NHS foundation trust for more than six years
- from the date of their first appointment; or
- is an appointed representative of the NHS foundation trust's university medical or dental school.

Appointments over 6 years

Ref Monitor's Code of Governance for FTs: provision B.7.1
Any term beyond six years for a NED should be subject to particularly rigorous review and should take into account the need for progressive refreshing of the Board. NEDs may, in exceptional circumstances, serve longer than six years but this should be subject to annual reappointment.

Board Member	Interest declared
Janet Rosser Trust Chair	None
Sheila Samuels Deputy Chair	None
Seth Crofts Senior Independent Director	Pro-Vice Chancellor, Health, Social Care and Medicine – Edge Hill University Review – Quality Assurance Agency
Sui Rai Non-Executive Director	Director, Raise Associates
Prof Nalin Thakkar Non-Executive Director	• Board of Governors – University of Manchester • Vice President for Social Responsibility and Professor of Molecular Pathology at The University of Manchester • Consultant Histopathologist at the Manchester University NHS Foundation Trust • Director, Alliance Investments Ltd
Barbara Spicer Non-Executive Director	• Director, Plus Dane Housing Association • Director, Northern Housing Consortium • Adviser for Housing to the Metro Mayor
Hayley Citrine Chief Executive	• Director, Liverpool Health Partners Limited
Andy Nicolson Medical Director	• Director of Limited Company for Private Clinical Practice
Jan Ross Director of Strategy and Operations	• Brother In Law is the Managing Director of Energy Innovation Solutions Ltd an alternative provider of PPE equipment. Only utilised due to COVID-19.
Lisa Salter Director of Nursing and Governance	None
Mike Burns Director of Finance and IT	None
Michael Gibney Director of Workforce and Innovation	None