NHS
The Walton Centre
NHS Foundation Trust

Public Trust Board Meeting

Thursday 10th June 2021

Agenda and Papers

Excellence in Neuroscience

OPEN TRUST BOARD MEETING
DRAFT AGENDA
10th June 2021
Virtual Meeting
WCFT
09:30 – 12:00

v = verbal d = document p = presentation

Item	Time	Item	Owner	Purpose
1	09.30	Welcome and Apologies	J Rosser	N/A
2	09.30	Declaration of Interests	J Rosser	N/A
3	09.35	Minutes and actions of meeting held on 6th May 2021	J Rosser	Decision (d)
4	09.40	Patient Story	L Salter	Information (v)
PERFORMANCE & GOVERNANCE				
5	10.00	Chair and Chief Executive's Update	J Rosser/ J Ross	Information (v)
6	10.10	Recovery & Restoration Update	J Ross/ Execs	Information (v)
7	10.20	Integrated Performance Report	CEO/Execs	Assurance (d)
8	10.40	Nurse Staffing – Biannual Acuity Review	L Salter	Assurance (d)
9	10.50	Guardian of Safe Working Report	A Nicolson	Assurance (d) **TO FOLLOW**
10	11.00	Mortality & Morbidity Report	A Nicolson	Assurance (d)
11	11.10	Staff Survey Action Plan	M Gibney	Assurance (d)
12	11.20	Chair's Report – Strategic BAME Advisory Committee	J Ross	Assurance (d)
13	11.25	Chair's Report – Quality Committee	S Crofts	Assurance (d)
14	11.30	Chair's Report – RIME Committee	S Crofts	Assurance (d)
15	11.35	Chair's Report – Business Performance Committee	D Topliffe	Assurance (d)
CONSENT AGENDA				
Subject to Board agreement, the recommendations in the following reports will be adopted without debate: • Infection Prevention & Control Annual Report (including Infection Prevention & Control Board Assurance Framework) • Quarterly Governance Report – Q4 2020/21				
CONCLUDING BUSINESS				
16	11.45	Any Other Business	J Rosser	Information

Date and Time of Next Meeting:
1st July 2021 commencing at 9.30am

UNCONFIRMED

Minutes of the Open Trust Board Meeting

Meeting via MS Teams

6th May 2021

Present:

Ms J Rosser	Chair
Mr S Crofts	Non-Executive Director
Ms K Bentley	Non-Executive Director
Ms S Rai	Non-Executive Director
Professor N Thakkar	Non-Executive Director
Mr D Topliffe	Non-Executive Director
Mr M Burns	Director of Finance and IT
Dr A Nicolson	Medical Director
Ms J Ross	Interim Chief Executive
Ms L Salter	Director of Nursing and Governance
Mr M Gibney	Director of Workforce and Innovation

In attendance:

Ms L Abernethy	Patient Access Centre and Performance Director (item TB19-21/22 only)
Mr J Baxter	Executive Assistant
Mr P Buckingham	Interim Corporate Secretary
Dr C Burness	Consultant Neurologist / Guardian of Safe Working (item TB22-21/22 only)
Mr J O'Sullivan	Director, Analytiqa (item TB20-21/22 only)
Ms E Sutton	Patient Experience Manager (item TB17-21/22 only)

Observing:

Ms E Parr	Communications and Marketing Manager
Ms E Pereira	Partnership Governor – Edge hill University

Trust Board Attendance 2021-22

Members:	Apr	May	Jun	Jul	Sept	Oct	Nov	Dec	Feb	Mar
Ms J Rosser	✓	✓								
Mr S Crofts	✓	✓								
Ms S Rai	✓	✓								
Prof N Thakkar	✓	✓								
Mr D Topliffe	✓	✓								
Ms K Bentley	✓	✓								
Ms H Citrine	✓									
Mr M Burns	✓	✓								
Mr M Gibney	✓	✓								
Dr A Nicolson	✓	✓								
Ms J Ross	✓	✓								
Ms L Salter	✓	✓								

TB14-21/22 Welcome and apologies

Ms Rosser welcomed those present to the meeting via Microsoft Teams and noted that Ms E Pereira was observing in her capacity as Partnership Governor for Edge Hill University and that Ms E Parr, Communications & Marketing Manager, was also observing

the meeting.

TB15-21/22 Declarations of interest

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

TB16-21/22 Minutes of the meeting held on 1st April 2021

The minutes of the meeting held on 1st April 2021 were agreed as a true and accurate record.

TB17-21/22 Patient Story

Ms Sutton joined the meeting.

Ms Sutton presented the patient story which had been provided by a long term patient who regularly attended for botox injections to assist with migraines. During a recent visit the patient slipped and fell in the hospital grounds on their way into the Trust. Dr Krishnan and staff from the Outpatient Department assisted the patient and provided first aid and the patient noted the kindness, consideration and care provided and stated that the additional support provided demonstrated that staff treat all patients as an individual. The patient recognised the difficulties brought on by the pandemic and noted that patients with long term conditions required continual consultations and treatments and wished to thank staff for continuing to support all patients who required regular treatment during these challenging times.

Ms Salter thanked Ms Sutton for sharing the story and stated that it was heart-warming to hear that despite the patient going through such a difficult time and being in such pain with their condition that they took the time to thank the staff and recognised the pressures that staff across the Trust had experienced during the pandemic.

Dr Nicolson noted that there were approximately 900 patients with overdue botox appointments at the end of 2020 and recognised that there had been delays and these would continue for some time which was challenging for the divisions to manage. The Trust had kept on top of follow-up patients who could attend remote consultations however it was recognised that it had been difficult for patients who required interventions for long term conditions.

Mr Topliffe noted that the patient had slipped on an icy patch on the way into the Trust and queried if there had been any learning from this incident. Ms Sutton stated that this had been raised as an incident on the Datix system and dealt with by the Estates team via the incident pathway.

Ms Sutton left the meeting.

TB18-21/22 Chair & Chief Executive's Report

Ms Rosser provided an update on activities since the previous Board meeting and gave an overview of the internal and external meetings attended during this time. It was noted that there had been a lot of time involved in external system working and this was likely to continue during the transition to an Integrated Care System (ICS) as set out in the Health White Paper. In response to a question from Ms Rai, who queried if the additional time commitment was sustainable, the Chair advised that it was sustainable but would necessitate effective time management. The new Health Act was due to be on the statute book by early 2022 and the ICS would be in place by April 2022. Mr Buckingham noted

the requirement for some consideration to be given to the roles of Deputy Chair and Deputy Chief Executive to provide assistance and support.

Mr Burns noted that regional Directors of Finance had met with NHS Providers regarding the white paper and discussed how best to interact with each other going forward to ensure good working relationships.

Ms Ross reported that the NHS remained at EPR incident level 3 with a review of the level expected in the coming weeks. She advised that numbers of COVID positive patients across Cheshire and Merseyside were at their lowest level since September 2020. The key focus for the Trust was the elective recovery programme and the hospital-cell was switching focus from COVID management to recovery. P2 patient recovery remained a concern across the region and an increase in the number of non-elective attendances at A&E departments had been recorded in recent weeks.

It was noted that the Government White Paper was due for a second reading during June 21. There was some discussion around how the Trust would align to the expectations however it was recognised that this provided a positive opportunity to impact population health and influence patient outcomes across the region. Discussions had been quite positive however as discussions progress through the detail there may be some issues to overcome. It was recognised that the Trust needed to organise itself internally to support the external focus on system working.

The Chair recognised that this provided a good opportunity to build relationships across the system however there remained a lot of uncertainty around implementation of developments set out in the White Paper.

The Board:

- **noted the report.**

TB19-21/22 Recovery and Restoration Presentation

Ms Abernethy joined the meeting.

Ms Abernethy noted that organisational planning guidance had been published on 25th March 2021 and a regional plan for H1 (Q1 and Q2 2021/22) had been compiled which was due for submission on 6th May 2021. An overview of national priorities for 2021/22 was presented along with the associated operational requirements. Criteria for accessing the Elective Recovery Fund (ERF) were highlighted and it was confirmed that all Trusts across the region needed to meet the criteria for the ERF to be accessed.

Activity assumptions for H1 against 2019/20 data were presented and it was noted that these were above the minimum data levels required. An overview of key planning assumptions was also provided and it was noted that this excluded spinal transfer activity as the service was still included within the LUFT plan.

The key risks for delivery were reviewed and discussed and it was recognised that a fourth wave of the pandemic would necessitate a review of current plans. Waiting List Initiative (WLI) requirements had been assumed in the recovery plan and there was currently appetite for these however there was a risk if appetite levels dropped. It was also noted that the waiting list of the planned transfer of spinal service was currently unknown

and discussions around this were ongoing. Ms Rai queried the risk regarding usage of WLI and Ms Abernethy noted that appetite to undertake the activity was currently good within Neurology, Neurosurgery and also Pain. She advised that the level of risk to the plan was minimal at present.

The Chair queried if the ERF was in addition to baseline funding and Ms Abernethy confirmed that this was the case and targets had to be achieved across Cheshire and Merseyside as a whole for this to be accessed. It was noted that the elective activity trajectory had been achieved during April 2021 across the HCP and progress was reviewed on a weekly basis. Some issues related to elective activity had been resolved utilising remote consultations and activity was reviewed weekly, it was noted that activity was now returning to 2019/20 levels.

Professor Thakkar noted the risk of a flu and COVID surge in winter and recognised that this was the time to build up resilience planning. Ms Abernethy noted that winter planning had been included in the recovery plan in accordance with NHSE/I guidance to incorporate incremental increases in activity over the winter period. Ms Salter advised that flu planning had begun in February 2021 and that plans had been put in place. Plans were also being prepared in conjunction with LUFT for a COVID vaccination booster programme. Ms Ross noted that lessons learned were reviewed internally and practice amended accordingly. She advised that the Trust was also participating in a national stock take of critical care arrangements.

Mr Burns queried if there had been any consideration of long COVID and how treatment for this patient cohort would fit into the recovery and restoration plan. Ms Abernethy clarified that this formed part of the internal plans and the Trust was linking with LUFT regarding this. Mr Gibney noted that a deep dive of the effects of long COVID on planning had been undertaken at the North West Partnership Forum and this had included testimony from patients with long COVID. The region was developing a set of principles however was not anticipating large numbers of patients. National guidance and practice was in development however work was underway regionally in the interim and reasonable adjustments would be required. Dr Nicolson advised that funding was available to deliver long COVID care and discussions were underway regarding the role of the Trust in providing this care as there were a number of Neurological symptoms. Work was underway with LUFT to provide support and advice and also implement pathways for patients who required Neurological input.

Ms Abernethy left the meeting.

The Board:

- **noted the report.**

TB20-21/22 Investors in People Assessment 2020

Mr Gibney stated that the Trust was committed to the Investors In People programme and this had been the third assessment in 7 years. Investors In People was the industry standard for people management and the most in-depth analysis of the Human Resources function.

Mr O'Sullivan joined the meeting.

Mr O'Sullivan presented a report detailing the successful gold award reaccreditation of the Trust and noted that this was particularly significant as the assessment had been undertaken during the COVID pandemic. It was highlighted that not many organisations achieve gold award status and to be reaccredited with this status during a pandemic was an excellent achievement. An overview of the key fundamental principles, processes and practices was provided and it was noted that a multi-faceted holistic approach was undertaken during the assessment. It was recognised that the response rate for the staff survey was 21% however a response rate of 11% or above was considered to be useful and relevant. Interviews and showcases were undertaken with more than 75 staff across all roles, demographics and length of service taking part.

An overview of the strengths identified was provided and it was recognised that the Trust wanted to be the best and had deeply embedded core values which were reflective of a strong culture. It was highlighted that a focus on innovation and ED&I came through strongly and the Trust was seen as a fair organisation that treated all equally. The outcomes demonstrated a run of positive results achieved over a period of time with the CQC Outstanding status, staff survey showing continued progression, excellent Friend and Family Test results and the top rating achieved in morale and team working.

It was noted that the vast majority of employee feedback had been positive however there had been some negative comments received. An overview of areas for development was provided with additional detail included in the full report. The next steps to be undertaken were reviewed and additional reviews would be held at 12 months and 24 months and it was noted that a health and wellbeing assessment was partially underway which would be concluded soon.

Mr Topliffe queried if there were many other Trusts across Cheshire and Merseyside engaged in Investors In People and Mr O'Sullivan advised that, while there were a number of Trusts engaged with Investors in People, there were very few operating at gold standard level. Ms Ross stated that she was proud of the report from a Trust perspective and the Trust strived for excellence so it was good to understand the next steps required to be taken. It was recognised that the Trust needed to celebrate this success and communicate this further.

Mr Crofts queried if there had been any disparity between the outcomes of the surveys and interviews and Mr O'Sullivan clarified that this had been the case in some areas which was why both approaches were undertaken to ensure a broader understanding. Internal surveys were reviewed in conjunction with the Investors In People survey and it was recognised that interviews provided an opportunity to delve deeper into staff responses.

The Chair thanked Mr O'Sullivan on behalf of the Board and noted that the report would be cascaded across the Trust.

Mr O'Sullivan left the meeting.

The Board:

- **noted the report.**

TB21-21/22 Integrated Performance Report

Ms Ross provided an overview of the Integrated Performance Report (IPR) noting that the report had been discussed in detail at Business Performance Committee and Quality Committee as noted within the Chair's reports. It was highlighted that complaints, sickness and agency spend had increased as had friends and family responses and mandatory training compliance.

Quality

Mr Crofts and Ms Salter noted that quality and safety metrics were progressing well and provided an overview of all HCAI targets noting that issues regarding MSSA remained and work around this was continuing. It was highlighted that there were currently 16wte nurse vacancies and the Trust was working with NHSE/I on the international recruitment programme which had experienced delays due to COVID, resulting in an increased reliance on NHSP staffing. An unstageable pressure ulcer had been reported and a piece of work was underway to review this, a tissue viability nurse had been successfully recruited and all band 5 and band 6 nursing staff would undertake mandatory pressure ulcer training. An improvement in Neurology risk assessment completion had been noted and this had been impacted by changes in ward manager posts.

Performance

Mr Topliffe and Ms Ross noted that the Trust had done well to hold the operational position during the last wave of the pandemic and this had provided assurance that plans were correct. It was highlighted that diagnostic and cancer targets continued to be met.

Workforce

Mr Gibney advised that staff sickness figures had improved and there were currently 11 members of staff off related to COVID, 7 of these staff were isolating with the remaining 4 COVID positive.

Finance

Mr Burns noted that the Trust had ended the year recording a small surplus and noted that the final accounts were subject to audit. It was noted that the Revaluation Reserve figure recorded on page 81 of the board pack had been updated and had reduced since this report was produced.

Mr Topliffe noted that the stretch target for capital expenditure had been met which provided a good platform for moving forward.

The Board:

- **noted the report.**

TB22-21/22 Guardian of Safe Working Report – Q3 & Q4 2020/21

Dr Burness joined the meeting.

Dr Burness presented an update on Q3 and Q4 of the Guardian of Safe Working report and provided an overview of issues escalated during the period August 2020 to January 2021. It was noted that the situation was now improving and there had been a full complement of rotas for the last 6 months. Junior Doctor training had been delayed and work to improve this was ongoing with positive feedback on the updated approach to training received. It had been identified that Junior Doctors were receiving less exposure

to theatres however this was now improving. Rotas had been amended for SHO and Registrars and this change had been managed well. Concerns had been raised in previous reports due to COVID and these had since been resolved however would be kept under review.

It was reported that a number of Junior Registrars had started in post and concerns had been raised regarding the RANA and thrombectomy programmes moving to a 24/7 service and staff had been encouraged to exception report any concerns around this. It was recognised that thrombectomy was the biggest risk and work was underway to mitigate any impact on training.

The Chair noted that this was a very useful report in providing an understanding of any concerns and issues reported. Ms Ross recognised the balance between trainees getting a good experience and observing practice that they wished to observe and the associated safety concerns of working beyond normal working patterns.

The Board:

- **noted the report.**

Dr Burness left the meeting.

TB23-21/22 Nurse Revalidation Report

Ms Salter presented an update on the progress of nurse revalidation and noted that registered nurses and registered nurse associates were required to revalidate every three years and the process for this was detailed. The Nursing & Midwifery Council (NMC) had provided a 12 week extension for the revalidation process to be completed due to the pandemic and at the time the report was produced all but one registered nurse had completed the revalidation process with work underway to support the remaining staff member.

Ms Rai queried the peak in staffing numbers due for revalidation in September and Ms Salter clarified that revalidation dates were based on the date of registration with the NMC.

The Board:

- **noted the report.**

TB24-21/22 Audit Committee Chairs Report

Ms Rai provided an update from the meeting of the Audit Committee held on 20th April 2021 and noted that the final accounts for 2020/21 would be presented for approval by the Board of Directors at an extraordinary Board meeting to be held on 24th June 2021. It was noted that the Anti-Fraud Annual Report for 2020-21 indicated a high level of compliance for the majority of measures however there were two measures that were rated amber. These were related to investigations and recovery of any losses and publicising any criminal or disciplinary cases in relation to fraud. It was recognised that there had not been any referrals during 2020-21 requiring action so the Trust had not been able evidence full compliance in these areas.

The draft report from the Head of Internal Audit had concluded an overall opinion of substantial assurance and this was not expected to change when the final report was published.

The Board:

- **noted the Chair's report.**

TB25-21/22 Charity Committee Chairs Report

Ms Rai provided an update from the meeting of the Charity Committee held on 15th April 2021 and highlighted that a risk management policy was currently under development and a risk register would be presented as a standing agenda item. A budget for the Charity would be implemented and this would be reviewed and agreed on an annual basis.

An updated 3 year strategy was under development and this would be presented at the July 2021 meeting.

It was noted that investment returns had been maintained during COVID and consideration was being given to the potential for merging certain funds if no plans for the utilisation of funds were forthcoming. The Charity accounts were subject to independent examination to be undertaken later in the year.

The Board:

- **noted the Chair's report.**

TB26-21/22 Quality Committee Chairs Report

Mr Crofts provided an update from the meeting of the Quality Committee held on 22nd April 2021 and highlighted that the Trust had experienced some challenges in relation to the thrombectomy service with some patients having to be diverted to Salford. A review of training had been undertaken and significant improvements made, the service was reported to be back on track with weekend cover now in place from 9am to 5pm. An extended weekend service from 8am to 8pm would be introduced from July 2021 and it was envisaged that a 24/7 service would be in place from September 2021. This would be kept under review going forward.

The Tissue Viability report had been presented which noted that there had been issues regarding service delivery due to a vacancy in the Tissue Viability Nurse post however the IPC team had worked to recruit to this post and ensure that patient safety was prioritised. A review of the service had been undertaken with substantial gaps identified and a detailed action plan was in place to address these gaps. A presentation about the Neurophysiology service had been provided which highlighted the dynamic work being undertaken within the department. It was highlighted that the Neurophysiology department provided a continually evolving service with a number of innovations and service developments introduced including the implementation of a mobile telemetry service.

The Board:

- **noted the Chair's report.**

TB27-21/22 RIME Committee Chairs Report

Mr Crofts provided an update from the meeting of the RIME Committee held on 31st March 2021 and highlighted the need to establish a financial recovery plan for the research function noting that the suspension of business as usual had an impact on activity and the potential for income generation. Most commercial trials other than those that were COVID related had been suspended and new trials had been put on hold. A comprehensive plan was under development in response to the external review and a financial recovery plan was central to this.

An independent review of the research unit at the Trust had been undertaken by the Director of Operations at Kings Cross College Trials Unit, an overview of the review process was provided and it was noted that the report proposed a number of potential actions to be considered. Further analysis and engagement would be undertaken and an action plan would be produced by the Committee.

The Chair noted that the Trust had been held up as a beacon of an excellent governance model on how to run a research department at a recent LHP Grand Round session.

The Board:

- **noted the Chair's report.**

TB28-21/22 Business Performance Committee Chairs Report

Mr Topliffe provided an update from the meeting of the Business Performance Committee held on 27th April 2021 and highlighted that the business plans had been approved in line with delegated authority approved at the previous Board meeting. These plans included the activity plan and the linked finance plan. Following this further amendments were required to be made to the plan and a further meeting was held on 4th May 2021 to review and submit the revised business plan.

The Apprenticeship Policy had been approved at the meeting and it was noted that the updated Q4 action plan for the Trust's People Plan had been presented for review. The NHS central people plan had not yet been published and it was noted that the internal people plan would be reviewed following publication of the central NHS people plan.

The Board:

- **noted the Chair's report.**

TB29-21/22 Consent Agenda

The Board agreed the following actions in relation to each Consent Agenda item:

- **Fit and Proper Persons Report** – received the report and noted the assurance provided.
- **Board of Directors Register of Interests** – confirmed the accuracy of the content of the report.

TB30-21/22 Any Other Business

There was no other business to discuss.

There being no further business the meeting closed at 12.00am

Date and time of next meeting
Thursday 10th June 2021 at 09:30 via Microsoft Teams

TRUST BOARD
Matters arising Action Log
June 2021

	Complete & for removal
	In progress
	Overdue

Date of Meeting	Item Ref	Agenda item & action	Lead	Update	Deadline	Status

Actions not yet due

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. **May 2020** Work on hold until after COVID-19	~~Oct 2019~~ ~~Jan 2020~~ ~~June 2020~~ ~~March 2021~~ June 2021	

REPORT TO TRUST BOARD

Date 10/06/2021

Title	Integrated Performance Report
Sponsoring Director	Name: Michael Woods Title: Interim Director of Operations and Strategy
Author (s)	Name: Mark Foy Title: Head of Information & Business Intelligence Name: Laura Abernethy Title Access & Performance Director
Previously considered by:	• Committee Quality Committee Business & Performance Committee

Executive Summary

This report provides assurance on all Integrated Performance Report measures aligned to the Business & Performance and Quality Committee's. 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.

Key performance highlights are detailed below:

Key Performance Indicators – Caring

High Performing Measures

Complaints – The number of complaints received has significantly reduced over the last eight months, both in raw numbers and when adjusted for total patient contacts.

This reduction has brought the Trust in line with the national average for written complaints received per 1000 WTE at the latest published period (Q2 2020/21).

Key Performance Indicators – Safe

Opportunity for Improvement Measures

Infection Control – There were two MSSA instances reported in month against a year end trajectory of eight. When measured against the benchmark standard of per 100,000 beds the current YTD rate is 58.57 which is outside of expected limits and is significantly above the latest national average (9.39).

Harm Free Care – Incidences of harm remain low and are performance within expected variation.

Key Performance Indicators – Well Led

High Performing Measures

Mandatory Training – Overall mandatory training compliance in April 2021 was still above the target of 85% with some individual topics dropping below target. Compliance remains high for E-Learning topics and hopefully now training has restarted we will see an increase in topics included on study days.

Opportunity for Improvement Measures

Nursing Turnover - Although still above the 10% target, performance has improved significantly over the last year and is experiencing special cause variation.

The Nursing vacancy rate is currently 4.74% and Medical is 0.05%. Nursing turnover remains high due to registered staff successfully being recruited into internal specialist nurse positions and career progression externally, two have returned to the ward areas, one from an internal position and one from an external post. The two divisional matrons have recently reviewed the skill mix across all areas and staff have been redeployed to maintain patient safety and to enhance staff clinical development.

Sickness/Absence - Sickness/Absence levels in April 2021 were above the target of 4.75% at 5.73%.

Appraisals – Appraisal compliance in April 2021 is 79.96% which is an improvement when compared with March 2021. The training team are continuing to work with individual departments to improve compliance

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

6 Week Diagnostic Waits – this standard has been achieved consistently in the last six months.

Underperforming Measures

Referral to Treatment – Welsh RTT performance continues to recover, but is still below the 95% target.

Key Performance Indicators – Effective

Opportunity for Improvement Measures

Activity – During April 2021 the Trust exceeded all activity targets set with the exception of elective activity. Elective activity is currently off trajectory due to two main drivers; 1) Delayed recommencement of pain daycase activity at Halton therefore reducing elective capacity on site, this is now planned to restart week commencing 24th May 2021. 2) Due to very short term, unexpected consultant staffing issues, presented only from 1st April 2021, it has not been possible to consistently undertake as many general anaesthetic interventional radiology procedures as anticipated when submitting the recovery plan. This has now been resolved.

Related Trust Ambitions	• Best Practice Care • Be financially strong • Be recognised as excellent in all we do
Risks associated with this paper	Associated access and performance risks all contained in divisional and corporate risk registers.
Related Assurance Framework entries	Associated BAF entries: • 001 Covid-19 • 003 Performance Standards • 005 Quality
Equality Impact Assessment completed	• No
Any associated legal implications / regulatory requirements?	• No
Action required by the Board	• To consider and note

The Walton Centre
NHS Foundation Trust

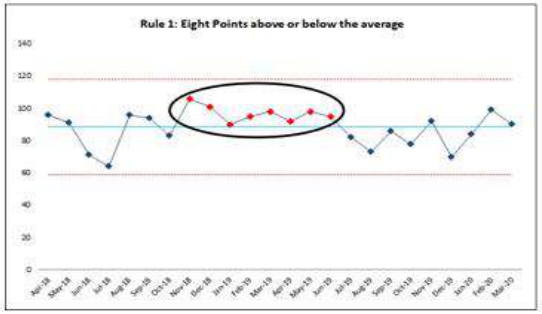
Board KPI Report
June 2021

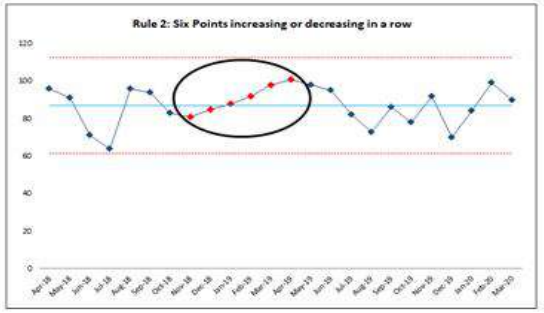
Data for April 2021 unless indicated

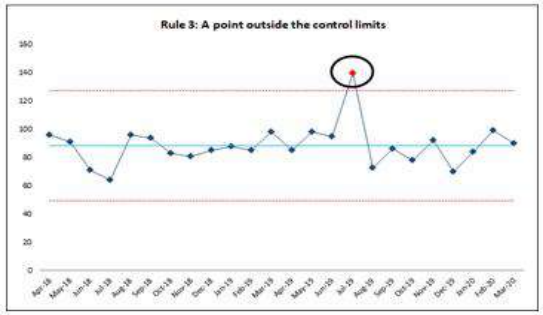
SPC Charts Rules

The Walton Centre NHS Foundation Trust

When using SPC Charts we are looking for unexpected variation. Variation occurs naturally in most systems, numbers fluctuate between typical points (control limits) the below rules are to assist in separating normal variation (expected performance) from special cause variation (unexpected performance).







All SPC charts will follow the below Key unless indicated

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

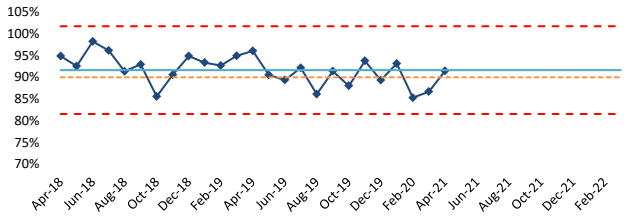
Excellence in Neuroscience

Operational

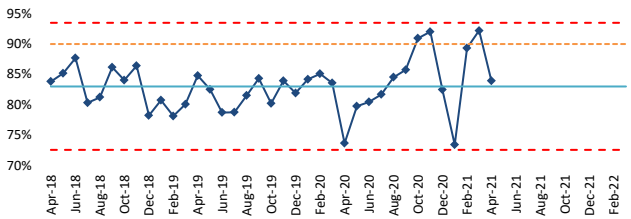
Effective - Theatres

The Walton Centre
NHS Foundation Trust

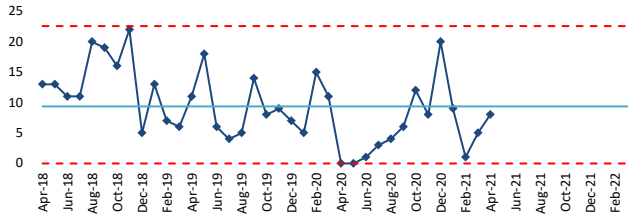
Theatre utilisation of Elective Sessions



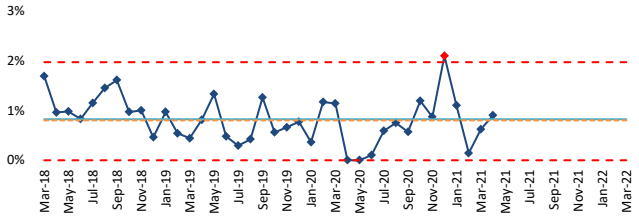
Theatre utilisation of in Session Time



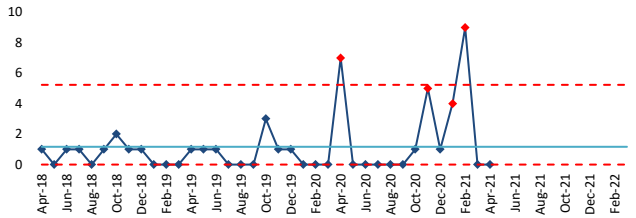
Number of Cancelled operations non clinical (on day)



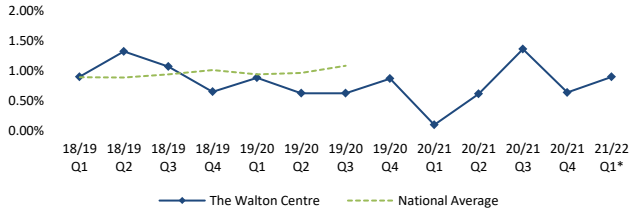
% of Cancelled operations non clinical (on day)



Number of cancelled operations not re-admitted within 28 days



Non Clinical Cancelled Ops as a % of Elective Admissions

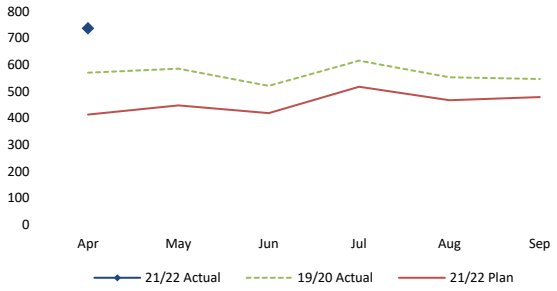


Operational

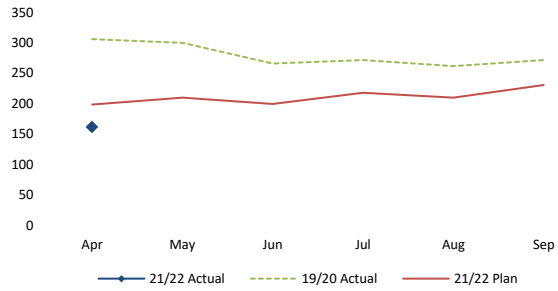
Effective - Activity Recovery Plan

The Walton Centre NHS Foundation Trust

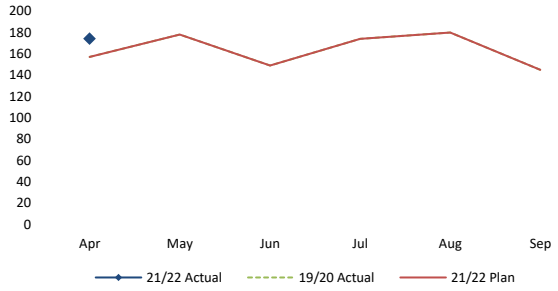
Daycase Activity v Plan



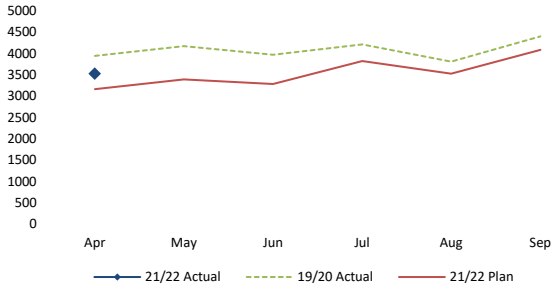
Elective Activity v Plan



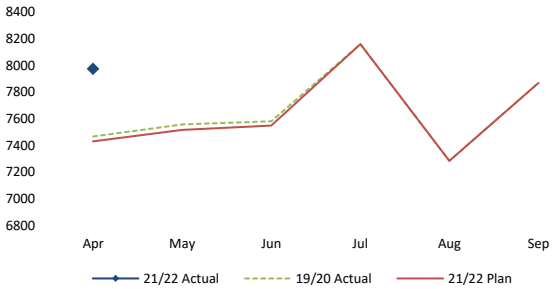
Non Elective Activity v Plan



New Outpatients Activity v Plan



Follow Up Outpatients Activity v Plan



April 21 Activity Performance

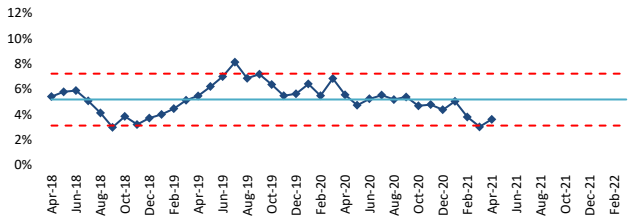
POD	Actual (% of 19/20)	Target (% of 19/20)
Daycase	129.07%	72.42%
Elective	52.94%	65.00%
Non Elective	110.83%	100%
New Outpatients	89.35%	80.23%
Follow Up Outpatients	106.78%	99.49%

Quality of Care

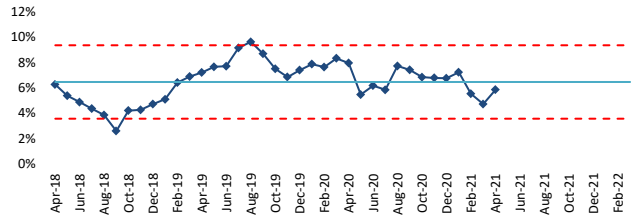
Well Led - Workforce KPIs

The Walton Centre NHS Foundation Trust

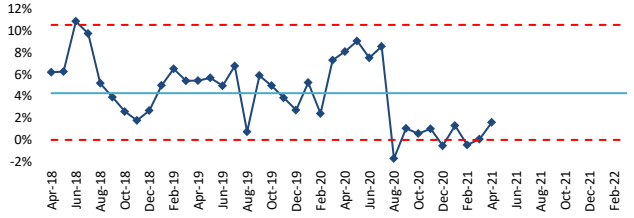
Overall Vacancy Level %



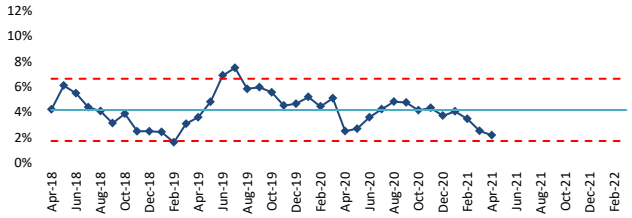
Nursing Vacancy Level %



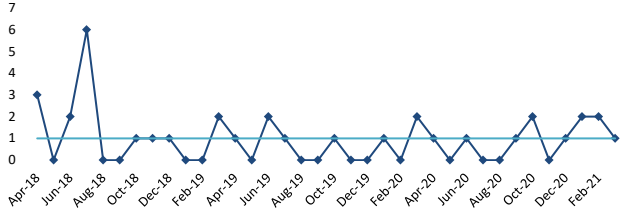
Medical Vacancy Level %



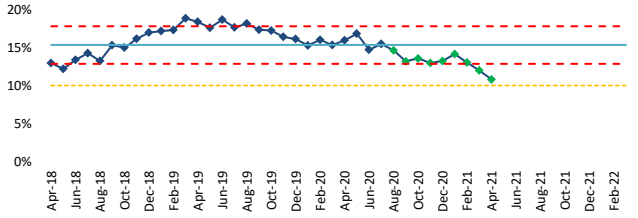
Other Staff Vacancy Level %



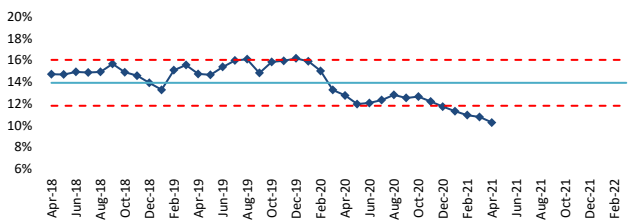
Medical Leavers



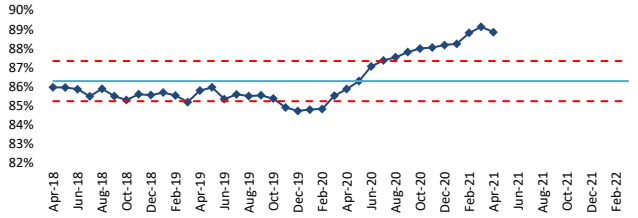
Nursing Turnover (Rolling 12 months)



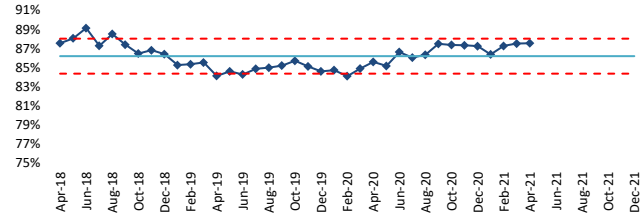
Other Staff Turnover (Rolling 12 months)



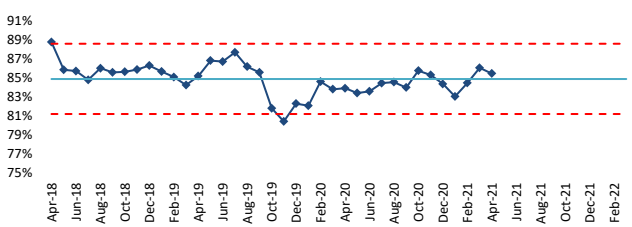
Staff Stability Index - All Staff



Staff Stability Index - Nursing



Staff Stability Index - Medical

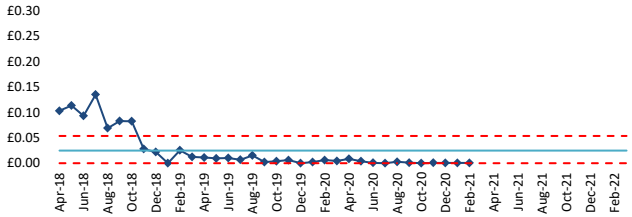


Quality of Care

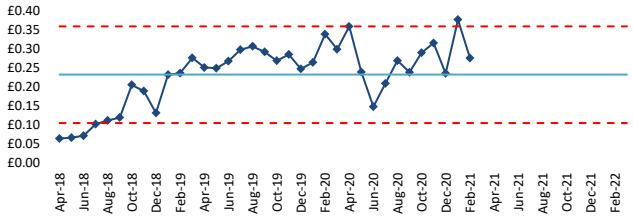
Well Led - Workforce KPIs

The Walton Centre NHS Foundation Trust

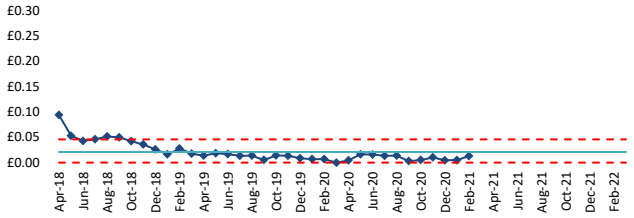
Nursing & HCA Agency Spend (£m)



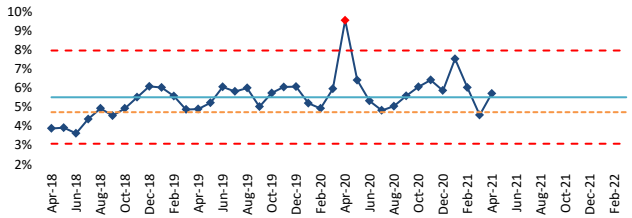
Nursing & HCA Bank Spend (£m)



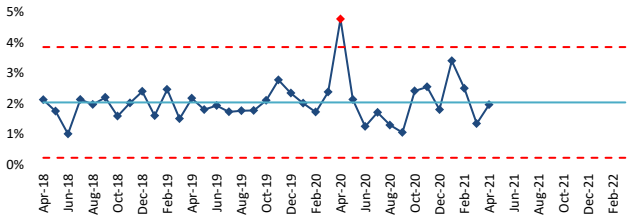
Nursing & HCA Overtime Spend (£m)



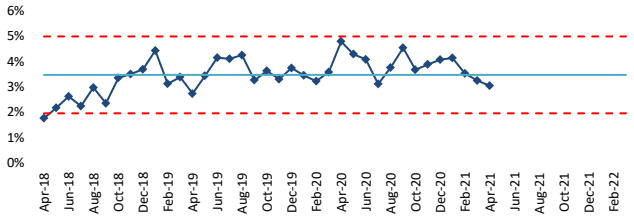
Sickness/Absence (Monthly)



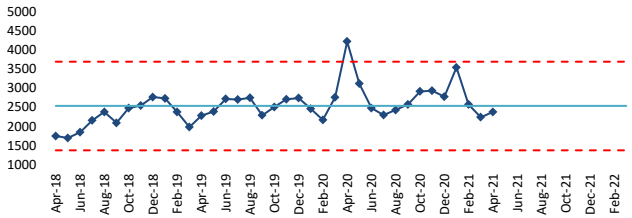
Short Term Sickness/Absence (Monthly)



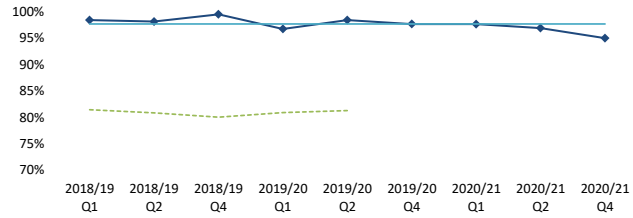
Long Term Sickness/Absence (Monthly)



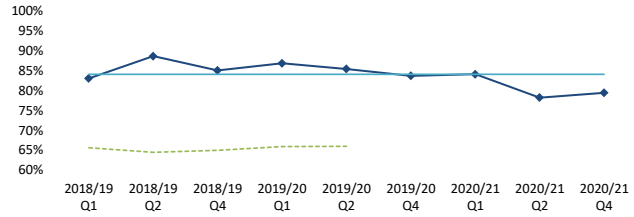
Lost Days due to Sickness/Absence (Monthly)



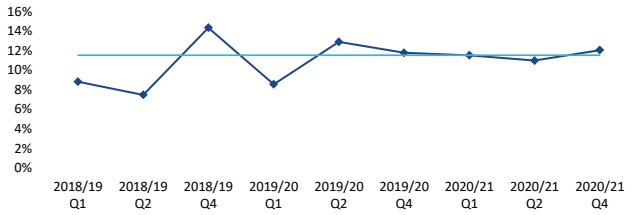
Staff FFT - % Recommend as Place of Care



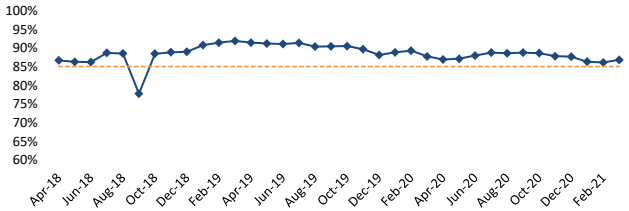
Staff FFT - % Recommend as Place of Work



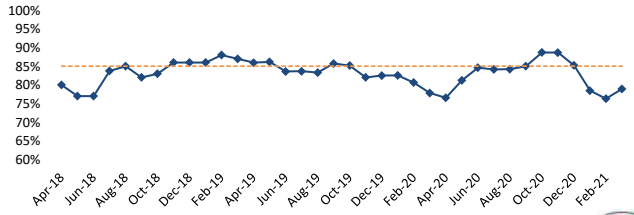
Staff FFT - % of Organisation Staff Responded



Mandatory Training Compliance (Rolling 12 months)



Appraisal Compliance (Rolling 12 months)



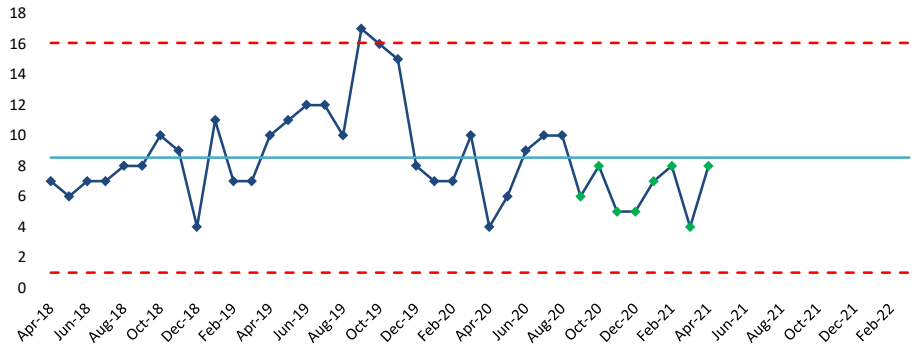
Excellence in Neuroscience

Quality of Care

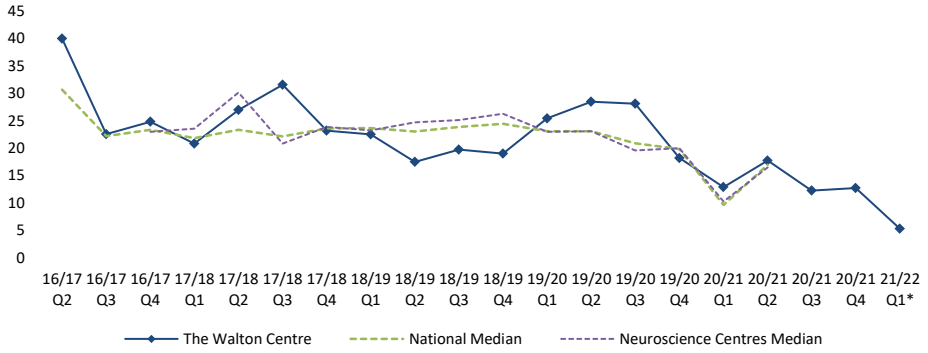
Caring - Complaints

The Walton Centre NHS Foundation Trust

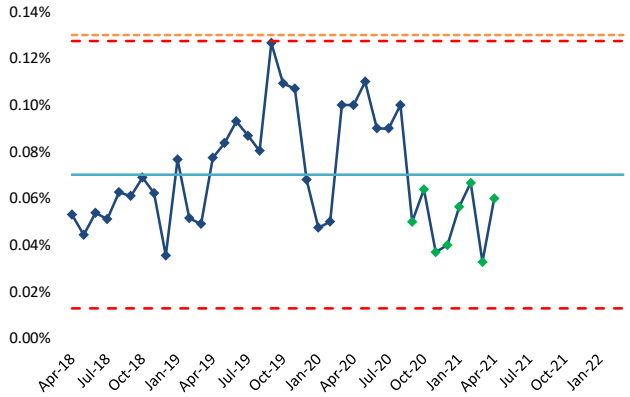
Total Complaints Received in month



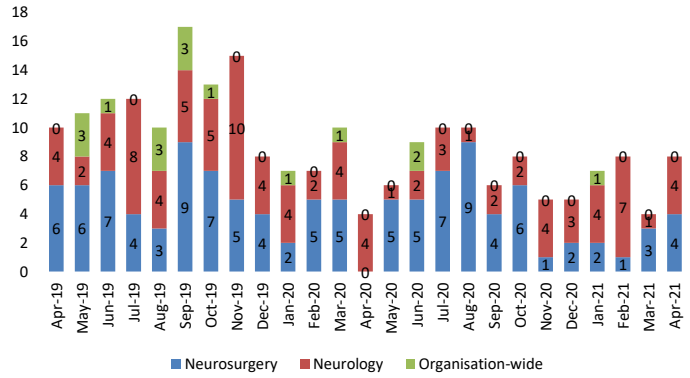
Quarterly Complaints per 1000 WTE



% Complaints Received against Activity



Total Complaints Received



Narrative

In April 2021 the Trust received 8 complaints. 4 Neurology, 4 Surgery (1 Reopened).

The number of complaints the Trust receives has a wide variation range meaning the expected numbers range from 1 to 16 at an average of 8 per month. The number of complaints received has significantly dropped during recent months.

Due to the reduction seen the Trust is now in line with the national average and neuroscience centres average up the latest published period of Q2 2020/21.

Local data for Q3 and Q4 2020/21 shows a further reduction.

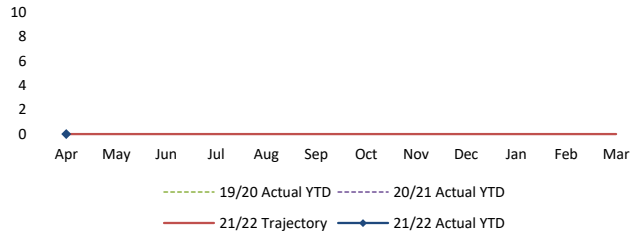
Excellence in Neuroscience

Quality of Care

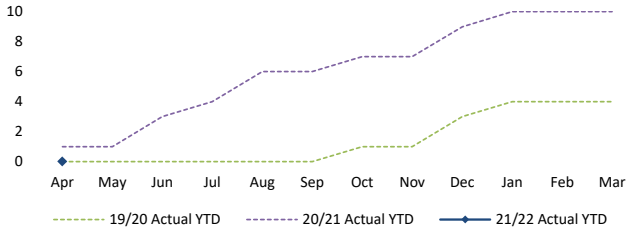
Safe - Infection Control

The Walton Centre NHS Foundation Trust

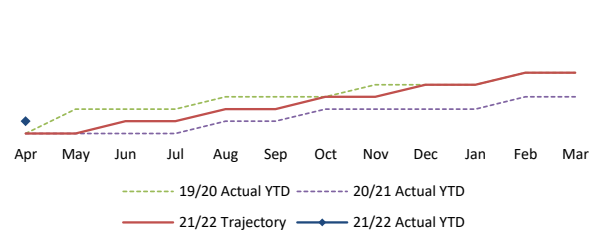
MRSA Bacteraemia



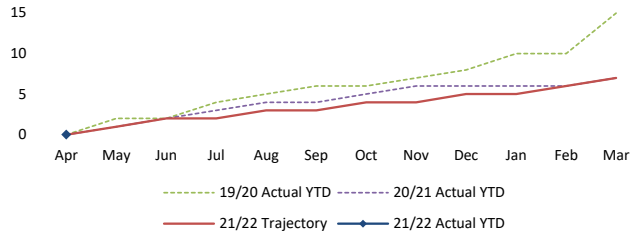
CPE



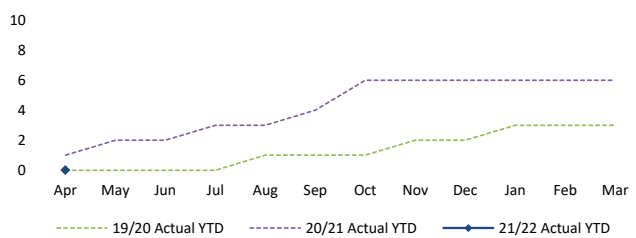
C.Diff



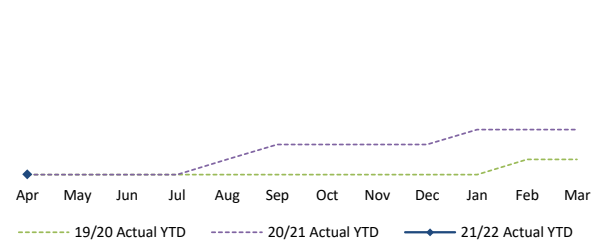
E.Coli



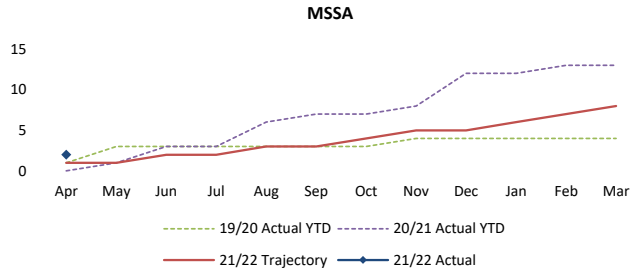
Klebsiella Bacteraemia



Pseudomonas Bacteraemia



MSSA



Total Healthcare Acquired Infections 2021/22

	MRSA B	CPE	C.Diff	E.Coli	KB	PB	MSSA	Total
Cairns								0
Caton								0
Chavasse								0
CRU								0
Dott							1	1
Horsley			1				1	2
Lipton								0
Sherrington								0
Total	0	0	1	0	0	0	2	3

April Breakdown by Ward

C.Diff - 1x Horsley
MSSA - 1x Dott, 1x Horsley

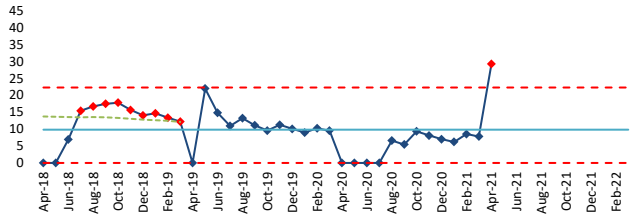
Excellence in Neuroscience

Quality of Care

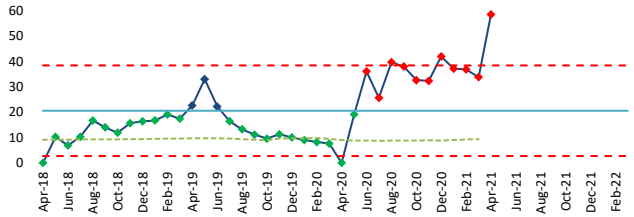
Safe - Infection Control

The Walton Centre
NHS Foundation Trust

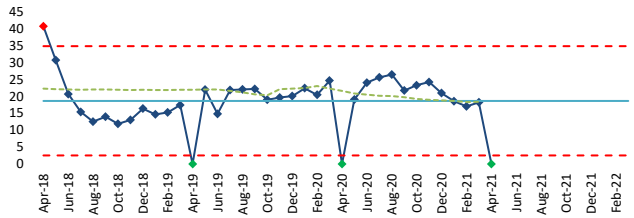
C.Diff Rate per 100,000 Bed Days YTD



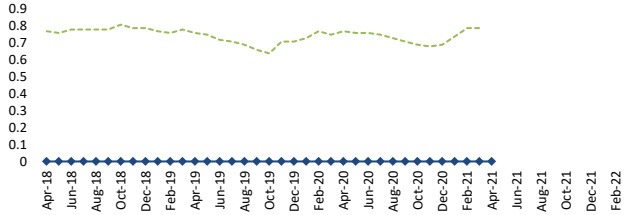
MSSA Rate per 100,000 Bed Days YTD



E.Coli Rate per 100,000 Bed Days YTD



MRSA Rate per 100,000 Bed Days YTD



Narrative

There were two MSSA instances reported in month against a year end trajectory of eight. When measured against the benchmark standard of per 100,000 beds the current YTD rate is 58.57 which is outside of expected limits and is significantly above the latest national average (9.39).

There was also one C.Diff instance in month against a year end trajectory of 5. The rate per 100,000 bed days is currently at 29.28 which is outside of normal limits.

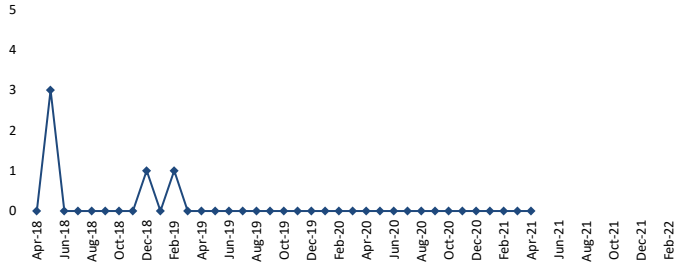
All other infections are within their trajectories. E.Coli rate per 100,000 bed days have typically been better or in line with the average, while MRSA has been consistently better.

Quality of Care

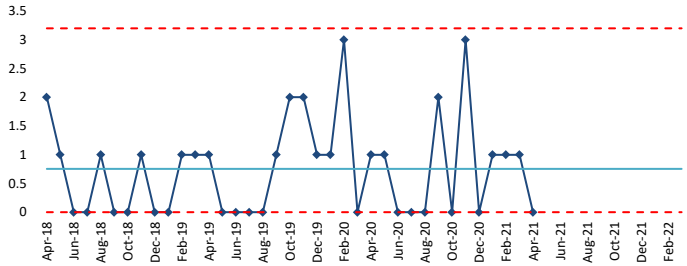
Safe - Harm Free Care

The Walton Centre
NHS Foundation Trust

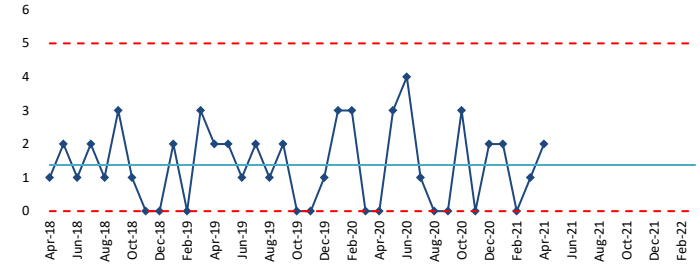
Total Moderate or Above Harm Inpatient Falls



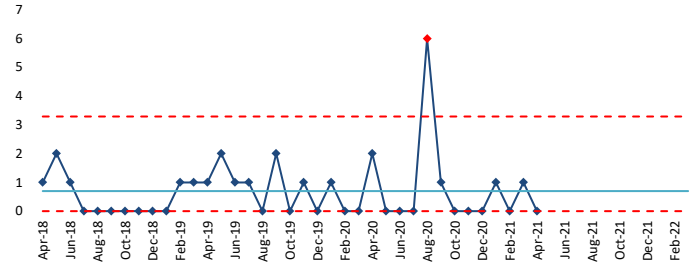
Total Hospital Acquired Pressure Ulcers (Category 2, 3, 4 & Unstageable)



CAUTI Incidences



VTE Incidences



Narrative

There were no falls which resulted in moderate or above harm in month.

There were no Hospital Acquired Pressure Ulcers in month

There was two CAUTI incidence in month

There were no VTE incidences in month

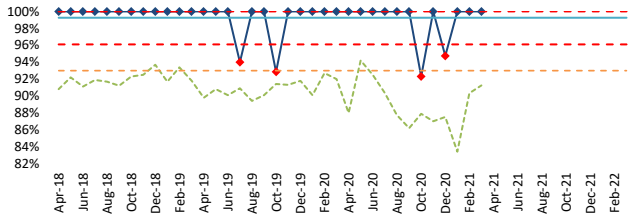
All harm measures are within normal variation.

Operational

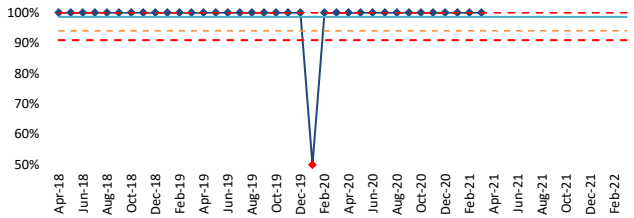
Responsive - Cancer

The Walton Centre
NHS Foundation Trust

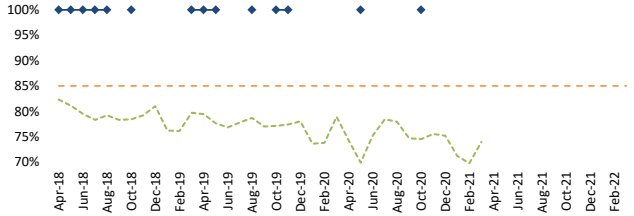
14 Day Performance



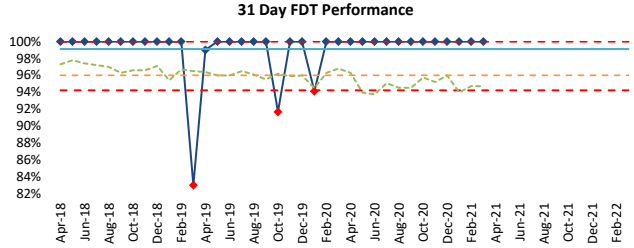
31 Day Subsequent Performance



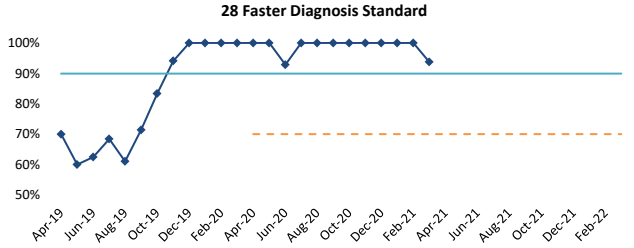
62 Day GP Urgent Referral



31 Day FDT Performance



28 Faster Diagnosis Standard



Narrative

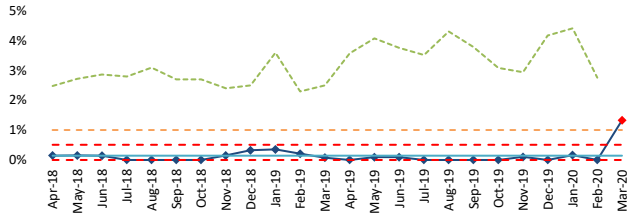
The Trust has continued to see and treat all cancer patients throughout March as these patients are designated as urgent, therefore COVID-19 has not impacted their care and treatment.

Operational

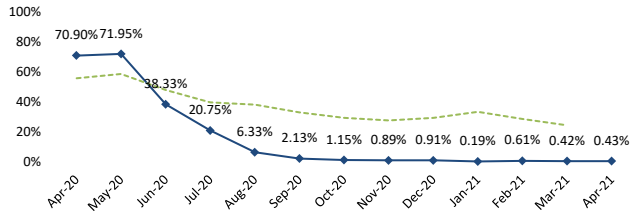
Responsive - Diagnostics

The Walton Centre
NHS Foundation Trust

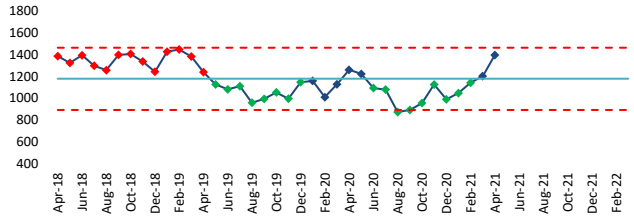
6 Week Diagnostic Performance (18/19 - 19/20)



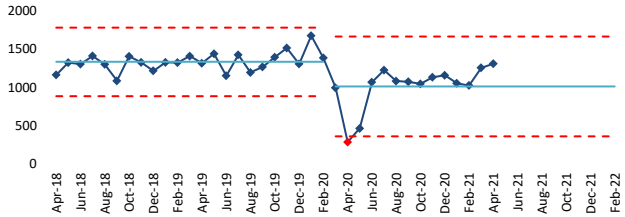
6 Week Diagnostic Performance (20/21 - 21/22)



Total Diagnostic Waits at Month End



Total Diagnostic Activity in Month



Narrative

The Diagnostic 6 week standard has continued to meet the target since November 2020 with performance at 0.43% in April 2021. Performance has improved significantly since May 2020, however due to Infection Prevention and Control measures Radiology capacity is at 90% therefore any increase in demand may impact performance.

Ward Scorecard

April 2021

The Walton Centre NHS Foundation Trust

	Safe Staffing				Workforce		Harms				Infection Control			
	Day Registered	Day Non Registered	Night Registered	Night Non Registered	Sickness Rate	Vacancy Rate	Pressure Ulcers	Falls (Mod+)	UTI	VTE	MRSA	MSSA	E Coli	C Diff
Cairns	99.5%	159.6%	104.9%	163.8%	7.77%	-1.79%	0	0	0	0	0	0	0	0
Caton	118.8%	98.9%	119.9%	122.5%	2.02%	-1.25%	0	0	0	0	0	0	0	0
Chavasse	101.6%	153.7%	119.1%	138.6%	9.12%	3.29%	0	0	0	0	0	0	0	0
Dott	99.9%	130.8%	96.8%	146.4%	10.12%	1.81%	0	0	1	0	0	1	0	0
Lipton	106.1%	153.7%	100.0%	139.4%	3.23%	-11.24%	0	0	0	0	0	0	0	0
Sherrington*	-	-	-	-	-	-	-	-	-	-	-	-	-	-
CRU	122.8%	148.1%	121.5%	221.8%	7.08%	6.41%	0	0	1	0	0	0	0	0
Horsley ITU	96.6%	104.7%	97.8%	97.7%	8.16%	2.13%	0	0	0	0	0	1	0	1

*Sherrington was closed during the month

Excellence in Neuroscience

WELL LED

Finance

THE WALTON CENTRE NHS FOUNDATION TRUST
SUMMARY FINANCIAL INFORMATION

Trust I&E	In month			H1 draft plan
	Plan £'000	Actual £'000	Variance £'000	Plan £'000
Patient Care Income	9,171	9,285	114	55,029
Exclusions	2,121	1,728	(393)	12,723
Private Patients	9	0	(9)	52
Other Operating Income	456	482	26	2,734
Total Operating Income	**11,757**	**11,495**	**(262)**	**70,538**
Pay	(6,168)	(6,233)	(65)	(37,395)
Non-Pay	(2,718)	(2,654)	64	(17,081)
Exclusions	(2,121)	(1,823)	298	(12,722)
COVID	(161)	(114)	47	(966)
Total Operating Expenditure	**(11,168)**	**(10,824)**	**344**	**(68,164)**
EBITDA	**589**	**671**	**82**	**2,374**
Depreciation	(464)	(487)	(23)	(2,784)
Profit / Loss On Disp Of Asset	0	3	3	0
Interest Receivable	0	0	0	0
Financing Costs	(51)	(53)	(2)	(306)
Dividends on PDC	(127)	(127)	0	(762)
I & E Surplus / (Deficit)	**(53)**	**7**	**60**	**(1,478)**
Capital donations I&E impact	**20**	**22**	**2**	**120**
I & E Surplus / (Deficit)	**(33)**	**29**	**62**	**(1,358)**

Due to COVID, the financial regime remains based on block funding for the 1st 6 months of the financial year (H1) and anticipated spend for the same period (based on average spend in Q3 of 2020/21). At the time of writing the H1 plan is £1.4m deficit (submitted to HCP in April).

The current H1 plan may be subject to change due to:

- It does not take account of any income that may be received as part of the Elective Recovery Fund (ERF);
- The H1 2021/22 financial plan of £1.4m deficit is draft only as financial income allocations from healthcare partnership for COVID-19, Growth, Top-up and Elective recovery is still to be confirmed, nationally the expectation is that the Trust will be required to break-even;
- 'Block' funding received for Top-up, COVID related costs & growth (based on fair share of sector funding).

It is expected that the HCP will deliver a balanced financial plan for H1 and work continues to understand how this will be achieved. A detailed financial plan is required to be submitted to NHSE/I on 24th May.

In month 1, the Trust reported a £29k surplus position. This is a £62k improvement on the planned in month deficit position of £33k. This improvement is due to a specialist commissioner adjustment to block payments for high cost drugs cost and volume forecasts (which was challenged and agreed to be included from May block payments).

The in-month position includes £0.1m spend incurred as a result of COVID-19.

STATEMENT OF FINANCIAL POSITION - 2021/22	March-21	April-21	Movement
	£'000	£'000	£'000
Intangible Assets	869	855	(14)
Tangible Assets	86,164	85,715	(449)
TOTAL NON CURRENT ASSETS	**87,033**	**86,570**	**(463)**
Inventories	1,157	1,570	413
Receivables	7,523	3,874	(3,649)
Cash at bank and in hand	35,689	35,891	202
TOTAL CURRENT ASSETS	**44,369**	**41,335**	**(3,034)**
Payables	(25,914)	(22,367)	3,547
Provisions	(226)	(226)	0
Finance Lease	(52)	(52)	0
Loans	(1,569)	(1,569)	0
TOTAL CURRENT LIABILITIES	**(27,761)**	**(24,214)**	**3,547**
NET CURRENT ASSETS/(LIABILITIES)	**16,608**	**17,121**	**513**
Provisions	(720)	(713)	7
Finance Lease	(63)	(60)	3
Loans	(23,635)	(23,688)	(53)
TOTAL ASSETS EMPLOYED	**79,223**	**79,230**	**7**
Public Dividend Capital	30,513	30,513	0
Revaluation Reserve	2,947	2,947	0
Income and Expenditure Reserve	45,763	45,770	7
TOTAL TAXPAYERS EQUITY AND RESERVES	**79,223**	**79,230**	**7**

STATEMENT OF CASH FLOW - 2021/22	April-21 draft plan	April-21 Actual	Variance
	£'000	£'000	£'000
SURPLUS/(DEFICIT) AFTER TAX	**(53)**	**7**	**60**
Non-Cash Flows In Operating Surplus/(Deficit)	642	669	27
OPERATING CASH FLOWS BEFORE MOVEMENTS IN WORKING CAPITAL	**589**	**676**	**87**
Increase/(Decrease) In Working Capital	423	992	569
Increase/(Decrease) In Non-Current Provisions	0	(7)	(7)
Net Cash Inflow/(Outflow) From Investing Activities	(1,374)	(1,456)	(82)
NET CASH INFLOW/(OUTFLOW) FROM INVESTING ACTIVITIES	**(362)**	**205**	**567**
Net Cash Inflow/(Outflow) From Financing Activities	297	(3)	(300)
NET INCREASE/(DECREASE) IN CASH	**(65)**	**202**	**267**
OPENING CASH	**35,689**	**35,689**	**0**
CLOSING CASH	**35,624**	**35,891**	**267**

COVID-19 expenditure:

Expenditure incurred on COVID-19 is included within the reported financial position.

In month (April) spend was £113k.

COVID-19 costs are subject to independent audit if requested through NHS Improvement.

COVID -19 Expenditure	Apr-21 Actual £'000	Year to Date Actual £'000
Pay cost (incl. additional shifts, on-call, etc)	93	93
Other	20	20
TOTAL	**113**	**113**

Other spend includes providing free car parking for staff.

Capital

In month variance - £401k below plan.

Year to date variance - £401k below plan.

The plan reflects the final submission to Cheshire and Merseyside Health Care Partnership as part of the 2021/22 planning process.

Annual capital funding is now set at a HCP level (rather than using a nationally determined formula). For 21/22 allocated capital funding is £6.2m, which is approx. 50% greater than if the nationally determined formula was used.

CAPITAL

	In month			Year to date			Forecast		
	Plan £'000	Actual £'000	Var £'000	Plan £'000	Actual £'000	Var £'000	Plan £'000	Actual £'000	Var £'000
Division									
Heating & Pipework	92	3	89	92	3	89	1,100	1,100	0
Estates	0	0	0	0	0	0	850	850	0
IM&T	81	23	58	81	23	58	969	969	0
Neurology	0	0	0	0	0	0	2,349	2,349	0
Neurosurgery	0	0	0	0	0	0	2,594	2,594	0
Corporate	0	0	0	0	0	0	491	491	0
Capital Slippage	(47)	0	(47)	(47)	0	(47)	(2,150)	(2,150)	0
TOTAL (excl. external funding)	**126**	**26**	**100**	**126**	**26**	**100**	**6,203**	**6,203**	**0**
Digital Aspirant	301	0	301	301	0	301	3,623	3,623	0
TOTAL (incl. external funding)	**301**	**0**	**301**	**301**	**0**	**301**	**3,623**	**3,623**	**0**
TOTAL	**427**	**26**	**401**	**427**	**26**	**401**	**9,826**	**9,826**	**0**

Capital spend in month is £26k.

- **Heating & Pipework**: Phase 4 works - £3k.
- **IM&T:** £23k
  Staffing in relation to project support.

The year-end forecast capital spend is £9.8m (including external funding) which is in-line with the agreed funding allocations.

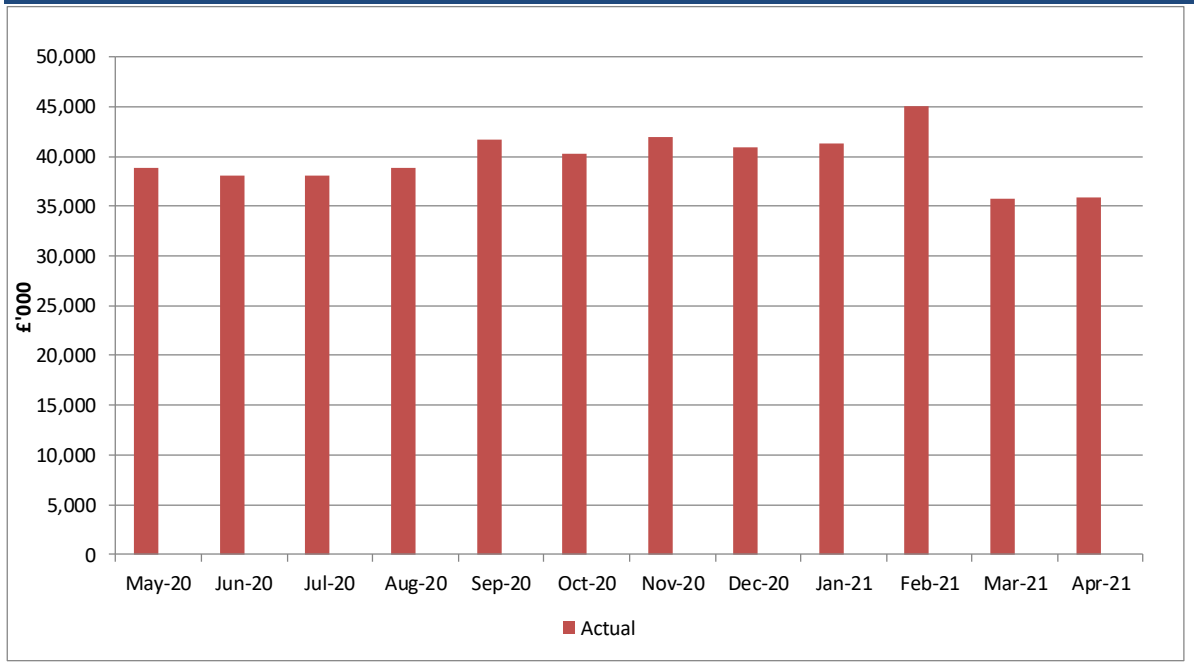
Work is currently being undertaken with clinical and operational staff to prioritise capital spend for 21/22 to ensure that it is delivered in line with agreed funding levels.

As of the end of April:

Actual Cash Balance: £35.9m.

Number of days operating expenses = 98 days.

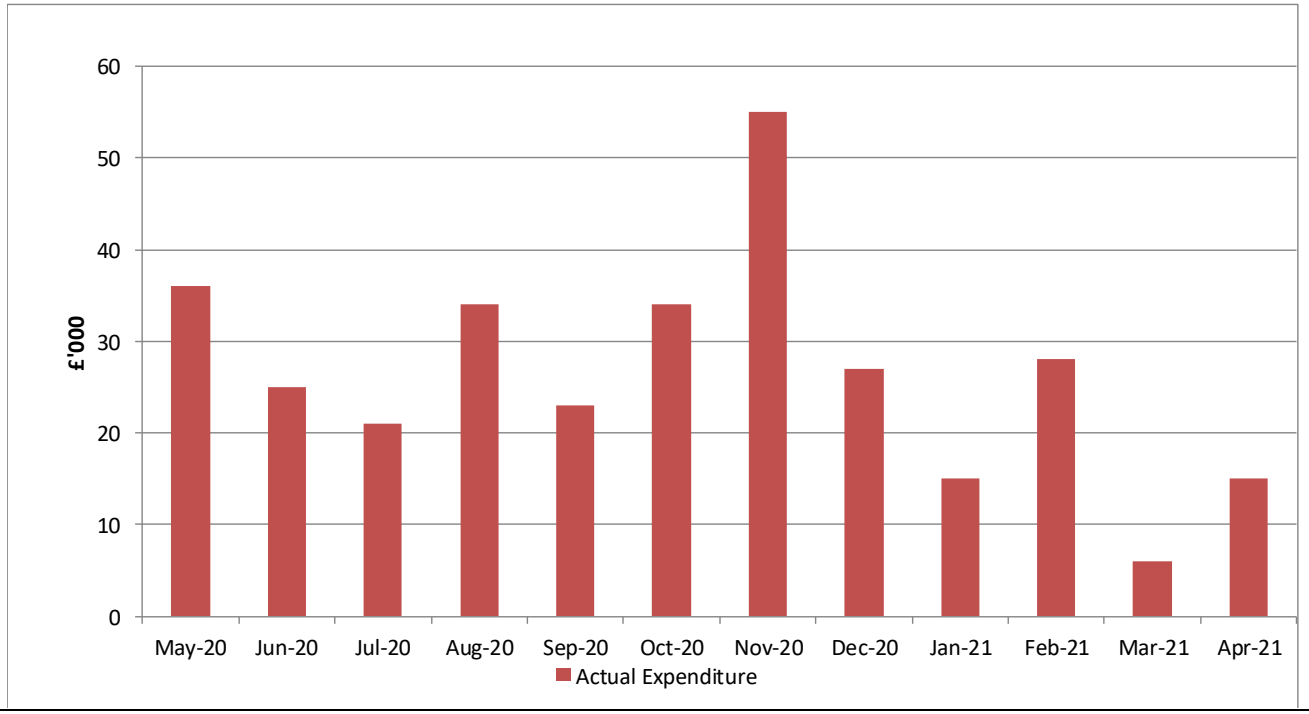
Cashflow against plan (Rolling 12 months)



The Trust cash balance at the end of April was £35.9m. This is an increase of £0.2m from the end of March.

The reduction of cash in March was due to the reversal of the advanced block payments that had been received from commissioners during the rest of 20/21, by the Trust each month for the new financial arrangements to cover the COVID-19 pandemic.

Block payments will be made in month and not in advance throughout 2021/22.

Agency Expenditure: In month Actual: £15k.	**Monthly Agency Expenditure (Rolling 12 months)**  	Agency spend incurred in April was £15k, an increase of £9k compared to March. At the end of April, £3k agency expenditure relates to COVID-19 (and is included within the COVID-19 expenditure analysis).

Key Risks and Actions in 2021/22.

As a result of the COVID-19 pandemic financial regulations have changed for 2020/21 and H1 2021/22, with the main changes being:

- Delay of 2021/22 business planning until 2nd half of 21/22, with finance regime of 2020/21 to continue for at least 6 months of 2021/22 (H1);
- Payment by Results (PbR) continued suspension for the first 6 months of the year and income being based on block values determined nationally (based on 2020/21 Q3 levels plus 0.5% inflation (incorporating a 0.28% efficiency requirement) and adjusted for the impact of CNST increases;
- Funding is being allocated for Top-up, COVID-19 (in relation to reasonable COVID-19 expenditure) and growth to C&M HCP for M1-6 which is to be distributed to all organisations;
- The trust is currently being monitored against draft plans for April to September forecast of £1.4m deficit submitted to NHSE/I and C&M HCP on 22nd April;
- System level financial targets will continue with an expectation that the system will breakeven at the end of H1, as such it is likely that the Trust will be expected to deliver a break even position at the end of H1 (financial plans are still being worked on meaning system allocations are still to be resolved)
- An Elective Recovery Fund (ERF) came into effect in April 21 in which the Trust is required to meet a set percentage of 2019/20 activity for outpatient, inpatient day-case and elective activity (M1-M6). If the Trust over-performs against this target then the Trust will be financially rewarded for doing so, but if it under-performs then will receive a retrospective financial penalty. The elective recovery scheme will be monitored at C&M HCP system level. At the present time there is no assumption around ERF income or costs have been assumed within the H1 plan (although operational and clinical teams will work to deliver planned activity levels);
- 2021/22 capital levels to be set at a Health & Care Partnership level and agreed across the C&M footprint. Note, this includes an allocation of additional PDC (digital Aspirant Funding) allocated for IM&T innovation;
- Financial governance and regulations remain in place and any financial management will be addressed in the same way it would regardless of the pandemic.

Further feedback will be provided to committee/ board members on the future financial framework once information is received from NHSI/E.

Even though the NHS and Trust are responding to the pandemic, there are a number of potential risks in 2021/22 that may impact in the delivery of the financial plan in the future;

RISK	COMMENT/ ACTIONS
Access to Elective Recovery Fund	The operational requirements for 2021/22 to aid restoration of outpatient and elective inpatient services within the NHS, the Trust is required to meet national targets for activity and income as follows: • Overall outpatient and elective activity value against 2019/20:

	○ 70% for April 2021; ○ 75% for May 2021; ○ 80% for June 2021; and ○ 85% from July to March 2022. Elective recovery gateway criteria; in order to receive additional funding for over-performing the national operational requirements per above the following criteria must also be met: • Addressing health inequalities; • Transforming outpatient services; • System-led recovery; • Clinical validation, waiting list data quality and reducing long waits; and • People recovery In addition the elective recovery fund will be managed and monitored at system level, therefore if the trust meets the national recovery targets set there is a risk that if the C&M HCP does not meet the requirements that the Trust will not the additional funding to meet the increased levels of activity.
Future NHS Financial Framework	As a result of the current national position with COVID-19, notification has been received that 2021/22 financial planning has been deferred. In addition to this, it has been confirmed that current financial arrangements will remain in place for at the 1st half of 2021/22. Current national guidance states that H1 funding will be based on Q3 20/21 spend extrapolated for 6 months, but there is currently no confirmation on how funds allocated to the HCP (e.g. COVID, growth elective recovery fund) will be allocated. Further work is being undertaken to understand the potential financial forecast for H1, draft financial plans have been submitted to the HCP with final plans to be submitted to NHSE/I on 24th May.
Efficiency requirements going forwards	Due to the current uncertainty around the financial framework, it is not

	clear what the efficiency requirements of the Trust will be and as such planning to deliver recurrent savings is difficult. Clearly the delay in 2021/22 business planning may impact on national efficiency requirements and it is currently not clear what internal efficiencies may need to be delivered to meet expected financial plans. However recurrent efficiencies will be required to be delivered in 2021/22 and work is being undertaken to identify these.
Future delivery of clinical services whilst still managing COVID-19	Organisations have to plan on how to deliver safe services whilst still managing COVID-19. 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 implement the required measures 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 fewer patients will be able to be seen given the additional PPE/ social distancing requirements).

REPORT TO THE TRUST BOARD
Date 10th June 2021

Title	**Nurse Staffing - Biannual Acuity Review**
Sponsoring Director	Name: Lisa Salter Title: Director of Nursing & Governance
Author (s)	Name: Lindsey Vlasman Title: Deputy Director of Nursing and Governance
Previously considered by:	• Senior nursing team • Quality Committee
Executive Summary The purpose of this paper is to provide assurance regarding nurse and other clinical staffing at The Walton Centre. This review is undertaken 6-monthly as per NICE guidance, with the last paper being presented in November 2020 (in a different format due to COVID 19). Due to the impact of COVID 19 there was no staffing paper undertaken in May 2020 and the November 2020 paper was an overview of staffing and not a full staffing paper. The review is undertaken to ensure that all stakeholders including patients, families, staff and the Trust Board recognise and understand any risks and assurances associated with current staffing levels and the actions required to ensure quality care is delivered in a safe and cost effective manner. This paper identifies that staffing is safe within The Walton Centre and the Quality Committee are requested to receive a further report in 6 months, or sooner should this be required. During the last 6 months the key area of focus has been ensuring all areas are staffed safely during the COVID 19 pandemic.	
Related Trust Strategic Objectives	Deliver best practice care Invest be financially strong Lead research, education and innovation Recognise as excellent in all we do
Risks associated with this paper	As contained within the paper
Related Assurance Framework entries	Related to BAF risk on national nurse shortages and ability to maintain safe staffing levels. Risk Number 0035 COVID 19 Risk Number 0001
Equality Impact Assessment completed	N/A
Are there any associated legal implications / regulatory requirements?	• Yes – NHSE / NHSI and CQC requirements and regulations
Action required by the Board	• To receive and note

1. Executive Summary

The purpose of this paper is to provide assurance regarding nurse staffing at The Walton Centre. This review is undertaken 6-monthly as per NICE guidance, with the last paper being presented in November 2020 as we were advised not to do staffing papers during COVID 19. The review is undertaken to ensure that all stakeholders including patients, families, staff and the Trust Board recognise and understand any risks and assurances associated with current nurse staffing levels and the actions required to ensure quality care is delivered in a safe and cost effective manner. This paper identifies that staffing is safe within The Walton Centre and the Board are requested to receive a further report in 6 months. The key focus for this staffing paper was to focus on how the trust were able to manage staffing during the COVID 19 pandemic and to give assurance that staffing was safe.

Also included in this paper is an overview of staffing in other clinical areas in the Trust, to ensure that staffing is safe within other front line staffing groups – Therapy Department, Neurophysiology and Radiology.

2. Introduction and Background

This review is ordinarily undertaken 6-monthly as per NICE guidance. Several national documents have been written about safe staffing in recent years including, “Safe and effective staffing: Nursing against the odds” (RCN, 2017), National Quality Board (2016), NICE safer staffing (2014), “The Francis review” (2013) and “The Berwick Review” (2013). The guidance from these documents has been considered when reviewing the staffing for nursing at WCFT. The Trust also acknowledges work undertaken by NHSE, CQC and NHS Improvement pertaining to safe staffing, efficiencies and the recent recruitment and retention work and this has also been referenced as part of the review. NICE guidance clearly notes that there is ‘no single nursing staff to patient ratio that can be applied across all acute adult in-patient wards.’

3. Staffing situation since the presentation of the November 2020 nurse staffing review

- The Deputy Director of Nursing and Governance has acted up as the Director of Nursing and Governance
- The Divisional Nurse Director for Neurology has acted up as the Deputy Director of Nursing and Governance
- The Divisional Nurse Director for Neurosurgery has been seconded to Neurology
- The Divisional Nurse Director for ITU and theatres has been covering Neurosurgery
- Diabetes Nurse for the Trust has now been appointed
- Tissue viability nurse for the trust has been appointed to and commenced in post in November 2020.
- A business case has been approved for additional staff in the Mental Health Nursing team
- The service level agreement with LUFT for the Practice Education Facilitator (PEF) role has now been completed and the trust has recruited into a second band 7 (PEF) role.
- The original Trust (PEF) is acting up into an 8A role to oversee International Recruitment, nursing education and competencies.

4. Methodology

Staffing data, Care Hours Per Patient Day (CHPPD) and actual and planned staffing is analysed monthly. This information is uploaded onto the national database (Unify), to the WCFT website for public access and reported to Trust Board, this reporting has continued throughout the COVID 19 pandemic.
During the pandemic the Trust set up a Command and Control structure with silver on call onsite 7 days a week 08:00-20:00. IPC daily reports, Trust sickness, staffing, beds and procurement management formed part of a daily review through command and control. The Trust safety huddle

was extended over the 7 days and a loggist was responsible for recording relevant actions and the frequent changes required.
As part of managing staffing the Trust was supported by 19 student nurses who opted into employment during this time. The second and third year students were deployed across the wards into band 3 and band 4 roles as part of the nursing teams dependent on their year of training status. Also to note that 6 out of 8 of the third year students transitioned over into substantive band 5 Registered Nurse posts in August 2020.
Redeployment of staff saw nurse specialists, neurophysiology, radiology, therapy and OPD staff supporting nursing teams on the wards. During this time our staff worked extremely flexibly and supported each other throughout the challenging period of uncertainty. Administration staff were utilised in different ways and a standard operating procedure was completed to inform how support could be provided appropriately. This level of commitment demonstrated the Walton Way of working, prioritizing patient safety and staff support.

5. Benchmarking

Usually we benchmark with other trusts to provide assurance however no further benchmarking exercise has been undertaken since COVID 19, and due to the redesigned ward pathways during the pandemic the numbers would not reflect the current ratios and the way we are working to ensure patients are allocated safely. The benchmarking exercise will be undertaken for the November 2021 staffing paper

6. Quality & Safety

Each division is working to ensure safe staffing for every area on a shift by shift basis. The Matrons and Ward Managers work closely to ensure effective and efficient strategic monitoring and management of staffing with the principle aim to promote patient safety and optimise patient and staff experience.

Following the safety huddle an additional daily bed meeting is held which incorporates a review of safe staffing. A new template has been devised for this meeting to capture any COVID issues that need to be raised to command and control. All ward areas are reviewed and report on activity, acuity and enhanced levels of care to understand the staffing levels required for the shift This does result in staff moves to manage safe staffing and patient risks, providing support to areas where acuity is higher. During this period there were no reported red flag events and all shifts were reported as safe.

Ward CARES assessments were not undertaken during the COVID 19 pandemic and the plan for assessments to recommence is June 2021.

7. Challenges and Risks

Registered Nurse Recruitment

This remains a challenge for the Trust and is recognised as a national problem across the UK. Despite proactive nurse recruitment, our registered nurse vacancies remain high. Current staffing continues to be supplemented by NHS Professionals (our nursing bank). Regular recruitment events are being held and flexible working opportunities promoted and considered.

We have continued to support the Trainee Nurse Associate (TNA) programme with four TNAs that have completed their training course in September 2020 and whom have now commenced in post as Registered Nurse Associates which support the Registered Nurse establishment. Four further TNAs have commenced training with Edge Hill University in 2020 following funding support from the Trust.

International Nurse Recruitment

With the national challenges in nurse staffing the Trust have joined the Cheshire and Merseyside collaborative to participate in International Recruitment. A business case was developed and approved by the executive team for 40 international nurses and we have already recruited into 11 of these posts which has now reduced to 7. A fixed term post for a band 6 pastoral care nurse has also been approved to support the international nurses which is currently out for advert.

Nursing retention

Nursing turnover is moving in the correct direction and is currently at 13% for the Trust. Further work is required to promote and ensure staff participate in exit interviews so their views can be captured and considered. The Trust has recruited our own practice education facilitator primarily to support and co-ordinate pre-registration students however they can further support the transition from student nurse to registered nurse and ensure staff are prepared and well equipped.

The Trust HR department promoted a range of options for staff to access support and maintain resilience during the pandemic. Feedback from debrief sessions following the first wave of the COVID 19 pandemic are being reviewed to ensure staff feel the Trust is responsive to their needs.

Management of sickness and absence

Management of staffing across all disciplines has proven extremely challenging during the COVID 19 pandemic. Risk assessments have been undertaken with staff resulting in redeployment of several staff following assessment. Management of staff shielding, self-isolating, COVID 19 related sickness and childcare issues has required joint working by the senior nursing team and senior HR staff. IT support and equipment has been readily available for staff to enable them to work at home. Alternative remote working duties have been assigned to several staff for example the daily relative calls for our in-patients.

Ward Reconfiguration during COVID 19

In response to the COVID 19 pandemic a review of the Trust's bed base was required.

CHAVASSE (Area A) **Covid-19 Isolation** **Side Rooms 1-13** **Bay 4**	• **Patients who have Temperature >37.8** • **and/or new persistent cough and loss of taste or smell** • **Positive Covid–19 result**
CHAVASSE (Area B) **Positive Step down area** **Bays 1,2,3**	• **14 days from positive result <u>AND</u> Immunocompetent**
DOTT **All <u>Non Elective</u> admissions** **&** **Elective admissions (if they DO NOT meet the criteria for Caton)**	• **All patients should be tested on admission. For patients who test negative, a further single re-test should be conducted on day 5 after admission.** • **Contact of Covid-19 positive case <u>(Isolate for 14 days)</u>** • **Asymptomatic**

	• **No known contact with a Covid-19 positive case**
CAIRNS **All <u>Non Elective</u> admissions** **&** **Elective admissions (if they DO NOT meet the criteria for Caton)**	• **All patients should be tested on admission. For patients who test negative, a further** • **single re-test should be conducted on day 5 after admission** • **Contact of Covid-19 positive case <u>(Isolate for 14 days)</u>** • **Asymptomatic** • **No known contact with a Covid-19 positive case**
CATON **All elective surgery including cancer**	• **Patients should self-isolate for 14 days prior to any scheduled surgery. If this is not possible Consultant to discuss with patient prior to admission re plan.** • **& tested in line with WCFT Covid-19 screening protocol** • **Asymptomatic**

Chavasse ward became our red / amber ward for COVID 19 positive or suspected cases. The 29 bedded ward was split into red and amber areas with amber being for the positive step downs. Dott and Cairns wards became amber wards for elective admissions that did not fit the green pathway and for non-elective admissions. Caton ward became our green ward with an altered patient pathway requiring patients to be screened, have a negative result and have self-isolated pre-admission. Sherrington ward was used for mutual aid locally and the acute stroke unit and hyper-acute stroke unit transitioned over from Liverpool University Foundation Trust (LUFT, Aintree site).

The ward reconfigurations led to cross cohorting of sub specialties which was a different way of working at the Trust. With both activity and patient pathways having changed our teams worked extremely flexibly whilst adapting to the changes and new governance processes required.

ITU/Theatres

Theatres during COVID 19

At the end of March 2020 the Trust commenced the first wave of the Covid 19 pandemic.

Due to the increased pressures on the NHS, the national decision was to cancel elective surgery unless the surgery was urgent, an emergency or on the cancer pathway. This was to ensure that there were beds available on the wards and ITU, if needed for patients with COVID 19.

Theatres were 13 staff down during the first wave due to the government's advice for vulnerable staff to shield. These members of staff were off work for 3 to 4 months. All other members of the theatre team were risk assessed and covered theatre sessions as required.

Due to the advice from Public Health England it was agreed to use clean and dirty runners in theatre for each procedure. Any new process was approved with the theatre management team, infection control, and clinical leads from anaesthesia and surgery. Due to the requirements of this

new process of clean and dirty runners, the Trust had to provide extra staff out of hours, implementing a second on call team. This resulted in staff being put on an on call rota at short notice, with impact of staff availability the following day. Staff rotas were also changed to support long day working.

Patients were anaesthetised in the theatre suite instead of the anaesthetic room (this is still the case now), and all staff in the department underwent education about donning and doffing of PPE. Most of this training was provided by the HCAs in the department. Fit testing in the department was a mammoth task, and was not in isolation in the department – 2 WTE members of the team were utilised to provide this, not only to the department but to other departments too. Different models of FFP3 masks proved to be a difficult task as the FFP3 masks provided kept changing, resulting in staff needed fit testing on an alternative mask regularly. It was later agreed it was best to fit test staff in theatres with reusable masks where possible to prevent the need for constant re testing.

Initially double cleaning of each area was undertaken in between patients which had an adverse effect on turnaround times as every item of equipment needed cleaning twice. The theatre team worked with Infection Prevention and Control team and benchmarked with other Trusts and found an alternative single cleaning solution.

Many of the theatre staff supported other departments, and several members of staff supported ITU for 3 months. Additional support was also given to procurement services with the increased demand and top up of PPE needed across the organisation seven days a week.

Mutual aid was also provided to LUFT, Aintree site for head and neck surgery. This involved providing a theatre and some staff to support their cases in the Walton Centre.

At the end of the first wave we started to increase normal theatre activity and following lengthy discussions we agreed a different process from clean and dirty running. We agreed that staff would don and doff when moving from clean to dirty areas instead, reinforcing the importance of hand washing and gelling of hands. The exception to this was confirmed COVID 19 positive patients would still use clean and dirty runners.

Several adjustments were required to ensure activity recommenced, different routes were taken for patients with COVID 19 or suspected infection with designated green and amber forward wait areas and recovery areas. Red patients were recovered post operatively in the theatre instead of recovery as they were in the highest risk category.

The COVID 19 pathways were decided based on the ward that the patients came from. For example, Caton ward allocated as a green pathway, enabling us with the required screening in place to deem these patients as low risk COVID 19 group.

ITU

During COVID 19, ITU was identified as providing mutual aid to other organisations. The Trust had a 3 stage approach to this, and following some building modifications to provide isolated areas, it was planned in 3 stages – first the utilisation of the negative pressure room. The second stage was the utilisation of the side rooms that had capacity of the gowning areas. The third phase was the utilisation of the bay area – cohorting the positive patients in a large area – in the first stage the Trust escalated rapidly into the main bay area – the maximum COVID 19 patient numbers at any one time were 7. There were issues with changing PPE, staff anxiety, changing drug locations and staff shielding. During this period we were able to staff safely due to having buddies from theatre and elective lists being cancelled. The staff feedback on the buddies has been very positive and a number of these staff were redeployed for a number of months.

The second surge proved to be more difficult – due to shielding, high maternity numbers, track and trace and shielding children, and more recently, the breaches in social distancing, requiring 14 staff

to be isolated. Staff resilience this time is also noted to be less, resulting in short term and long term sickness. Specialist Trusts tried to maintain a COVID 19 status free, so mutual aid has mainly focused on those COVID 19 negative level 3 patients, although the Trust did take COVID 19 positive cases, these have been from admission screens from those emergency admitted patients. It was also acknowledged nationally that staffing ratios should not exceed 2:1 utilising 1 critical care staff member and 1 'buddy' for 2 patients. Due to the geographical nature and side rooms of the unit – the Business Continuity Plan has been altered to reflect this with the ability to escalate to this ratio in the bay only.

8. Uplift

The uplift of establishments is set at 21% RN and 19% HCA to ensure that staffing is appropriate and financially viable. The uplift whilst lower than the national average, accounts for the higher dependency on newly qualified staff who do not have the additional leave (week) that staff who have worked for the NHS longer are entitled to, training requirements of each staff groups, as well as other leave arrangements.

Actions have been taken to improve fill rate of shifts with NHSP and the nurse bank has successfully been implemented across the Trust. This has been really positive and from September 2018 when work was commenced, we have continually seen a reduction in agency and an increase in bank which was the pattern we required and anticipated.

9. Revalidation

The implementation of the revalidation process by the Nursing and Midwifery Council in April 2016 has been supported within WCFT by a revalidation administration support who has worked with registered nurses Trust-wide to ensure that all revalidation requirements have been fulfilled. The Nursing Quality Lead also supports with the revalidation process. This has resulted in every RN revalidating and ensuring that all RNs could re-register and no PIN numbers have lapsed. All staff have been supported throughout this process.

The NMC provided an extra 3 months for staff to re-register during COVID 19 in case of delays however we have maintained 100% compliance.

10. Staffing Each Shift

Staffing has been reviewed by the senior nursing team alongside the finance team and shifts have been altered and improved due to staff wanting to work long days which has allowed extra staffing on some shifts whilst being cost-neutral.

Meetings are held regularly with the budget holders, the Director of Nursing and Governance and the Deputy Director of Finance to work closely with the Ward Managers and ensure they are managing their budgets effectively.

11. Staffing in other Areas

The need to consider the wider MDT when reviewing staffing is thought to be essential. Staffing concerns for these areas are also highlighted at the safety huddle and work prioritised.

Radiology

Against a backdrop of a national shortage of Consultant Radiologists and Radiographers WCFT currently have no Consultant Radiologist vacancies, following the appointment of 2 Clinical fellows to Consultant posts in 2020. Reporting from home has increased reporting volumes and has removed the requirement for reporting WLI.

The Radiographer staffing group, remains relatively stable, but has been under pressure throughout 2020 due to members of the team on Maternity leave and 1 member of the team on a long term career break. Recruitment to vacant posts has so far been successful, although non Neuro trained radiographers take approximately 18 months to train fully in the department. All members of the Radiographic team have had HCPC registration confirmed until 2022.

The department continues to place a high level of importance on the investment of training, together with in house professional development. Two radiographers are undertaking Post graduate courses in CT and MRI advanced Imaging. Two Principal Radiographers have successfully completed the Mary Seacole course, and one is now undertaking a Masters programme in Management, as part of the Trust apprenticeship scheme.

In addition, we have radiographer Advanced Practice to support different ways of working. There has also been an appointment to 1 x Apprenticeship trainee Assistant Practitioners

Managing staffing

The Radiographer and Radiographic Department Assistants team staffing rosters are available 3 months in advance. Taken into account are also the minimum staffing levels (agreed locally in the department) and clinical supervision requirements of trainee Assistant Practitioners. Any pressure areas are escalated to Service Manager / Principal Radiographers for action.

Neurophysiology

The impact of COVID 19 resulted in the majority of Neurophysiology clinical work being suspended, although urgent referrals continued to be accepted. As a result, the Clinical Physiologists were redeployed to support the HCAs on the wards. Throughout this period of time and since, the feedback from the nursing staff on the wards has been extremely positive, which has been particularly poignant, as coming from a scientific and technical training background, the Clinical Physiologists had no previous experience of providing personal care to patients. The Clinical Physiologist team were very grateful for the support provided by the nursing team.

After a turbulent year, in terms of staffing vacancies and maternity leave, the department has reached a stable position. After recruiting 1.4 WTE Consultant Neurophysiologists, who have settled into their roles, additional clinics are now being set up to reflect their areas of special interest. Activity is increasing slowly after the suspension of routine Neurophysiology work during the first COVID 19 wave, there is currently no requirement for any WLI EMG capacity to meet demand at this time.

The department continues to place importance and focus on continued professional development and the Consultant Neurophysiologists and Clinical Physiologists have a CPD programme they have developed to ensure they meet regularly with evidence of key learning outcomes for their clinical portfolios.

In collaboration with Manchester Metropolitan University, the team is an integral part of the delivery of the Clinical Physiologist student degree programme, BSc (Hons) Healthcare Science. This involves not only supporting work based placements but also the delivery and assessment/examination of the academic teaching. As a result of the pandemic, the Neurophysiology team has been working hard to restructure all of their academic lectures and as a result they are all now delivered via both live and recorded webinars.

In March 2020, the Neurophysiology service purchased two new long term video EEG systems for use in the home setting. Whilst this service is not new, these systems use new innovative technology which provides a very reliable camera recording, which is particularly easy for the

patients to use. The team is currently exploring further developments associated with this exciting technology.

Therapies

Background and current staffing

The Walton Centre Therapies service consists of 5 AHP disciplines that are required to hold valid HCPC registration: Occupational Therapy, Physiotherapy, Speech & Language therapy, Dietetics and Orthoptists. Together these teams provide specialised therapy intervention to acute wards, ITU, rehabilitation units CRU & Lipton Hyper acute, community rehab and out patients.

The attrition rates for band 6 and band 7 are of concern across the Cheshire and Merseyside region with some Trusts experiencing higher staff turnover than others. This trend is less evident within The Walton Centre due to the specialist nature and band 6 and band 7 staff tend to move around less when working within a chosen specialty. However there are very limited opportunities for progression from band 6 to band 7 and career progression beyond band 7 is extremely rare for AHPs' within Walton Centre NHS FT.

All therapy staff have delegated leadership and clinical responsibilities appropriate to grade and experience. Via a hierarchic approach, all registered staff provide and receive clinical supervision and performance appraisal. Newly-qualified Band 5s joining the service complete a preceptorship process during the first six months of their employment to ensure competence to practice. All band 3 support staff undertake a framework of clinical competencies. Each of the AHP disciplines is led by a band 8a Professional lead responsible for the clinical assurance and operational leadership of that team and reports directly to the Therapy Services Manager who is accountable to the Executive Director Nursing and Governance.

Undergraduate education: All registered therapy staff of each discipline are accredited to provide pre-registration education and there is an identified Practice Placement Coordinator for each professional group who is responsible for organising clinical education placements across the Centre for students from universities all over the country. All therapists' are actively involved in providing internal and external training and education and many participate in multiple external specialist clinical groups and profession-specific work for professional and clinical development. During the past 6 months all undergraduate student placements have been curtailed due to the pandemic and AHPs are now experiencing a significantly higher demand for clinical placements . We have also successfully emailed a distance learning / virtual clinical placement for Occupational therapy and we are working with the regional IHE to explore and support creative approaches to learning for undergraduate trainees.

The main body of the service remains at a consistent level which is fortunate as there is a regular stream of leavers and new starters, mostly of band 5 and band 6 level as these staff take up development opportunities. Despite this, the Walton Centre Therapy service has had no difficulty in attracting skilled staff from across the country. The greatest challenge for recruitment is within Speech and Language Therapy within a highly specialist Centre. Succession planning is a constant theme but this is limited beyond band 6 due to fewer highly specialist roles available within the Trust. A business case is underway to support the SLT shortage.

The sickness absence rate for therapies across the past 6 months has ranged from 3.03% to 5.02%. There is no provision for enhanced staffing to cover shifts or annual leave, this is absorbed within current staffing levels. Over the past 6 months the service has experienced a higher level of sickness than average due to COVID 19. However, this has been offset to some degree by the lower numbers of admissions during the period April 2020 to April 2021.

12. Conclusion & Recommendations

It continues to be a challenging period for all staff. High levels of flexibility and adaptability has been seen during this period. Due to the ward changes staffing and patient acuity requirements have been reviewed by the Trust's senior nursing team, on a daily basis Trust wide staffing and acuity is considered to ensure all patients can be cared for safely. All shifts have been reported as safe.

Trust Board are asked to:

- Receive assurance that staffing across all areas is considered safe
- Receive the next 6-monthly staffing report in November 2021, unless further changes require reporting.

The Walton Centre NHS Foundation Trust

REPORT TO Trust Board
Date 10th June 2021

The Walton Centre NHS Foundation Trust

Title	Morbidity & Mortality Report 2020-2021 Quarter 4 (Q4)
Sponsoring Director	Name: Dr A Nicolson Title: Medical Director
Author (s)	Name: Patricia Crofton Title: Clinical Quality Lead
Previously considered by:	• Committee (please specify) ____Quality Committee_____
Executive Summary This report is Q4 of the quarterly review of Morbidity & Mortality within The Walton Centre. The rate of readmission within 28 days of discharge remains low at 3.3%. Surgical site infection rate was also low at 1.62%. There were 26 deaths during Q4, 24 in neurosurgery and 2 in neurology. 14 of the deaths occurred on the Critical Care Unit. Following review all deaths were considered unavoidable, but due to the complexity a more detailed structured judgement review has been recommended in three cases.	
Related Trust Ambitions	Delete as appropriate: • Best practice care • Be recognised as excellent in all we do.
Risks associated with this paper	None
Related Assurance Framework entries	N/A
Equality Impact Assessment completed	• Yes – (please specify) ____N/A_____ • No – (please specify) _____
Any associated legal implications / regulatory requirements?	Compliance with National guidance on Learning , candour and accountability (A review of the way NHS trusts review and investigate the deaths of patients in England)
Action required by the Board	The Board is requested to: • Discuss and note the position

Quarter 4 (Q4) Morbidity & Mortality Report 2020-2021

Executive Summary.

This report is a quarterly review of Morbidity & Mortality within The Walton Centre NHS Foundation Trust. Unless stated, figures relate to both Neurosurgery & Neurology combined.
Section 1, Morbidity, details information relating to admission and readmission rates, surgical site infection.
Section 2 Mortality, provides information relating to inpatient deaths in Q4 (January – March, 2021).
As with previous reports CHKS data is included, this data is also included in the Integrated Performance Report. Although CHKS data does not include full Q4 data it shows how we compare with our peers.

There were 26 inpatient deaths during Q4, 24 in neurosurgery and critical care and 2 in neurology.

There has been an increase in the number of deaths in year 20/21 (111) when compared to the year 19/20 (92).This increase in deaths relates to the period when the Trust was supporting Liverpool University Foundation Trust (LUFT) with the delivery of their stroke services and deaths due to Covid.

There were 24 deaths where patients tested positive for Covid, 7 patients were admitted with Covid, and 17 patients had developed nosocomial infection. The patient deaths have been presented at Divisional Mortality review groups, the outcomes were neurosurgical or neurology focused with the acquisition of Covid as a contributory factor. NHS England and NHS Improvement (NHSEI) in consultation with NHSEI nursing directorate have recently provided guidance to provide a framework for reviewing Covid-related deaths (Appendix1).

The impact of the increase in the number of deaths particularly those who developed nosocomial Covid, together with the exclusion of families at this difficult time have been challenging stressors for staff working in acute care areas. Staff support is provided for all staff by the Network of Staff Support Services (NOSS) using group and individual sessions. Neuropsychology has also been available for staff support during this time.

A total of 21 coroner's requests were received in 2020/21 compared to 12 in 2019/20. There are 6 Coroners Inquests in progress; available updates are detailed within the report.

It has been recognised by the senior clinical teams that the format of the divisional Mortality and Morbidity process should be reviewed and the Policy revised accordingly, although previously planned Covid has delayed this process. Going forward the format of the report will support these changes. The appointment of the Lead Medical Examiner Officer for LUFT and The Walton Centre may have an influence on this process.

SECTION 1 MORBIDITY

1 Admission data 1st January 2021-31 March 2021

The Neurosurgical & Neurological admissions and re-admissions are detailed below. Admissions in Q4 have increased due to changes related to Covid restrictions. Understandably elective activity remains lower in comparison to 19-20.

Table 1
Admission and readmission for Q4, January- March 2021

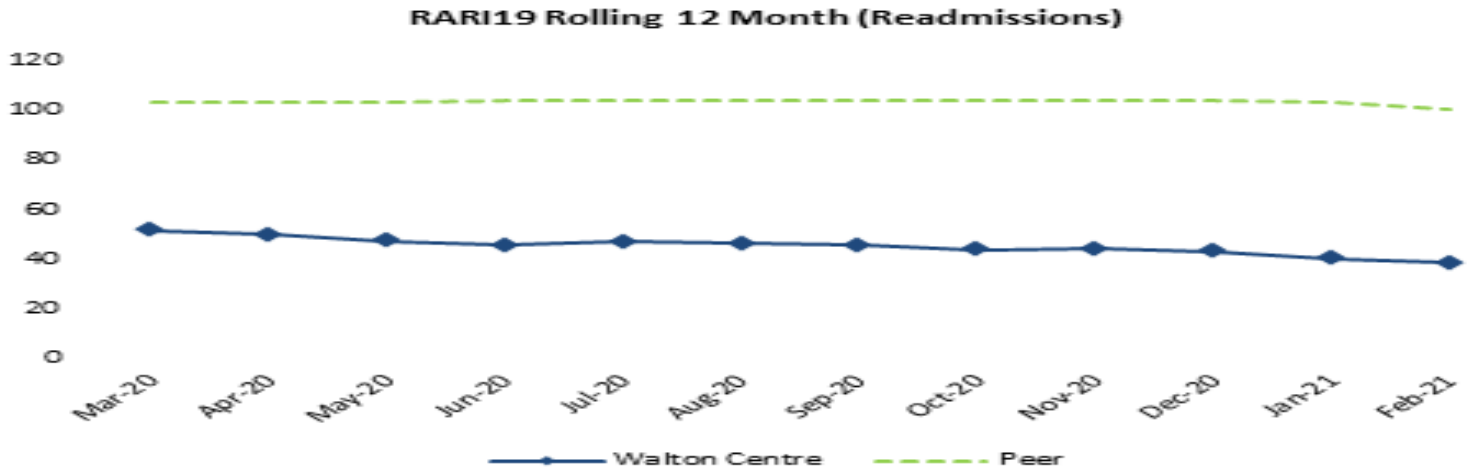
Q4 2020-21	Jan-21	Feb-21	Mar-21	Total
Admissions	226	186	254	666
Re-admissions	10	4	8	22
%	4.4	2.2	3.1	3.3

Table 2
Admissions and readmissions Q1 19 - Q4 2021

Q	Q1 19-20	Q2 19-20	Q3 19-20	Q4 19-20	Q1 20-21	Q2 20-21	Q3 20-21	Q4 20-21
A	1331	1290	1242	1198	601	987	1020	666
R	74	63	56	52	22	53	44	22
%	5.6	4.9	4.5	4.3	3.7	5.4	4.3	3.3

CHKS Data Readmissions:

Risk adjusted readmission data.



2 Surgical Site Infection (SSI) data-

	Elective	Infec	%	Urgent	Infec	%	Immediate	Infec	%	Expedited	Infec	%	Not recorded	Infec	%	Total ops	Total Infec	% Infec Rate
Q1 20/21	103	1	1.0	121	2	1.7	37	0	0.0	46	1	2.2	5	0	0.0	**312**	**4**	**1.28**
Q2 20/21	318	3	0.9	149	1	0.7	56	0	0.0	108	4	3.7	10	0	0.0	**641**	**8**	**1.25**
Q3 20/21	553	6	1.1	187	3	1.6	48	0	0.0	124	4	3.2	4	0	0	**916**	**13**	**1.42**
Q4 20/21	214	3	4.7	169	3	1.8	43	1	2.3	69	1	1.4	0	0	0	**495**	**8**	**1.62**

SECTION 2 MORTALITY Q4 2021.

There were 26 inpatient deaths in Q4; 24 in neurosurgery and critical care and 2 deaths Neurology. Of these deaths 3 were patients transferred from Aintree with a primary diagnosis of Covid as part of our mutual aid to assist LUFT with critical care capacity.
A number of these patients were either admitted with Covid or developed Covid as a nosocomial infection during their care which was considered as a contributory factor to the patient's death.
19 surgical and critical care deaths have had initial mortality reviews and 16 have been reviewed at the surgical mortality meeting.
15 reviews demonstrated no evidence of avoid ability, 1 initial review suggested slight avoidability and has been summarised below. Surgical practice has been reviewed and changes recommended as stated those deaths where the patient was found to have acquired a nosocomial covid infection, the patient deaths will be reviewed within NSGE/ NHSI Guidance using the recommended KLOE (Appendix 2).

There were 14 deaths in critical care and 8 deaths in Chavasse ward. This demonstrates an increase in the numbers of deaths in Chavasse ward which is allocated as the Covid cohort ward.

1) Quarterly Analysis – Neurosurgery and Neurology

Deaths by Admission Day of Week- There was no significance identified in relation to day of the week of admission

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday	Quarterly Total	Annual Total
Q1 20/21	8	7	2	7	2	3	6	35	
Q2 20/21	5	3	3	2	4	2	4	23	
Q3 20/21	4	2	3	5	3	5	5	27	
Q4 20/21	3	3	4	3	3	4	6	26	**111**

Deaths by Day of Week- There were no significance identified in relation to day of the week of the patient's death.

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday	Quarterly Total	Annual Total
Q1 20/21	4	3	6	6	10	4	2	35	
Q2 20/21	0	5	7	4	1	2	4	23	
Q3 20/21	4	5	5	4	4	4	1	27	
Q4 20/21	3	2	8	6	4	1	2	26	**111**

2) Update from Q2 / Q3

In Q2 there was a death of a patient with Learning disability, this has been reported via the LEDER process and is subject to an external review which remains outstanding, progress is monitored through the Safeguarding team.
The outstanding recommendations have been completed and approved by the Surgical Divisional Director.

As detailed in the Q2 mortality report there had been an unexpected death within critical care, this was identified as a serious untoward incident and was investigated following the Trust Serious incident policy. A full report was sent to HM Coroner, the patients' family and the Specialist Commissioners. Senior members of the Critical Care team attended the recent Coroner's inquest. The conclusion of the Coroner as to the cause of death was hypoxic cardiac arrest following dislodgement of the tracheostomy tube. The Coroner accepted the report and action plan and did not make any recommendations for practice .The family were supported throughout by the patient experience team. The staff were supported by the critical care team and the Claims and Legal Enquiries Manager.

3) Coroner inquest update.

A total of 21 coroner's requests were received in 2020/21 compared to 12 in 2019/20. Several families have raised concerns regarding their relatives care with the Coroners officer directly rather than contact the Trust through the patient experience Team.

There has been an unexpected cardiac arrest leading to a patient death in critical care during Q4. This was reported externally to STEIS and the Specialist Commissioners and has been investigated according to the Trust Serious Incident Policy (SI). The Coroner has opened a file on this matter. A Pre-Inquest Review has been scheduled for June 21. A Detailed Mortality Report has been completed and the Trust Solicitors have provided this to the Coroner.

There is an ongoing Coroner's inquest from 2018, previously updated at Quality Committee. The next PIR was scheduled for May 21; Trust solicitors have advised this has been postponed with no date set as yet.

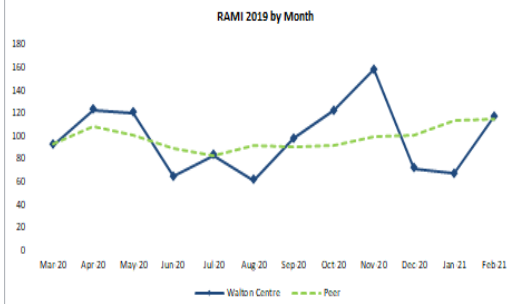
A Patient death was reported following a transfer from the Complex rehabilitation unit. A PIR took place in January 21 an inquest is scheduled for May 21. At present the legal team do not feel legal representation is required, however, this will be kept under review.

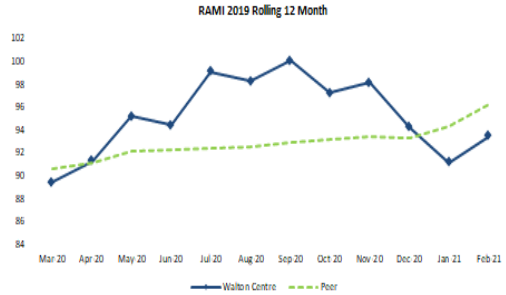
4) CHKS Data.

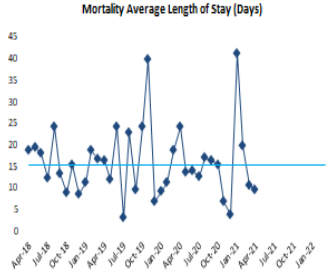
Quality of Care

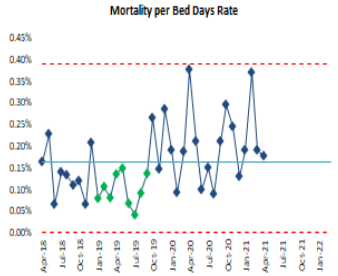
Safe - Mortality

NHS
The Walton Centre
NHS Foundation Trust







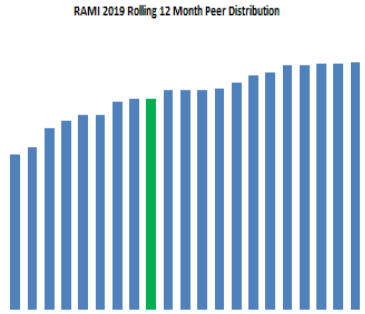


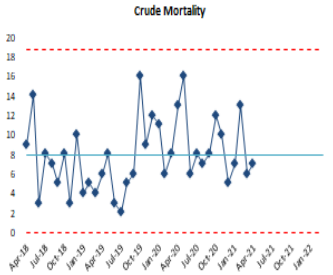
RAMI 2019 for all condition groups March 2021 to February 2021

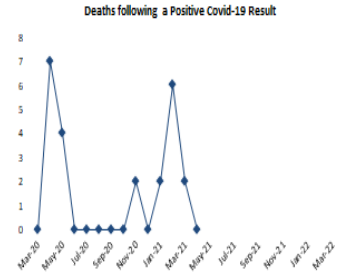
CCS Group (Top 5)	Observed	Expected	Risk	25th Percen	Peer Valu	75th Percen
RAMI (Risk adjusted mortality index) 2019	**90**	**96**	**93.4**	**86.13**	**96.2**	**104.6**
109 - Acute cerebrovascular disease	50	53	93.48	86.37	94.97	107.15
233 - Intracranial injury	21	18.8	111.6	99.11	113.9	126.37
81 - Other hereditary and degenerative nervous system conditions	5	2.22	225.4	39.08	68.68	99.22
78 - Other CNS infection and poliomyelitis	4	1.48	269.6	62.25	107	193.36
47 - Other and unspecified benign neoplasm	2	0.47	424.1	93.11	142.4	227.43

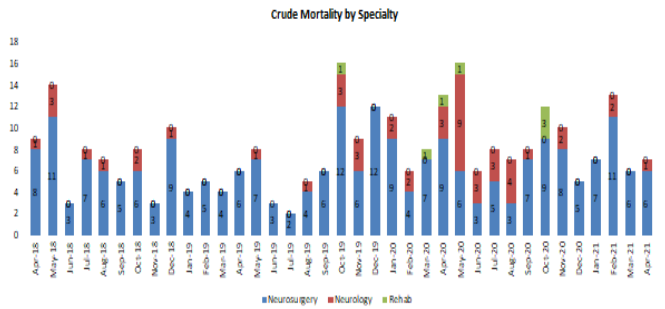
RAMI 2019 for HSMR condition groups March 2021 to February 2021

CCS Group	Observed	Expected	Risk	25th Percen	Peer Valu	75th Percen
RAMI (Risk adjusted mortality index) 2019	**74**	**79**	**94.1**	**84.52**	**95.4**	**105.9**
109 - Acute cerebrovascular disease	50	53	93.48	86.37	94.97	107.15
233 - Intracranial injury	21	18.8	111.6	99.11	113.9	126.37
127 - Chronic obstructive pulmonary disease and bronchiectasis	1	0.05	2107	67.98	91.05	110.42
134 - Other upper respiratory disease	1	0.03	3803	63.78	147.7	249.16
231 - Other fractures	1	1.09	91.45	75.39	113.8	140.44









As at February 2021 the rolling 12 month RAMI19 figure is 93.40. During the period there were a total of 90 observed deaths against 96 expected deaths. Compared to the peers The Walton Centre is currently back below the average following a period of being above.

When looking at the 56 HSMR condition groups for the rolling 12 month period the RAMI risk is 94.12.

RAMI19 excludes deaths following a positive covid-19 result. During the rolling 12 month period there have been 15 deaths following a positive covid-19 result. In the most recent two months there have been a further two.

Analysis of the supporting measures (to the right of the page) show that all indicators are within normal variation so they should not impact the RAMI19 Risk greatly over the coming months.

Appendix 1.

NHSEI guidance framework for reviewing COVID related deaths.

Over the year 20/21 there has been 24 deaths of patients who had Covid infection, as a contributory factor. 7 were admitted with Covid either as a primary diagnosis or an additional presenting condition. All of these patients were admitted to critical care; 3 patients were transferred from LUFT as part of mutual aid and had Covid pneumonitis as the primary diagnosis. There were 17 patient deaths where the patient had developed nosocomial Covid infection after presenting with a primary neurological condition and often significant co-morbidities.

The NHS defines a Covid hospital death as the death of a patient in hospital who has a positive specimen result where the swab was taken within 28 days of death and/or Covid and is cited on either Part 1 or Part 2 of the death certificate.

.

The NHS England and NHS Improvement (NHSEI) guidance document suggests the infection prevention and control (IPC) and mortality process should link together and provides a framework for reviewing Covid deaths that captures the information required in relation to IPC using Key Lines of Enquiry, (KLOE). The framework will enable identification of strengths and weakness both in the caring process, the systems and environment in which care is delivered.

The focus of the reviews should be on definite cases of nosocomial deaths, in line with the definition" Hospital-Onset Definite Healthcare-Associated: a positive specimen date 15 or more days after hospital admission.

Judging the level of the avoidability of a death is a complex assessment that can be challenging to undertake as the assessment needs to take account of such issues as comorbidities and estimated life expectancy. Defining whether a death was avoidable by the standard definitions is not considered to be possible for the majority of hospital acquired Covid-19 patients. There may be exceptions where there is clear evidence that the death of an inpatient with hospital-onset healthcare-associated COVID-19 is the result of something other than the COVID19 infection. What is reassuring is that all trusts have struggled to a lesser or greater extent when considering investigation.

The Office for National Statistics provides a definition of avoidable as those deaths that are either preventable or amenable. Arguably for Covid deaths, applying these in a linear manner would indicate that all COVID deaths would be deemed to be avoidable. However as the guidance suggests the complexities in relation to contributory factors i.e., patient risk factors/transmissibility risks/variant risks/environmental risks/ behavioural factors that influence IPC compliance/patient compliance/community prevalence/ hospital burden of Covid and many other unknowns mean that application of these criteria is too simplistic.

Retrospective case note review as used in initial mortality reviews is not considered an effective tool for learning in nosocomial infection and should not be undertaken in isolation as it does not record issues such as staffing, ward acuity, PPE compliance or other known contributory factors.

The trust Governance and IPC leads have reviewed the KLOE and will undertake a further review of those patient deaths which included acquisition of nosocomial COVID. The focus will be on definite cases of nosocomial deaths, in line with the guidance. This will be presented at the serious incident group, will be shared with Specialist Commissioners and included in Q1, 21/22 mortality report.

REPORT TO BOARD
10 June 2021

The Walton Centre NHS Foundation Trust

Title	**Staff Survey People Action Plan 2021/22**
Sponsoring Director	Mike Gibney, Director of Workforce & Innovation
Author (s)	Jane Mullin, Deputy Director of Workforce & Innovation
Previously considered by:	• Committee (please specify) Staff Partnership Committee • Group (please specify) • Other (please specify) _____

Executive Summary

Following the staff survey which was presented to Board last month, this is the Action Plan that has been developed in partnership with Staff Side to be delivered during this financial year.

Board should note that it was formally approved by Staff Partnership Committee on 1 June 2021.

The action plan aligns with the key requirements of the annual People Plan that has been published w/c 31 Mary 2021. Fundamentally the challenges centre around looking at the staff post COVID, addressing new ways of working and continuing to challenge inequalities.

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
Risks associated with this paper	The retention and productivity of the workforce following the pandemic
Related Assurance Framework entries	005: If the Trust does not attract, retain and develop sufficient numbers of qualified staff, both medical and nursing, in shortage specialties, then it may be unable to maintain service standards leading to service disruption and increased costs
Equality Impact Assessment completed	• No
Any associated legal implications / regulatory requirements?	• Standard duty of care to employees
Action required by the Board	Delete as Appropriate • To consider and note

Staff Survey People Action Plan 2021/22

Objective	Action	Lead	Progress Update
Look after our staff ensuring staff safety is a priority whilst creating a place that recruits, retains and supports a resilient and productive workforce	• Encourage staff to take time off to recover, making use of annual leave which may have been carried over from 2020/21 • Assist managers to " free up" staff to participate in initiatives • Individual health & wellbeing conversations should be a regular part of supporting all staff with an expectation that a plan is agreed at least annually. • Ensure all staff are offered a risk assessment and they are reviewed as appropriate • Compliance with IPC and testing policy • A range of preventative health & wellbeing support to be available • Occupational Health and wellbeing support available to all staff, including rapid access to psychological and specialist support	Line Managers Line Managers Line Managers IPC team HR HR HR	

	• Ensure staff have safe rest areas/spaces and appropriate facilities to manage all the demands of work • Roll out the carers passport • Tackle bullying and harassment and create a culture of civility • Prevent and control violence in the workplace in line with legislation	HR HR Risk Manager	
Deliver the NHS COVID vaccination programme	• Offer all staff first dose by July 2021 • Be prepared for a re-vaccination programme from autumn with high uptake ambitions for seasonal flu vaccination, alongside	HR IPC	
Address inequalities	• Develop improvement plans based on the latest WRES findings, including to improve diversity through recruitment and promotion practices • Accelerate the delivery of the model employer goals	ED&I Lead ED&I Lead	
Embed new ways of working.	• Be open to all clinical and non-clinical permanent roles being flexible • Maximise the use of and	T&D Project Lead E	

	potential benefits of e rostering, giving staff better control and visibility of their working patterns, supporting service improvements and the most effective deployment of staff • Promote agile working	Rostering HR	
Grow for the future	• International recruitment of Nursing staff • Support the recovery of the education and training pipeline by putting in place the right amount of clinical placement capacity to allow students to qualify and register as close to their initial expected date as possible • Develop and implement robust postgraduate (medical and dental) training recovery plans that integrate local training needs into service deliver y planning • Support workforce plans across health and social care • Continue to expand apprenticeship offer	HR T&D/Med Ed Med Ed HR T&D	

The Walton Centre NHS Foundation Trust

REPORT TO TRUST BOARD
10/06/21

Report Title	**Chair Assurance Report – Strategic Black, Asian and minority ethnic Advisory Committee 26th April 2021**
Sponsoring Director	Jan Ross Acting CEO
Author (s)	Jan Ross Acting CEO
The Strategic Black, Asian and minority ethnic Advisory Committee provides assurance to the Board of Directors against its work programme via a summary report Full minutes and enclosures are made available on request.	
Purpose of Paper: This paper provides an update to the Board of the meeting of the meeting held on 26th April 2021.	
Recommendations	The Board is requested to: • Note the summary report

1. **Items for the Board's attention:**

- Importance of undertaking/ reviewing risk assessments. Process being monitored by HR
- Terminology agreed from the advice given by the @Race Forum to use the term 'Black, Asian and minority ethnic' in full in documentation and communications and to explain to readers' if/ when the full term has not been used.

2. **Items for the Board's information and assurance**

'Getting under the skin' – presentation from Edna Boampong and Karen Swan (C&M HCP research)

- Received third presentation 'Getting under the skin' research from Edna Boampong and Karen Swan (C&M, HCP) focussing on the disproportionate impact of COVID-19 on Black, Asian and minority ethnic communities.

'**Liverpool and the legacies of slavery'**

- Received presentation 'Liverpool and the legacies of slavery' delivered by local historian. Presentation focussed on the history of Liverpool and how the city was shaped by events relating to slavery, the slave trade and its connections to health and medicine

North West Regional Committee

- Ms Rai provided an update from the North West Regional Committee held in March. Key points from the meeting include:
    - The disproportionate effect of COVID-19 on those under 60 with mental health and learning disabilities and people from Black, Asian and minority ethnic communities. The Regional Committee is undertaking work to explore reasons for this;
    - Focussing on communication with key communities and progress of the vaccination programme;
    - Importance of undertaking risk assessments on Black, Asian and minority ethnic staff continually stressed.

Feedback from WCFT @Race forum

- Committee agreed with the advice given by the @Race Forum to use the term 'Black, Asian and minority ethnic' in full in documentation and communications and to explain to readers' if/when the full term had not been used

- Line managers encouraged to enable staff to take time out of working day to attend meetings. Ms Ross and Ms Mullin fully support this.

Measurement for improvement – understanding our Data

Presentation focussed on:

- Monitoring of WRES standards throughout the year; ongoing work with HR team to build into this functionality;
- Breakdown of data to look for any inequalities in Recruitment
- Breakdown of ESR data to show sickness; filtered by division to see changes;
- Examination and breakdown of turnover looking from divisional service and ward level perspective;
- Looking at changes over time and starters and leavers;

WRES action plan and approach

- Focussing on the WRES indicators and review of action plan.

Overview of Racial Incidents, Abuse, Complaints and High BAME staff turnover

- Deep dive undertaken to identify and target key areas.
- Ms Ross was assured that support measures for staff affected are in place (Debrief sessions, held by Personal Safety Trainer and ED&I Lead, Last Lap Initiative, Violence and Aggression meetings)

Update on International recruitment

- Update, seven nurses were due to arrive from India on 30th April 2021, however due to worsening situation in India with COVID-19, it was uncertain whether this would go ahead. Update to be given on situation in June meeting.

3. Progress against the Committee's annual work plan

- Review of progress to be undertaken at June 2021 meeting on ambitions 'From good to great'

Jan Ross
Acting CEO
May 2021

The Walton Centre NHS Foundation Trust

REPORT TO TRUST BOARD
10/06/21

Report Title	**Chair's Assurance Report – Quality Committee 20/05/21**
Sponsoring Director	Seth Crofts, Non-Executive Director
Author (s)	Lisa Salter Director of Nursing & Governance
The Quality Committee continues to receive reports and provide assurance to the Board of Directors against its work programme via a summary report submitted to the Board after each meeting. Full minutes and enclosures are made available on request.	
Purpose of Paper: This paper provides an update to the Board of the meeting of the Quality Committee held on 20/05/21.	
Recommendations	The Board is requested to: • Note the summary report

1. Items for the Board's attention:-

- Incident of Pressure Ulcer Category 4 on ITU
- Fractured humerus following a patient fall on Caton Ward
- Application for Tessa Jowell Brain Cancer Mission (TJBCM) Centre of Excellence Designation
- Peer Review on Critical Care – achieved 151 out the 155 areas for review.
- Governance & Risk Management Q4 report & Infection, Prevention & Control report Q4 – to recognise the work achieved within a challenging 12 month period

2. Items for the Board's information and assurance

a) ***Patient Story***
The patient and family story related to their experience through the hospital, having been admitted for treatment of epilepsy. The story highlighted the complexity of the situation and how various teams and external stakeholders were engaged to provide the best outcome for the patient. It was noted that this was a complex case in which staff caring for the patient were supported by the senior nurse team. The story also demonstrated the importance of an MDT approach for obtaining positive outcomes.

b) ***Medical Director's update***
Dr Nicolson provided an update regarding the out of hours Thrombectomy Service. A lot of work has been undertaken by the teams in Radiology, Theatres and the two Divisions to resolve staffing issues. The action plan has been approved by the Executive Team to progress this work. Weekend cover was restored on the first weekend in May and it is hoped that extended weekend hours will be possible during the summer with a view to commencing a 24 hour/7 day service in September.

c) ***Integrated Performance Report (IPR)***
Ms Salter and the Divisional Nurse Directors presented key elements of the IPR. Incidents of x 2 MSSA and x 2 C. Difficile infections to date in this new financial year are a cause for concern. Focussed meetings are underway to identify causes and improvement work is underway.

Attention was drawn to x 2 recent incidents (not in the report) – a category 3 pressure ulcer had deteriorated to a category 4 for a patient on ITU/Dott Ward The rapid review indicated no lapses in care. On Caton Ward, there was a patient fall in a bathroom from which the patient suffered a fractured humerus. Full RCA reports are underway for each.

International Recruitment of nurses has been delayed due to the pandemic crisis in India. The Trust continues to recruit staff to both nurse and heath care vacancies.

d) **Governance & Risk Management Q4 Report**
Mr. Fitzpatrick and Ms Gurrell presented the report. There have been significant increases in the number of concerns but a reduction in the number of complaints and in complaint response times. The increase in claims and Coroner's referrals was also noted. Communication was a theme with regards to complaints and this has been discussed in the Divisional meetings with the PET and is being managed closely. It was noted that this theme often includes complaints from patients when they disagreed with their clinician's diagnosis.

A strategy is required in relation to violence and aggression competencies – this is being developed and will be presented to Quality Committee.

e) ***Mortality & Morbidity Report***
Dr Nicolson advised that guidance has recently been released on how to review Covid-19 related deaths. Within WCFT there were 24 covid related deaths of which 17 are recognised as nosocomial.

f) ***Infection, Prevention & Control Annual Report***
Ms Oulton presented the report. It was noted that C.Difficile infections had decreased year on year. The IPC team had reviewed incidents of C.Difficile with NHSE/I Special Commissioners earlier this week with x 2 incidents noted as no lapses in care for x 2 cases last year. Excellent work has been undertaken to reduce infections in EVDs.

MSSA remains an issue and exceeded the year's trajectory. Significant work is underway to reduce the number of infections. The team are working with informatics to identify themes and enable Trust staff to view incidents of HCAIs in real time.

Reflections on the pandemic were shared and thanks conveyed to all for supporting the team.

g) **Nurse Staffing Report**
Ms Vlasman presented the report which is a summary of the last 6 months staffing. It was noted that staffing was reviewed on a daily basis and that an extra daily staffing meeting was implemented. Assurances were provided that staffing had been safe. It was highlighted that both Matrons had worked tirelessly to ensure safe staffing on the wards. It was noted that the CQC whistleblowing this month had been responded to and shared Trust wide, recognising significant support being given to staff. It was recognised that our staff and their families have experienced some very challenging times in the past 15 months in their personal as well as their professional lives.

h) **Local Cancer Patient Survey Update**
Ms Crofton presented the report drawing attention to a revised pre-op service which will support this patient group. A neurosurgery training programme has been introduced for half hourly weekly sessions (Fridays) which have an MDT approach and are already having a positive impact.

The Trust is applying for Tessa Jowell Centre of Excellence designation. This would allow the Trust to use the BRIAN app to gain patient experience feedback. If the application is successful, this would be an accolade for the Trust.

i) **C&M Audit Critical Care Delivery Network Peer Review**
A positive review was presented and the team are awaiting the overall report. Out of 155 areas of assessment, only x 4 require further work, demonstrating a positive outcome.

j) **ToR Quality & Patient Safety Group**
The ToR for Quality and Patient Safety Group were approved.

k) **ToR Neurosurgery Risk & Governance**
The ToR for Neurosurgery Risk & Governance were approved.

l) **QC work plan**
The Quality Committee work plan was received and ratified.

m) Chairs Reports/mins

- **Quality & Patient Group**
  Chair's report for 15/04/21 was noted.

- **Infection Control**
  Chair's report for 12/04/21 was noted.
  RCAs were delayed in being reviewed and work is now back on track.

- **Clinical Effectiveness**
  Minutes for 25/03/21 & Chair's report 20/04/21 were noted and thrombectomy work was referenced.

- **Corporate Governance**
  Chair's report for 27/04/21 noted – positive feedback received with regards to NOSS support for staff.

- **Sharing & Learning Forum**
  Minutes 13/03/21 were noted – focus on lamp testing and vaccination programme.

3.0 Progress against the Committee's annual work plan

The NCEPOD and Safeguarding Annual Reports were deferred until the June Quality Committee.

The Walton Centre NHS Foundation Trust

REPORT TO TRUST BOARD
10 June 2021

Report Title	**Chair's Assurance Report – RIME Committee 31/03/21**
Sponsoring Director	Seth Crofts – Non-Executive Chair
Author (s)	Mike Gibney, Director of Workforce and Innovation
Purpose of Paper:	
The Research, Innovation and Medical Education Committee continues to receive reports and provide assurance to the Board of Directors against its work programme via a summary report submitted to the Board after each meeting. Full minutes and enclosures are made available on request. The paper provides an update to the Board of the meeting of the Research, Innovation and Medical Education Committee held on 5 May 2021.	
Recommendations	The Board is requested to: • Note the summary report

1.0 Matters for the Board's Attention

- **Innovation Update**
  The following was highlighted:
  Collaborative partnerships are being supported which develop income, equity or royalties. The Innovation Strategy approved in 2019, contains a pipeline of projects which have been developed and are progressing. The BAF innovation action tracker shows the trust is doing well despite the delays. The Strategy Annual Implementation Plan is progressing well and some items are complete.

- **Medical Education**
  There have been two new appointments within the Medical Education Faculty. Dr Rhys Davies has taken over from Dr Dougan as Director of Medical Education and Elaine Anderson has succeeded Sue Griffiths as Royal College Tutor for Anaesthetics.

  Student experience continues to be good in relation to undergraduate education, placements are well evaluated despite Covid restrictions affecting on site activity. The University of Liverpool are running a timetabling project which is looking at creating a uniform student timetable for all clinical placement sites. This may suit the fluidity of the hospital better than a strict timetable but it also provides the medical school with documented activity and clear evidence of when the schedule is not being met.

  Conversations are ongoing internally and with colleagues at other trusts to see find out their plans in relation to returning to business as usual and bringing students back on site both nationally and internationally.

  It appears that a number of honorary contracts have lapsed. Once the process has been agreed at Medical Education Committee, the SOP will be circulated to all consultants.

  In relation to educator accreditation, it has been 5 years since GMC training standards were introduced. The internal process for monitoring accreditation has been reviewed and a SOP will be created to provide clarity which will be circulated to the consultant body.

  From August, ST2 trainees will be rotating through Neurology and ITU as part of their ST2 year.

  Funding has been sourced from study leave monies for a coaching course for registrars in Neurology which will take place in June.

Renovations have taken place to one of the office spaces on the second floor for the Neurology registrars for new office space with a break out area and upgraded AV kit to facilitate the remote teaching and online activity.

- **Neuro Podcases Project**
  Dr Williamson discussed the recent development of an educational neurology podcast which was originally designed for medical students. Although there were many podcasts available the team wanted to tie this podcast to a learning resource that was available online.

  It is mainly Walton Centre consultants who are taking part in the episodes and they are keen to continue with the project. Consent was sought to affiliate the project with the Walton Centre NHS Foundation Trust and promote the trust from a Medical Education perspective, encouraging other Consultants to become involved in the project, possibly neurosurgeons and neurorehab.

- **Clinical Senate meeting takes place on Wednesday, 16 June 2021**
  .

2.0 Items for the Board's Information and Assurance
N/a

3.0 Progress Against the Committee's Annual Work Plan
- Discussed and currently on track.

Board of Directors' Key Issues Report

The Walton Centre NHS Foundation Trust

Report Date: 10/06/21		**Report of:** Business Performance Committee
Date of last meeting: 25/05/21		**Membership Numbers:** Quorate
1.	**Agenda**	The Committee considered an agenda which included the following: • Capital Programme Update • Integrated Performance Report • Transformation Programme & QIP Update • Operational Risk Register • Feedback from BPC Task Group • Neurophysiology IT Business Case • Radiology Information System (RIS) Business Case • Guide XT Agreement - 6 Month Review • Finance & Procurement - Strategy Update • Intelligence - Strategy Update • Sub-Committee Chair's Reports • 2021/22 H1 Business Planning Update
2.	**Alert**	• Board members will be aware of the complexity of the financial planning process for 2021/22, which is being coordinated at a system level and is based on plans for the six-month period April - September 2021 (H1) with a system requirement for Trusts to deliver a breakeven position. The Trust's plan was initially submitted to Cheshire and Merseyside Health & Care Partnership (CMHCP) on 4 May 2021. Further iterations of the plan were subsequently prepared during the period 5 - 21 May 2021 as a result of discussions between system Directors of Finance and further instruction provided by CMHCP on system funding allocations and Elective Recovery Fund (ERF) contributions. A further submission of the Trust's financial plan was originally scheduled for 24 May 2021 but was delayed pending confirmation of funding allocation. The Director of Finance presented the latest iteration of the plan, which included an efficiency saving requirement, to the Committee in advance of a revised submission deadline of 6pm on 25 May 2021. The Committee approved submission of the financial plan to the HCP but agreed that, at present, there was only a moderate level of assurance that a break-even position for the half-year to 30 September 2021 would be achieved. There is little clarity yet on the HCP finance regime for H2 (October 2021 onwards).

		• During consideration of the Finance & Procurement Department Strategy Update (see Assurance section below), the Committee was advised of work with staff in relation to resumption of on-site working arrangements post-21 June 2021. The Committee noted that some staff, some of whom have worked remotely throughout the pandemic period, had expressed concerns about a return to on-site working and/or a preference to maintain a 'blended' balance of remote / on-site working in the longer term. The Committee was assured of the proactive approach being taken by the management team, with input from the HR team, to support staff in the transition to 'normal' working practices. However, this situation may be experienced by other departments in the Trust and the Committee suggested that some form of organisational guidance would be helpful for departments in planning arrangements for the post-21 June 2021 period.
	Assurance	• The Deputy Director of Finance presented a 2021/22 Capital Planning Update and the Committee noted the Trust's capital allocation of £6.2m which resulted in a shortfall of £2.2m against planned expenditure of £8.4m. The Committee received positive assurance that a robust prioritisation process is in place to prioritise capital schemes on the basis of risks to patient safety, health and safety, operational efficiency, statutory/regulatory requirements and delivery of the Trust Strategy. The Committee was also assured that a comprehensive asset register review is to be undertaken to inform 5-year capital planning. • In reviewing the Integrated Performance Report (IPR) the Committee noted positive assurance in relation to performance in April 2021 against the 52-week breach trajectory with 213 52-week waiters compared with a trajectory position of 256. Overall performance against the Recovery Plan was positive with target levels achieved in all areas with the exception of elective activity. • Mr B Davies, Service Improvement & Transformation Lead joined the meeting to present a report detailing plans to refresh and progress Service Improvement and Transformation activities following on from the Covid-19 pandemic. The Committee took positive assurance from plans relating to the three key transformation programmes for; Outpatients, Theatres and Discharge & Patient Flow and the associated governance arrangements for the overall programme. With regard to the Quality Improvement Programme (QIP) and associated efficiency requirements, the Committee emphasised the importance of robust and comprehensive communications to promote understanding of, and engagement with, the programme. • The Committee took positive assurance from an update on the Finance & Procurement Department Strategy which demonstrated that good progress had been made in many areas over the last six months including an Internal Audit report on finance systems which had resulted in an overall assessment of Substantial Assurance. The Committee noted in particular the Department's commitment to personal and professional development and endorsed the approach in continuing to successfully progress these activities in the context of the pandemic situation. • The Committee also took positive assurance from a report detailing progress

		against the Intelligence Strategy. Mr M Foy joined the meeting to present a report which demonstrated that milestones for 2020/21 had been achieved with good progress in relation to culture change and relationship with data. Evidence presented showed how data was being accessed more and used in different ways via the Minerva self-service tool.		
	Advise	• The Committee approved a Business Case for Radiology Information System (RIS) Replacement at an annual revenue cost of £59,211 which represents a recurrent annual saving of £11,986 against the current contract. • The Committee approved a Business Case for Neurophysiology IT with the preferred option to replace the clients interfacing of EEG/EMG systems with PAS (upgrade to Windows 10) licence costs, server upgrade and backups required to provide resiliency and additional IT hardware for a total cost of £154,804.74 (part revenue / part capital / part Digital Aspirant capital funding). • The Committee has established a Task Group to consider development areas identified through a Committee Effectiveness Review completed in March 2021. An initial meeting held on 11 May 2021 resulted in two definitive outcomes: 1. Establishment of a Workforce Sub Group which will report to BPC; and 2. Trial of the 4As approach for Chair's reports. A second meeting of the Task Group is scheduled to be held on 3 June 2021.		
2.	Risks Identified	• Delivery of the H1 efficiency programme		
3.	Report Compiled by	David Topliffe, Non-Executive Director	Minutes available from:	Corporate Secretary

The Walton Centre
NHS Foundation Trust

Report to Trust Board
Annual Report 1 April 2020– March 2021

Title	**Infection Prevention and Control Annual Report April 2020 – March 2021**
Sponsoring Director	Name: Lisa Salter Title: Director of Nursing and Governance/DIPC
Author (s)	Name: Helen Oulton Title: Lead Nurse Infection Prevention and Control
Previously Considered by	Quality Committee

Executive Summary:-

1. The attached paper details the activity of the Infection Prevention and Control Team during 2020-2021 to deliver and maintain patient and staff safety. The Infection Prevention and Control Board Assurance Framework is included in APPENDIX A.

2. Annual Report including Quarter 4 Report
The purpose of this report is to provide assurance to The Walton Centre Trust Board of compliance with the Care Quality Commission Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 12. The report also outlines the work undertaken by the Infection Prevention and Control Team (IPCT) to meet the Trusts statutory requirements, improve quality and maintain patient/staff safety.

3. End of year performance against external and internal HCAI reduction objectives 2020-2021.

Organism	Objective 2020-2021	31st March 2021	Objective 2021-2022
MRSA	0	0	0
Clostridium difficile	5	*3	5
MSSA BSI	8	13	8
E.coli BSI	11	7	7
Klebsiella BSI	No threshold set	6	No threshold set
Pseudomonas BSI	No threshold set	3	No threshold set
CPE	No threshold set	10	No threshold set

4.

- There have been no MRSA bloodstream infections attributed to the Trust since 2017
- A reduction in Clostridium difficile infections (CDI)
- A reduction in Escherichia coli (E. coli) bloodstream infections
- The Trust achieved 81% for staff influenza immunisation
- The sustained reduction External Ventricular Drain (EVD) infections by collaborative working with the specialist teams
- The pressures of the COVID-19 pandemic had a significant impact on the Infection Prevention and Control Team (also covering tissue viability service) and all clinical services.

Related Trust Strategic objectives/goals	Goals □ Always Caring	Strategic Objectives □ Quality of Care
Risk and Assurance	Risks associated with infection prevention and control will be recorded on divisional and Trust risk registers and monitored via the Patient Safety Committee	
Related Assurance Framework entries	Risks associated with infection prevention and control will be recorded on divisional and Trust risk registers and monitored via the Patient Safety Committee	
Are there any associated legal implications / regulatory requirements?	Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 CQC Fundamental Standards	
Equality Impact Assessment completed?	N/A	
Action required by the Committee	To receive and note	

The Walton Centre
NHS Foundation Trust

Excellence in Neuroscience

Infection Prevention and Control

Annual Report

April 2020 to March 2021

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 prevention and control activity undertaken from April 01 2020 to March 31 2021, 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 during a global Pandemic.

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/Improvement
- Liverpool CCG
- Sefton CCG
- Public Health England (PHE)
- 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 since 2017
- A reduction in Clostridium difficile infections (CDI)
- A reduction in Escherichia coli (E. coli) bloodstream infections
- The Trust achieved 80.3%% for staff influenza immunisation
- The sustained reduction External Ventricular Drain (EVD) infections by collaborative working with the specialist teams
- Good catch award for staff `flu campaign

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 (until February 2021)
Mrs H Oulton	Lead Nurse Infection Prevention and Control/Tissue Viability
Mrs C Chalinor	Senior Nurse Specialist Infection Prevention and Control
Mrs Z Rushton	Nurse Specialist Infection Prevention and Control
Mrs A Stockley	Nurse Specialist (until October 2020)
Mrs J Smith	Administrative support
Mrs C Crompton	Clinical audit support (from November 2020)

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 were the named microbiology consultants for the Walton Centre during 2020/21.

The Trust has access to 24 hour microbiology/infection prevention and control via the on call Microbiologist.

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).

The 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 2020 to 2021.

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 2021-2022 and performance against 2020-2021 thresholds

Organism	Objective 2020-2021	31st March 2021	Objective 2021-2022
MRSA	0	0	0
Clostridium difficile	5	*3	5
MSSA BSI	8	13	8
E.coli BSI	11	7	7
Klebsiella BSI	No threshold set	6	No threshold set
Pseudomonas BSI	No threshold set	3	No threshold set
CPE	No threshold set	10	No threshold set

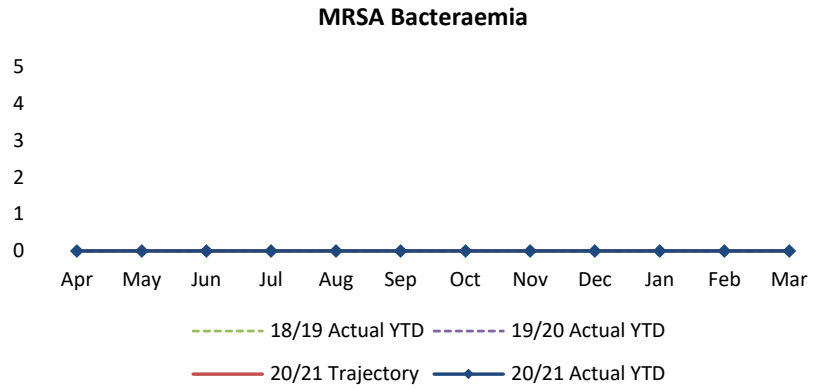
* Although the total number Clostridium difficile infections (CDI) were three cases, one of the patients was a transfer from another trust. It is an anomaly of the reporting process that has allocated this case of CDI to the Walton Centre, rather than a Trust acquired infection.

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 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 2021

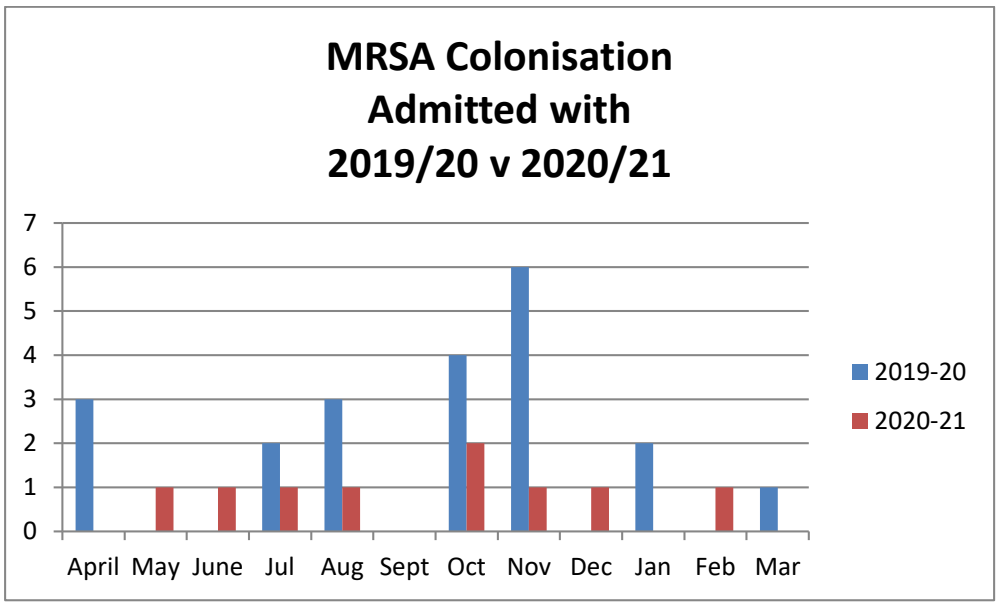


There were no patients who acquired an MRSA bloodstream infection during 2020-2021. The last MRSA bloodstream infection was in November 2017. We continue to strive for zero avoidable infections.

Although there is a focus on reporting MRSA bloodstream infection there is the potential for patients to become colonised with MRSA whilst in hospital, without infection. This is actively monitored and during 2020/2021, there were eleven patients admitted to the Trust who became colonised with MRSA during their inpatient stay compared to six patients for the period April 2019 to March 2020.

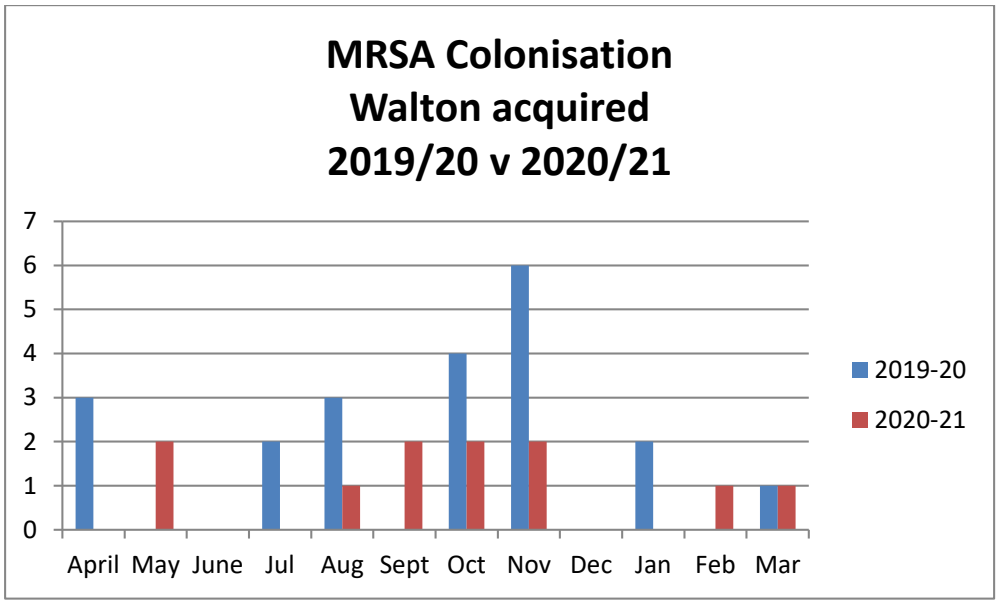
The graph below shows comparative data from April 2020 to March 2021 of the number of patients who were colonised with MRSA on admission to the Trust.

Graph 2 Patients colonised on admission April 2020 – March 2021



The graph below shows comparative data from April 2020 to March 2021 of 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



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 92.5% for the period 2020-2021.

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 that require 30-day screening are reviewed on a daily basis.

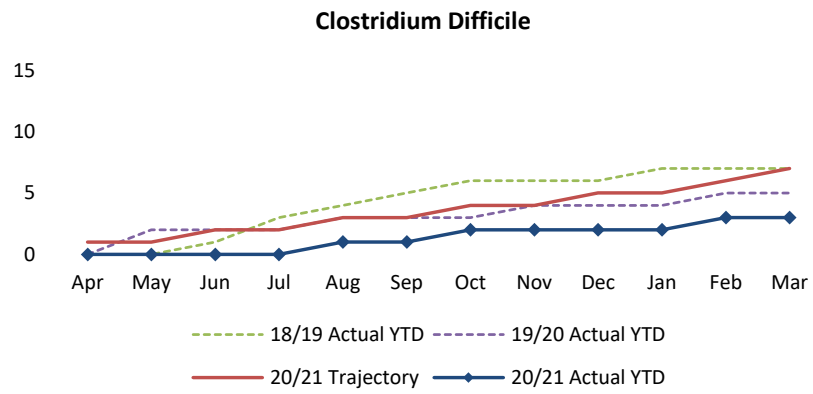
All patients who have a positive MRSA result are commenced onto the eP2 MRSA care pathway that is audited quarterly and the results are reviewed at the IPCC.

3.3 Clostridium Difficile

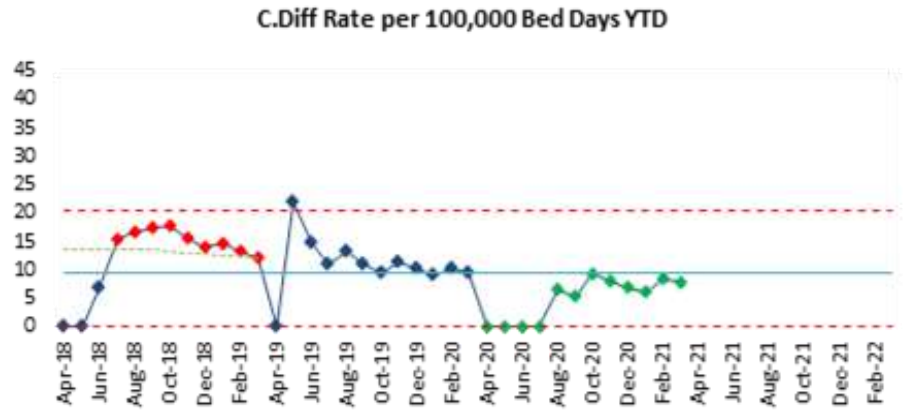
NHSI did not set trusts a reduction threshold for 2020-2021 due to low numbers seen nationally. However, there is the expectation that Trusts will work towards reducing the number of patients who acquire Clostridium difficile to the irreducible minimum. At year end, there were three patients who acquired a Clostridium difficile infection (CDI) therefore ending the financial year below the Trust internal target of five cases.

Although the total number was three cases, one of the patients was transferred from another trust where they had received multiple courses of antibiotics. It is an anomaly of the reporting process that has allocated this case of CDI to the Walton Centre.

Graph 4 Walton Centre CDI rates April 2020 to March 2021



Graph 5 Walton Centre CDI rates per 100,000 beds April 2020 to March 2021



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 during the past four years.

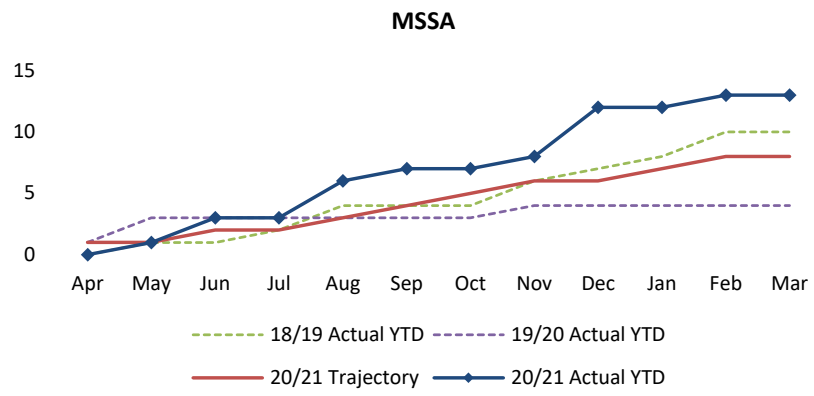
Patients are commenced on the Clostridium difficile care pathway to ensure optimal care and treatment, and the pathway is audited quarterly, and the results are reviewed at the IPCC. Preventative measures include; emphasising the importance of environmental cleanliness, use of HPV and UV technology are all key measures to reduce the risks of transmission of infection.

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 13 patients who have acquired an MSSA bacteraemia by year-end. This is an increase of eight cases compared to 2019-2020.

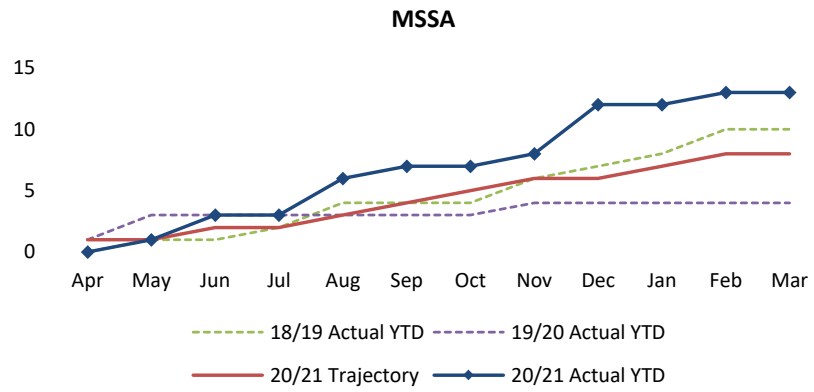
The following graph compares Walton Centre MSSA rates year on year from April 2020 to March 2021.

Graph 6 -MSSA rates from April 2020 to March 2021



The graph compares Walton Centre MSSA rates per 100,000 beds day from April 2020 to March 2021.

Graph 7 - MSSA rate per 100,000 bed days April 2020 – March 2021



The Trust is an outlier both regionally and nationally in relation to the number of MSSA bloodstream infections and it is extremely disappointing that there has been a significant increase infections. Blood culture contaminants remain a cause for concern as this indicates suboptimal clinical practice when obtaining blood cultures.

To address these concerns, a task and finish group was formed to undertake a quality improvement project which includes:

- Audit of decolonisation therapy
- Development of line competencies
- Blood culture competencies
- Thematic review of cases
- Observation of ANTT
- Refresh of ANTT

3.5 Escherichia coli (E-coli) Bacteraemia

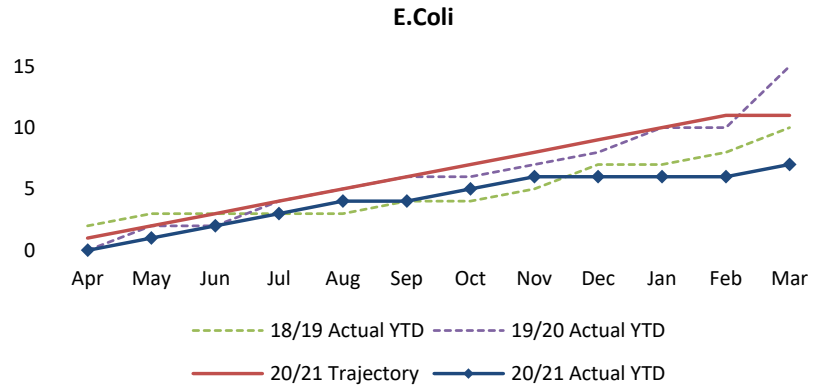
The Trust set an internal reduction threshold of 12 cases. There have been seven patients who acquired a E.coli bacteraemia by year-end. This is below the Trust internal annual reduction threshold of 12.

To drive the reduction, the following interventions were implemented.

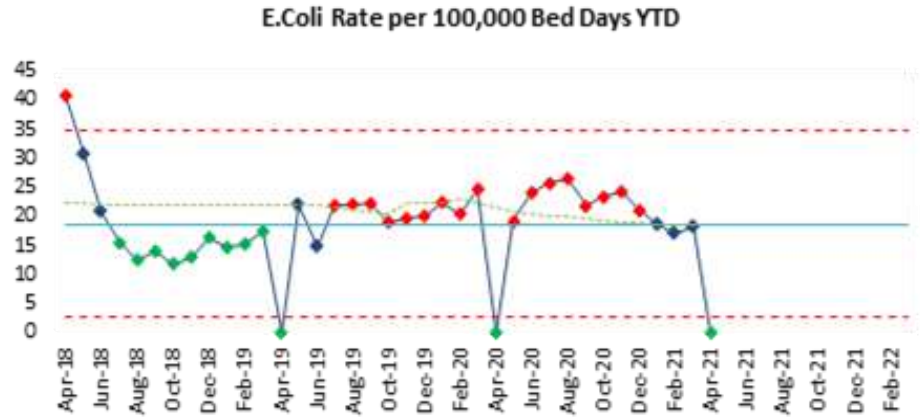
- E. coli Quality Improvement Project
- Catheter prevalence audits
- Thematic review
- Observation of practice
- Development of catheter management policy

The graph Compares Walton Centre E.coli rates year on year from April 2020 to March 2021.

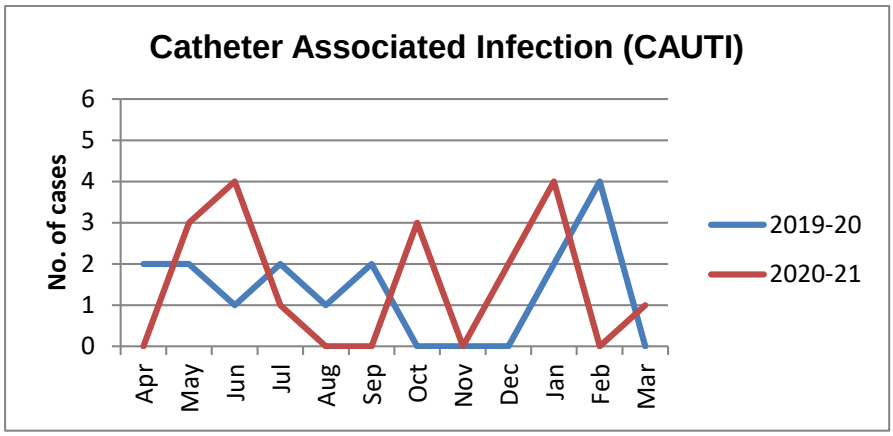
Graph 8 E-coli bacteraemia April 2020 – March 2021



Graph 9 E.coli bacteraemia rate per 100,000 bed days April 2020 - March 2021



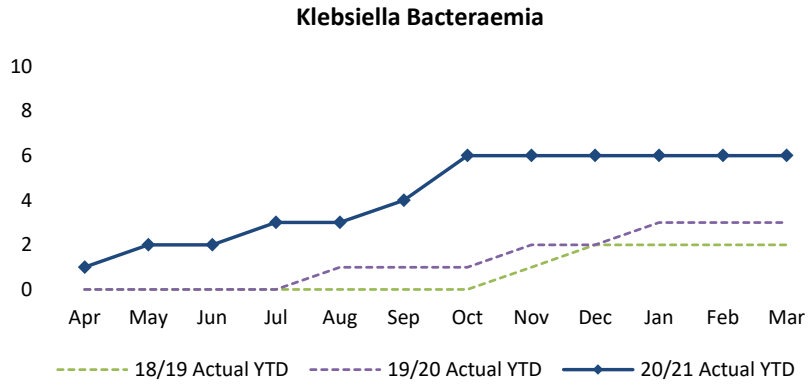
Graph 10 Number of Catheter Associated Infections (CAUTI's) 2020 – 2021



The Trust had 18 catheter-associated infections (CAUTI's) during 2020 - 2021 against an internal threshold of 17. Out of the 18 cases, E.coli was cultured in three cases. There was no mandatory or Trust annual reduction thresholds for gram-negative bloodstream infection during 2020-2021.

Four patients acquired a Klebsiella bloodstream infection during 2020 - 2021 compared to two in 2020-2021.

Graph 11 Number of Klebsiella bacteraemia April 2018 – March 2021

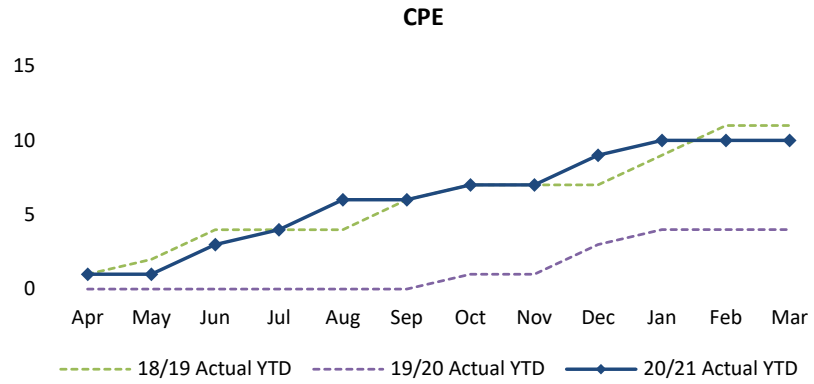


4. Multi-drug Resistant Organisms (MDRO) including Carbapenemase Producing Enterobacteriaceae (CPE)

MDROs are defined as microorganisms, predominantly bacteria, that are resistant to one or more classes of antimicrobial agents. 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 MDROs.

During 2020-2021 there were ten patients who acquired CPE during their inpatient stay compared to 4 in 2019-2020.

Graph 12 CPE April 2018 – March 2021



It has been identified that there were missed opportunities in the screening patients who may have been colonised on admission. In view of this, the following interventions have been undertaken:

- Review of the patient pathway
- CPE policy reviewed and updates
- Programme of upgrading toilet and bathroom areas
- Change to the process of initial risk assessment when patients are accepted for admission

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.

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.

.

There have been a number of changes in the Antimicrobial Stewardship team during 2020-2021. The Trust would like to thank Mr David Lawson, who has stepped down as Chair after many years championing Stewardship at The Walton Centre, and welcome Mr David Carter Consultant Neurosurgeon/Divisional governance lead and Mark Peasley Antimicrobial Pharmacist, who have joined the team. Ms Sian Davision, Antimicrobial Pharmacist, has gone on maternity leave.

It has been a challenging year throughout the COVID-19 pandemic and the Trust has seen the antimicrobial formulary being adapted several times during the course of the year. The Stewardship Group have continued to support the audit programme, which

is ongoing and are planning to increase the teaching provided across the Trust over the next 12 months.

The point prevalence audit data collected during 2020 - 2021 demonstrates relatively good overall antimicrobial prescribing within the Trust, with high levels of compliance with Trust formulary and use of stop/review dates. Improvements to the rate of antibiotic reviews for prescriptions that extend over 72 hours are required, as compliance with this is below our internal target of 85%.

The Trust provides an OPAT service which is a multidisciplinary team who will discuss patients who would benefit from having their antibiotics given at home. This ensures that patients receive an appropriate ongoing review of their treatment plan when discharged from the Trust.

The Antimicrobial Stewardship Group met four times during 2020-2021, and the minutes of the meetings are submitted to the Drugs and Therapeutics Committee.

Antibiotic ward rounds are undertaken Monday to Friday in critical care and weekly on the acute wards.

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 the microbiology laboratory. The Microbiologist also notifies any urgent results to the Infection Prevention and Control Team. 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 post-operative phases of care to reduce the risk of infection.

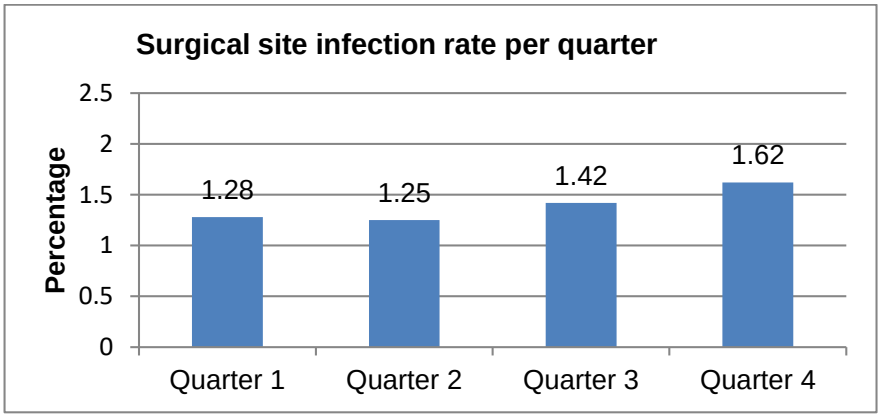
The total percentage rate of surgical site infections for the period April 2020-March 2021 is 1.40% below the 5% internal threshold set by the Trust. The data collection workstream regarding surgical site infection has continued into 2020-2021.
The IPC team has worked closely with the nurse specialist teams in an attempt to promote timely reporting of infections during ward rounds, therefore encouraging a more robust reporting system. Prevention of surgical site infection group has been created with a Trust-wide action plan in place to ensure ongoing quality improvement

in infection prevention and to continue to reduce the rate of SSI. The action plan focuses on:

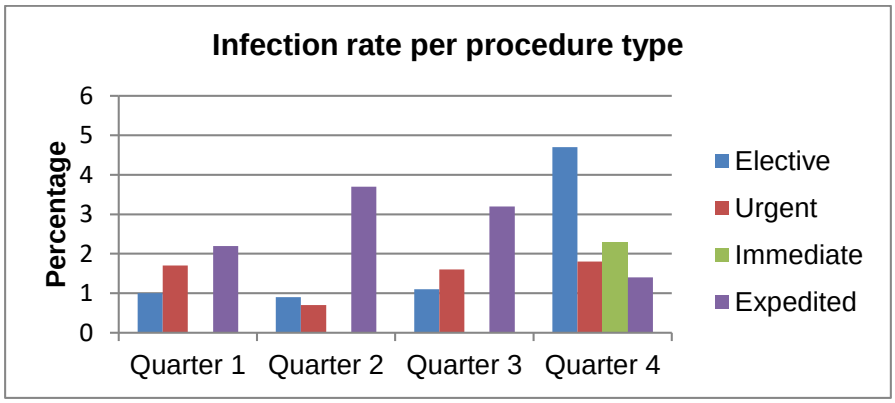
- Ensuring SSI data quality
- Theatre environment optimisation to reduce SSI
- Preoperative assessment
- Post-operative care
- Trust-wide education regarding SSI

There is now a surgical site infection dashboard that will hold all the data required and produce a comprehensive report at the end of each month. The implementation was delayed due to COVID-19 priorities, and it is anticipated that the dashboard will go live during quarter one in 2021/2022.

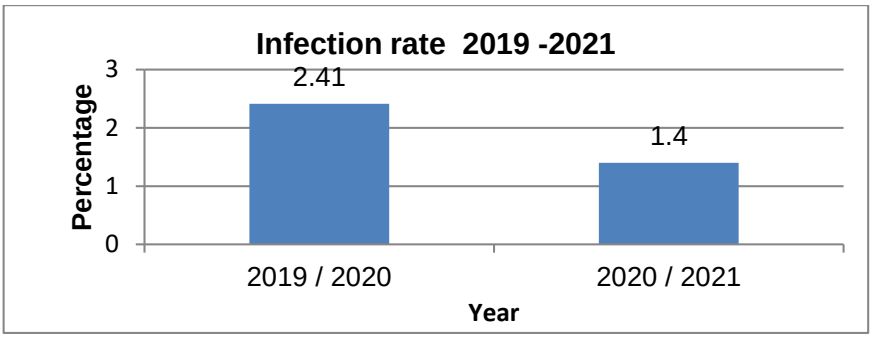
Graph 13 Surgical site infections per quarter 2020-2021



Graph 14 Infection rate per procedure type 2020-2021



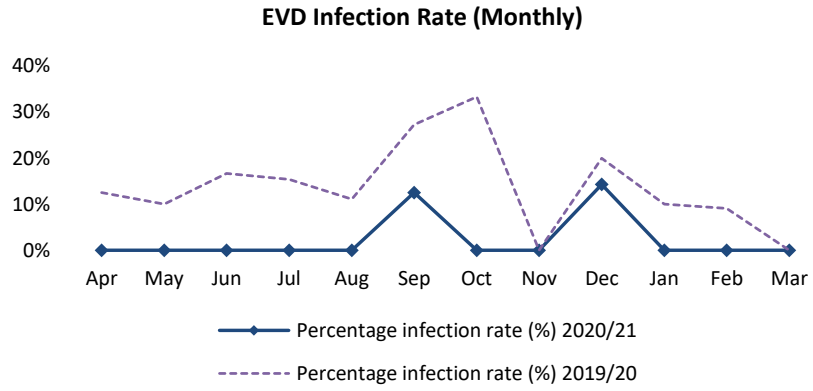
Graph 15 SSI Infection rate 2019 - 2021



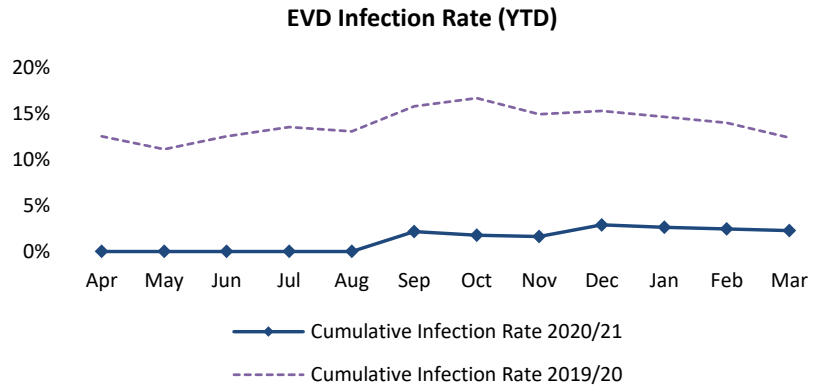
The decrease in SSI seen during 2020-2021 needs to be considered alongside a year of reduced elective activity due to the COVID-19 pandemic.

The reduction in extra-ventricular drain (EVD) infections has highlighted successful multidisciplinary engagement, which has led to a sustained reduction in infections. We would like to thank everyone that has contributed to this project which has significantly improved the quality, safety and patient experience of the care delivered.

Graph 16 EVD infection rate April 2019 – March 2021



Graph 17 EVD infection rate YTD April 2019 – March 2021



8. Infection prevention incidents and Outbreaks

8.1 Please refer to section 17 for Covid-19 outbreaks

8.2 CPE

There were three cases of Verona Integron-Mediated Metallo-β-lactamase (VIM) CPE identified in the Trust during quarter one. This was potentially due to transmission between case two and case three, as they were nursed in the same bay.

Case one was identified on routine screening. This was not able to be undertaken within the timeframe stipulated in the Trust policy due to the patient refusing. Case two was positive on admission screen to HITU, and case three was identified as a bay contact of case two and it was on week two of contact screening that they were confirmed as being colonised with CPE. It was established that both case two and three were the same strain (VIM).

An SBAR was undertaken and presented at the Divisional Risk and Governance Group and Infection Prevention and Control Committee. Enhanced patient screening did not identify any further cases.

8.3 Gastrointestinal infections

In June 2020, the Trust experienced increased cases of diarrhoea and vomiting on Sherrington Ward. Due to the COVID-19 pandemic, the ward was functioning as a stroke ward and managed patients from Liverpool University Foundation Trust. During this time, there were two patients and four staff members affected, and testing did not identify the causative organism. The main area of the ward was closed to admissions; however, the Hyper Acute Stroke Unit remained open to admissions with dedicated staff. Public Health England and NHSE/I were informed, and no further actions were required; an outbreak meeting was also held to ensure all appropriate measures were in place.

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

9.1 Covid/Agile Working

This past year has been particularly challenging to ensure the team provided a safe and effective facilities service for both patients & staff within The Walton Centre & Sid Watkins Building. At the height of Covid, all non-essential staff worked from home to mitigate risk and spread. Subsequently, the agile working project was brought forward sitting within the facilities/developments umbrella.

9.2 Capital

Facilities have worked closely together with estates in implementing Capital works to upgrade/renew areas identified in the ward, clinical as well as the main hospital site footprint, bringing all projects in on time and on budget before year-end.

9.3 Soft FM Services

This service provision in its entirety, currently provided by ISS, is due to expire on March 31 2022. Facilities are working closely with procurement in ensuring the tender pack is populated and completed within the scheduled timetable, ready to be sent out at the beginning of June 2021 to all relevant bidders. This has entailed a lot of hard work and engagement of various key stakeholders.

The senior facilities manager undertakes a comprehensive audit programme, 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 ultraviolet light systems continue to be used to enhance the cleaning process of infected isolation rooms. The effectiveness of the cleaning is monitored via 3M Clean Trace. The Trust has invested in an additional ultraviolet light system.

Due to the COVID-19 pandemic, PLACE inspections were suspended, and further guidance on the 2021 inspection are awaited.

9.4 Waste

A significant amount of work has been undertaken to ensure correct segregation at ward and departmental level. There have been additional pressures around some waste service providers, more so with clinical waste due to COVID-19. The contractors were under an unsustainable amount of demands/requests for collections which was difficult for everyone involved at the time. The Trust has worked together with the North West Consortium and have ensured a 12-month extension of the contract with renewal due next year. This also has come at an additional cost to the Trust.

10. Water Safety

The function of the Water Safety Group is to provide a multidisciplinary approach to assess and manage risks from water systems in the context of clinical risk to patients.

The Water Safety Group met regularly due to the detection of legionella in the water system. The testing regime was extended to other areas with similar findings. A detailed report of water management was presented to IPCC. Considerable work has been undertaken by the Estates department to remove piping and ensure water systems in the Trust achieve the appropriate temperatures to ensure water safety. Due to the recognised challenges with the flushing on non-touch taps, these were removed on Chavasse ward as part of the water safety programme.

Remedial work has continued to be undertaken to safely manage Pseudomonas aeruginosa (PA) in Horsley ITU and HDU, and filters remain in use, where required.

The Trust embedded the Hydrops water management system, which provides 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.

11. Theatre Ventilation

As documented in previous reports, the air flow 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.

Work has been undertaken to replace various components of the ventilation system to improve air flow, air changes and there is ongoing work to identify solutions and theatre ventilation is on the risk register.

12. Audit Programme 2020-2021

There is an extensive IPC audit plan which includes audits undertaken by the IPC team and clinical staff on their wards.

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.

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 has been formed to review the current tools and the needs of the Trust. This will be presented to IPCC to be clear regarding the future of these interventional tools.

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 2020/21 staff flu' campaign was 90% uptake of staff vaccination. All staff, clinical and non-clinical, were offered `flu vaccination. The IPCT led the flu campaign again this year along with peer vaccinators (which included the across the Trust. As a result of their hard work and commitment, 81% of patient-facing staff were vaccinated (payment made for trusts achieving (70-90%). Trusts were asked to complete their `flu programme early due to the introduction of COVID-19 vaccination.

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.

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

- Donning and doffing of PPE to ensure safe use of PPE during Covid-19 pandemic
- Vaccinator training to support the seasonal staff flu campaign
- Provision of mandatory training

15. Policies

The COVID-19 pandemic continued to delay routine policy review; however, there continued to be a programme of continuous updating and production of standard operating procedures and policies that were required to manage the COVID-19 pandemic. However, progress has been made to address this during quarter one in 2021 and a plan is in place to ensure all policies are appropriately review and updated.

16. HCAI Reduction Plan 2020 – 2021 (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; staffing was placed on the Trust register.

Despite these challenges, significant progress was made in the completion of the majority of core objectives. In view of this, some work streams will be included in 2021-2022. In addition, there has been a significant reduction in the numbers of Clostridium difficile and E.coli which is down to the hard work of both the IPCT and staff in the Trust.

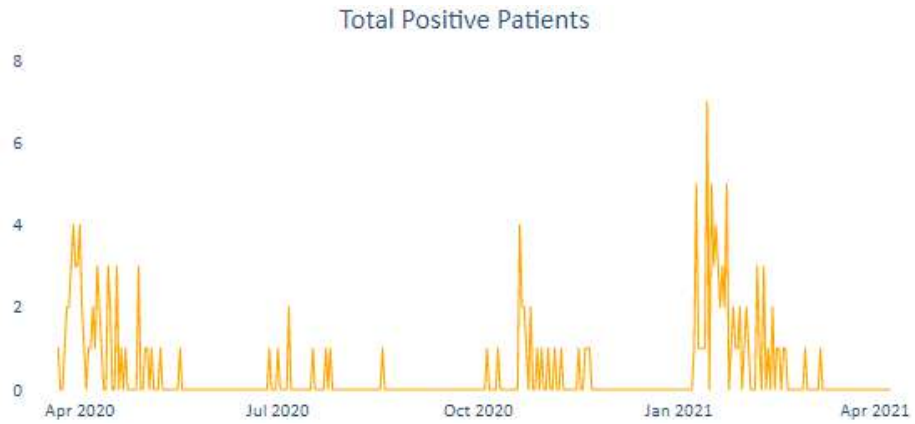
17. COVID-19 pandemic

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 exemplary infection prevention and control strategies are fully implemented and adhered to.

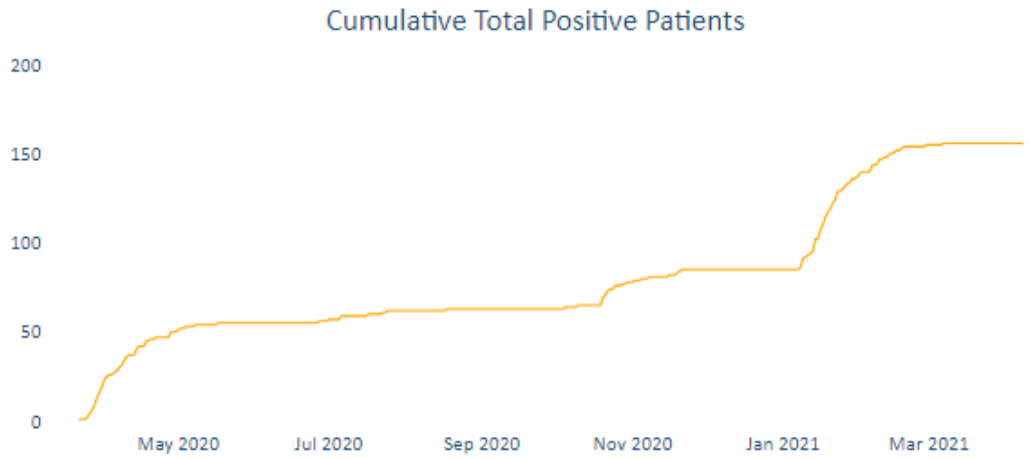
The majority of people infected with the COVID-19 virus experience mild to moderate respiratory illness and recover without requiring treatment. However, older people and those with underlying medical problems like cardiovascular disease, diabetes, chronic respiratory disease, and cancer are at a higher risk of developing a serious illness.

The pandemic continued to evolve during 2020 - 2021 with an unprecedented impact on the NHS, staff, patients and relatives. During this time, the North West Region had one of the highest numbers of COVID-19 infections per 100,000 in England, which presented challenges to the Trust and its partner agencies.

Graph 18 Total number COVID-19 positive patients April 2020 – April 2021



Graph 19 Cumulative total COVID-19 positive patients



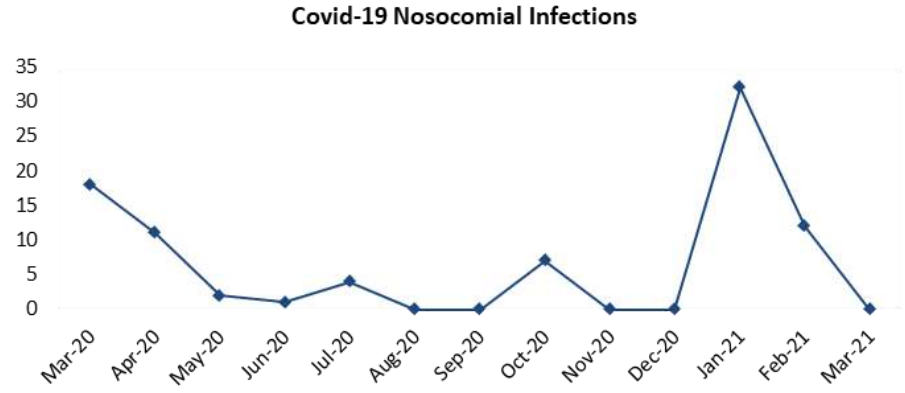
Of the 156 COVID-19 positive patients, a total of 87 were 8 days after admission (55.77%)

Nosocomial infections are defined by date range in the table below.

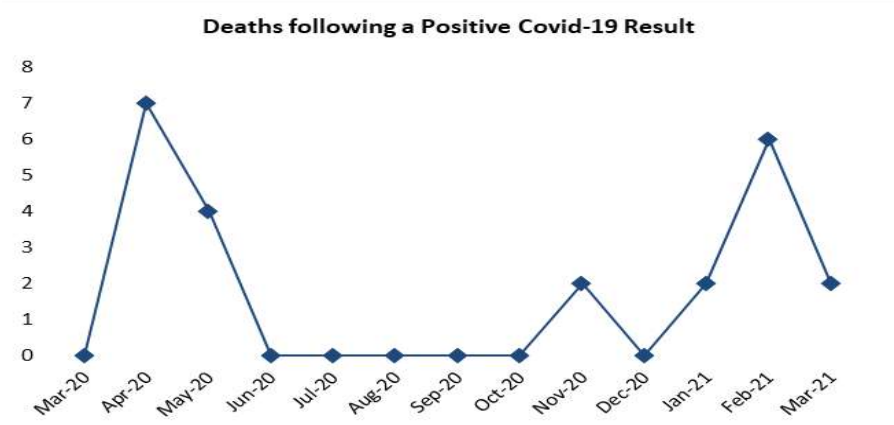
Nosocomial Group

Month	a) 0-3 Days	b) 3-7 Days	c) 8-14 Days	d) 15+ Days	Total
Mar 20	1		4	14	19
Apr 20	15	5		11	31
May 20	3		1	1	5
Jun 20			1		1
Jul 20	2		1	3	6
Aug 20		1			1
Oct 20	3	5	1	6	15
Nov 20	5	2			7
Jan 21	11	9	9	23	52
Feb 21	6		2	10	18
Mar 21	1				1
Total	47	22	19	68	156

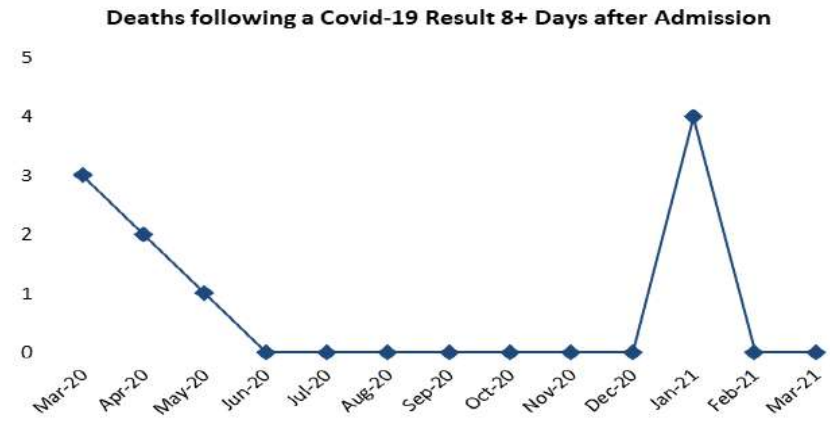
Graph 20



Graph 21 Deaths within 28 days of a positive COVID-19 result

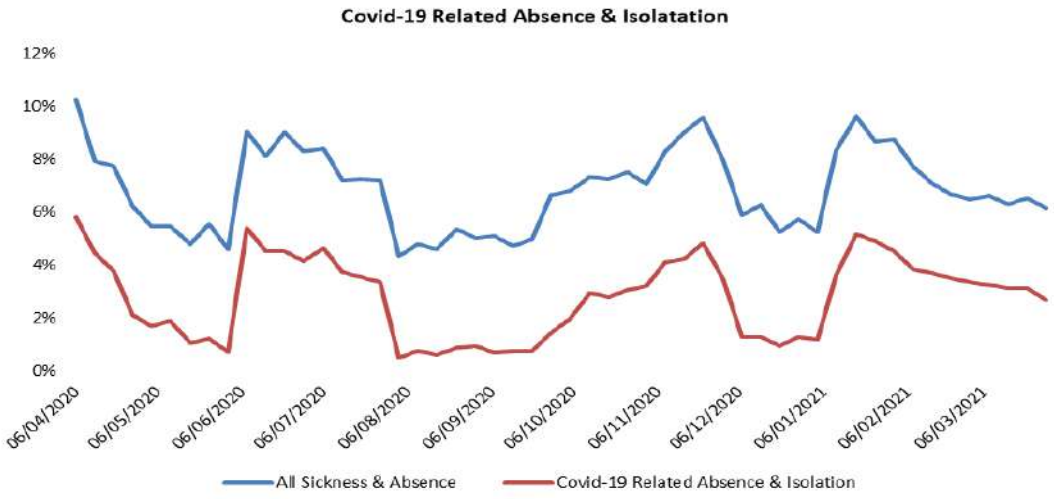


Graph 22 Deaths following a positive COVID-19 result 8+ days after admission



A total of 23 COVID-19 positive patients died as inpatients, with a further 3 after discharge within 28 days of the result. 85.26% of patients were either discharged or stepped down.

Graph 23 COVID-19 sickness absence and isolation



Total sickness & absence mirrored the same 4 phases as positive patients, with total absences peaking at 10%, covid-19 related absence and isolation made up just over half of this.

The IPC Team has been engaged at a Strategic and Operational Level to support the organisation in the prevention and management of patients with COVID-19, and to ensure patient and staff safety has led/supported the following interventions:

- Implementation of COVID-19 Board Assurance Framework
- Development of COVID-19 dashboard
- Development of ward COVID-19 screening boards
- Temporary increased IPC on-call provision
- Senior Managers On-Call rota/Command and Control
- Extensive work undertaken with the Procurement department
- Extensive training programme to support infection prevention strategies and safe working practice, e.g. PPE, COVID-19 testing
- Supported ISS domestic services with advice, education and training
- Ongoing review and implementation of patient pathways with clinical services/departments.
- Continued to develop and update an extensive library of standard operating procedures and policies
- Development of rapidly changing patient placement strategies
- Staff COVID-19 testing
- Asymptomatic staff point prevalence screening
- Patient and staff contact tracing
- Supported the COVID Team
- Implemented COVID-19 patient and staff antibody testing
- Collaborative working with the estate's department
- Participated in local, regional and national teleconferences
- Collaboration with external infection prevention and control colleagues.
- Implementation of rapidly changing guidance, especially in relation to PPE
- Development of COVID-19 investigation process
- Provision of extended COVID-19 testing
- Championed COVID-19 vaccination
- Increased support visits in ward areas

- Supported clinical areas with terminal cleaning programmes/bed moves
- Released IPC staff to work/support in ward areas

Due to the unprecedented nature of the pandemic, all staff in the Trust faced challenges in the delivery of patient care during 2020-2021. These ongoing challenges caused significant staff anxiety, and the IPCT has provided ongoing support.

Sufficient stock of PPE and consumables were maintained throughout the pandemic. 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 there were severe shortages of fit testing solution. The provision of soap and alcohol hand rub also became challenging. The Procurement team worked closely with IPC and Trust services during this period and we would like to extend our thanks for their hard work and dedication during a difficult year.

The Trust introduced lateral flow testing for all clinical staff in line with national requirements and then transferred to LAMP testing.

COVID-19 Outbreaks

- There was an outbreak of COVID-19 on Chavasse ward at the beginning of July 2020. A third member of staff who had worked on Chavasse and CRU also tested positive. In total, the outbreak affected Chavasse and CRU and consisted of three patients and six members of staff.
- Outbreak meetings and daily reviews.
- Enhanced programme of screening for COVID-19 for patients and staff
- Chavasse reinstated as a red ward.
- Restrictions on the number of staff in break areas and use of the family room as an additional area for ward staff breaks.
- Enhanced cleaning was undertaken.
- Increased use of UV and HPV decontamination.
- Deep clean undertaken in Chavasse and CRU.
- Restricting the number of staff in break areas.
- COVID-19 positive patients had allocated staff to reduce the risk of transmission.

Theatres

Initially, there were two members of staff who tested positive for COVID-19. All contacts were identified and interviewed by the IPC Team with support from the theatre manager. Twelve staff members were sent home to self-isolate due to either breaches of PPE or exposure from lack of social distancing in break areas.

An outbreak meeting was convened, and it was agreed that all theatre staff would be screened for COVID-19. The asymptomatic screening identified a further three positive cases.

The department was deep cleaned, and a programme of enhanced cleaning implemented. The tea room was made COVID-19 secure, and a second break area identified.

In total, there were 14 staff members who tested positive for COVID-19. The combination of COVID-19 positive staff and those who were required to self-isolate due to their contact with a positive case impacted on service delivery and led to the cancellation of some theatre lists. No patients were found to be positive from their contact with staff.

Cairns Ward

On October 19 2020, a patient who had been an inpatient (with no visitors) since September 2020 developed a temperature and had low blood pressure, which was thought to be due to a wound infection. The patient was tested for COVID-19 and was moved into a side room and commenced on high flow oxygen (AIRVO).

It was subsequently recognised that there was no signage outside the patient's room to inform staff of the correct PPE which needed to be worn. The Trust guidelines for the placement of patients who are symptomatic and, therefore, potentially COVID-19 positive were not followed as the patient remained on Cairns (amber ward) rather than transferring to Chavasse (red ward). It is understood that this was a clinical decision as the source of infection was initially thought to be non COVID.

Two patients who had shared the same bay as the index case became symptomatic and tested positive for COVID-19. An outbreak meeting was convened, and actions agreed. All contact patients were identified, and those who had been discharged informed of their contact with the index case and advised to isolate.

A staff member who had been in contact with the index case also became positive and all staff that had provided care for the patient were subsequently screened. A programme of enhanced staff screening was implemented.

In total, there were seven patients and eight staff who tested positive for COVID-19 on Cairns ward. Four of the seven patients were nosocomial infections, i.e., infection as a result of healthcare interaction (inpatient episode).

Dott Ward

The first case was a patient who, on October 05 2020, developed symptoms of COVID-19; the patient was screened and confirmed as COVID-19 positive. All the patients in the bay were screened and found to be negative, and isolation was continued.

The second patient was admitted on October 16, 2020, and developed symptoms on October 20 2020, and was found to be COVID-19 positive. It was identified that the patient had regular visits from their parent who was caring for a family member with COVID-19; following this case, a further three cases were identified. One patient had been transferred and screened on admission at the receiving trust; although the first screen was negative, the screen was repeated and found to be positive. The second patient attended screening in the community and was found to be positive. The third patient did not have a positive screen but clinically displayed COVID-19 on chest radiography.

The outbreak did not become apparent at an early stage as the cases appeared sporadic. In total, there were seven patients who developed a COVID-19 infection. Of these patients, two were nosocomial infections, with the remainder a combination of community and probable nosocomial infections.

An enhanced programme of cleaning was increased, and regular asymptomatic screening of staff was commenced, with one staff member who tested positive for COVID-19.

Complex Rehabilitation Unit (CRU)

CRU is a 30 bedded unit that had 28 patients at the time that a COVID 19 outbreak was declared on 5 January 2021. In total there were 14 patients with nosocomial COVID-19. There are no shared bays in the unit and all patients have individual side rooms but have socially distanced meal times as part of their rehabilitation. The source of this outbreak is thought to be a patient who transferred from the acute site who had been in contact with a case of COVID-19. Following this incident despite the availability of side room isolation, transfers who had not completed their 14 day isolation remained on the acute site. An outbreak meeting was held and enhanced screening of patients and staff, additional cleaning and IPC interventions were implemented. The unit was closed and staff movement restricted.

The factors contributing to this outbreak were multifaceted. There were extremely high levels of COVID-19 in the community and enhanced screening identified a number of staff and patients who were COVID-19 positive but did not have any symptoms but could transmit infection and staff movement due to high levels of sickness absence or staff isolation due to COVID-19.

A cluster review has been completed for the outbreak and the outcomes will be presented to Neurology Risk and Governance and IPCC.

NHSE visit

In light of the number of COVID-19 outbreaks the Trust welcomed a support visit from NHSE/I. The visits consisted of a clinical focus group, IPCT focus group and a walk around the ward areas. In addition to the positive feedback there were some areas that required review e.g. signage, and an action plan has been developed.

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, the complexity of treatments, and the continued emergence of new organisms.

Although 2020 – 2021 proved challenging with increased pressures evident throughout the Trust in due 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 2021-2022 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 2020-2021

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 of 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 2020 -2021

COMPLETED		IN PROGRESS		NO PROGRESS TO REPORT		NO PROGRESS -COVID-19	

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, November 20, February 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 20 – March 21	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					COVID-19 priorities delayed work stream. This will be carried forward to 2021-22
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					Thematic review presented to IPPC October 20.
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	March 2021	Lead Nurse IPC					Covid-19 impacted on scheduled policy review. Plan to complete updating Q1 2021-2022 which is currently on target

Provide specialist support to services to develop policies, procedures and guidance within the Trust							Extensive updating of a range of Covid-19 SOPS, Policy and guidance
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					COMPLETE
Implement IPC audit programme and monitor outcomes/progress	July 20, November 20, February 21	Senior IPC Nurse					Additional resource in IPCT programme completed
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					COMPLETE
Prepare core training plan and deliver formal and informal education to all grades and disciplines of staff	April 20 - ongoing	IPC Team					COMPLETE
Maintain IPC Ambassador education programme	June 20 September 20 December 20 March 21	IPC Team					Suspended due to COVID-19 Pandemic
Embed ANTT across the Trust	August 20	IPC Team					COVID-19 pandemic and IPC staffing impacted on implementation reviewed and programme refresh Q1-2 2021-2022
Undertake blood culture competencies and audit of practice	September 20	IPC Team/PEF's					New competencies introduced in ITU

Continue to support IPCC spoke placements for student nurses, Trainee Nurse Associates and *adhoc* placements for students and ward staff	April 20– March 21	IPC Team					Placement's restricted due to COVID-19 pandemic
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					Suspended due to COVID-19 Pandemic
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					COMPLETE
Undertake TNA for immuniser training	July 20	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	October 20	IPC Team					
Monitor MRSA admission and 30 day screening	November 20	IPC Team					To be reviewed in Q1 2020-21
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					Suspended nationally due to COVID-19 Pandemic

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					Delayed due to COVID-19 pandemic
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					COMPLETE SSI form digitised and in use. Work to strengthen reporting underway
Develop SSI dashboard	March 21	Lead Nurse IPC/Informatics					Review and sign off on target in Q1
Provide support to Theatre User Group	Monthly	IPCT					Attendance sporadic due to COVID-19

							Pandemic Now attended by IPC Theatre link
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					Covid-19 BAF Covid-19 assessment checklist
Maintain PPE education programme	Ongoing	IPCT					
Continue to develop COVID-19 dashboard	July 2020	IPCT					

APPENDIX 2

Infection Prevention and Control; Healthcare Associated Infection (HCAI) Reduction Plan 2021 - 2022

2. Introduction

This proposed Plan outlines the core activities which will be undertaken by the Infection Prevention and Control Team (IPCPT) during 2021 to 2022. 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 of 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
- SMART

HEALTHCARE ASSOCIATED INFECTION REDUCTION PLAN 2021 -2022

COMPLETED		IN PROGRESS		NO PROGRESS TO REPORT		NO PROGRESS -COVID-19	

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 21, July 21 , Nov 21, Feb 22	Lead Nurse IPC					
Maintain COVID-19 Assurance Framework	May 21 Sept 21	Lead Nurse IPC					
Support Divisions in restoration of services post COVID-19	Monthly	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 2021-22 IPC Annual IPC Report to Quality Committee/Trust Board	May 21, July 21, November 21, February 22 May 22	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 21 – March 22	IPC Team					
Continue to develop digital HCAI reporting in the Trust to reduce duplication and increase efficiency • Integrated Performance Report • Surveillance • Hand hygiene • Saving lives	May 21 September 21 October 21 January 22	Informatics					
Undertake surveillance and monitor • Cranial infections • EVD infections • Implant infections • Lower level spinal infections	Monthly	IPCT/ Hydrocephalous Nurse Specialist Spinal Nurse Specialist					
10 % reduction in the number of MSSA blood stream infections • Quality Improvement Group • Competencies • Training plan • Refresh ANTT programme • IPCT rostered sessions in link area • MSSA action plan to be monitored via IPCC	April 21 – March 2022	IPCT/ Divisional Nurse Directors					

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	April 21 March 2022	Lead Nurse IPC					
Provide specialist support to services to develop policies, procedures and guidance within the Trust	April 21 March 2022						
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 2021	Senior Nurse IPC					
Implement IPC audit programme and monitor outcomes/progress	July 21 , Nov 21, Feb 22	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 21 – March 22	IPC Team					
Deliver IPC Ambassador education programme	June 21 September 21 December 21 March 22	IPC Team					
Review and refresh ANTT across the Trust	Sept 21	IPC Team					
Undertake blood culture competencies and audit of practice	September 20	IPC Team/PEF's					

Support spoke placements for student nurses, Trainee Nurse Associates and *adhoc* placements for students and ward staff	April 21– March 22	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 21 - March 22	Lead Nurse IPC					
Support attendance at regional forums and attend relevant local and national study days and conferences	April 21 – March 22	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 20-21 campaign	May 21	IPC Team					
Undertake TNA for immuniser training	July 21	IPC Team					
Develop Elearning package	July21	Workforce Analyst					
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					
Implement national CPE guidance	June 21	IPCT					
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**
Review of mini PLACE inspections PLACE and mini PLACE assessments will be undertaken and action plans formulated to address any concerns	June 21	Divisional Nurse Director/Matron IPCT/ Estates ISS					
Review and implement new national standards for cleaning	September 21	Head of Facilities					
Undertake environmental audits within clinical areas	Monthly	Facilities					
Provide expertise and specialist IPC input into Estates and Facilities meetings/works	April 21- March 22	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	Medical Lead/ Antimicrobial Pharmacist					
Further develop antimicrobial audit programme	March 22	Antimicrobial Pharmacist					

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**
Deliver SSI action plan	June 21	IPCT/Theatre R & G Lead					
Implement SSI dashboard	June 21	Lead Nurse IPC/Informatics					
Introduce education plan for management of surgical wounds	March 22	TV Nurse Specialist					
Provide support to Theatre User Group	Monthly	Senior IPC Nurse					
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 21 October 21 January 22 April 22	SMART Lead					
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					

Publications approval reference

Infection prevention and control board assurance framework

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	• Transfer handover • Admission risk assessment form • Positive results stored on PAS system • HITU admission risk assessment	• Potentially not filed in patients case 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 bed managers and IPCT • COVID-19 patient pathway • De-escalation protocol • Trust COVID -19 policy • COVID-19 dashboard – status of all positive patients accessible	• Decisions being made outside of the IPC Ward RAG rating (evenings/weekends) • Non-compliance with PHE /Trust guidance • Non-compliance with guidance	• COVID-19 Dashboard updated in real time • Escalation to bronze or silver on call if required • Continued staff support and education • Daily ward visits • IPCT staff support and education
• compliance with the national guidance around discharge or transfer of COVID-19 positive patients	• Trust COVID -19 policy in line with PHE guidance		
• monitoring of IPC	• Register of staff training for fit testing		• PPE discussed at daily Trust wide safety

practices, ensuring resources are in place to enable compliance with IPC practice	• IPC Audit program • Daily escalation • Visual aids of PPE guidance – patients/staff • Audit • Safety huddle notes	• Staff may not engage • Conflicting guidance	huddle • Ongoing education and support • IPC Walk about`s • Engagement with clinical teams
• monitoring of compliance with PPE, consider implementing the role of PPE guardians/safety	• IPC team communicates any changes noted within national guidance in a timely manner. This is managed through command and control (dependent on level) and communications	• None identified	• Ongoing education and support
• champions to embed and encourage best practice		• None identified	
• staff testing and self-isolation strategies are in place and a process to respond if transmission rates of COVID-19 increase	• Staff screening guidance • Outbreak screening guidance • Electronic notification of staff results • COVID Team formation • Enhanced screening protocols in place where required • Lateral flow database		
• training in IPC standard infection control and transmission-based precautions are provided to all staff	• Mandatory training • Bitesize sessions • Area specific as required • Intranet resources		
• IPC measures in relation to COVID-19 should be included in all staff Induction and mandatory training	• Training records		

• all staff are regularly reminded of the importance of wearing face masks, hand hygiene and maintaining physical distance both in and out of work	• Daily safety huddle • Communications bulletins • Posters • Daily ward IPC visits		
• all staff (clinical and non-clinical) are trained in putting on and removing PPE; know what PPE they should wear for each setting and context; and have access to the PPE that protects them for the appropriate setting and context as per national guidance	• Mandatory training • Bitesize sessions • Area specific as required • Posters • Intranet resources		
• national IPC guidance is regularly checked for updates and any changes are effectively communicated to staff in a timely way	• Daily Gov.uk COVID-19 update • Communication bulletin • PHE communication		
• changes to guidance are brought to the attention of boards and any risks and mitigating actions are highlighted	• Daily emails circulated Trust wide • Daily Safety Huddle • Command a & Control structure • Tactical meetings • Direct escalation to executive team • Operational risk on Datix which informs the Trust BAF • COVID-19 BAF • IPC quarterly reports • HCAI surveillance within the Trust		

• risks are reflected in risk registers and the board assurance framework where appropriate • robust IPC risk assessment processes and practices are in place for non COVID-19 infections and pathogens • that Trust CEOs or the executive responsible for IPC approve and personally signs off, all data submissions via the daily nosocomial sitrep. This will ensure the correct and accurate measurement and testing of patient protocols are activated in a timely manner • ensure Trust Board has oversight of ongoing outbreaks and action plans.	reported via Datix • Integrated performance report • Mandatory HCAI reporting • Training records • Care pathways • Patient placement guidance • Minutes of Quality Committee • compliance with the national • guidance around discharge or transfer of COVID-19 positive patients • As above		

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. • Compliance with mandatory training and reported through to Heads of Departments and monitored by Divisional Risk & Governance	• Movement of staff due to sickness/annual leave	• Staffing only to be moved when absolutely necessary • Therapies management pathway
• 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 required, logged on database (as above) • ISS domestic services management guidance compliant with PHE guidance • COVID 19 policy • Cleaning policy • ISS/facilities operational group minutes	• Poor communication • Staff anxieties • Non adherence to policy	• Continued staff support and education/visual aids • Education & training provided • ISS/Facilities Operational Group
• decontamination and terminal decontamination of isolation rooms or cohort areas is carried out in line with PHE and other national guidance • increased frequency, at least twice daily, of cleaning in areas that have higher environmental	• COVID -19 Policy • Decontamination Policy • Isolation Policy • Monitoring and discussion at Trust safety huddle • Facilities Manager audits • COVID-19 Policy • Isolation Policy • Cleaning schedules amended during Covid 19 • Facilities/ISS audit programme	• Non adherence to policy / schedule	• Refer to appropriate policy during education sessions, signpost to intranet page • Education/training sessions • Refer to appropriate policy during education sessions, signpost to

contamination rates as set out in the PHE and other national guidance	• Housekeeper check list • Terminal clean check list • Cleaning of frequent touch areas increased	• Non adherence to policy / schedule	intranet page
• cleaning is carried out with neutral detergent, a chlorine-based disinfectant, in the form of a solution at minimum strength of 1,00ppm available chlorine, as per national guidance. If an alternative disinfectant is used, the local infection prevention and control team (IPCT) should be consulted on this to ensure that this is effective against enveloped viruses.	• Procurement ordering system • COVID-19 policy • Decontamination policy • ISS Service Level Agreement • Decontamination policy • COVID-19 policy • ISS cleaning schedule • Outbreak meeting minutes	• Non adherence to policy / schedule • Non-adherence to policy	
• Manufactures' guidance and recommended product 'contact time' must be followed for all cleaning/disinfectant solutions/products	• COVID-19 policy • ISS schedule • ISS/Facilities group minutes	• Non-adherence to policy	
• 'frequently touched' surfaces, eg door/toilet handles, patient call bells, over-bed tables and bed rails, should be decontaminated at least twice daily and when known to be contaminated with secretions, excretions		• Non adherence to policy	

or bodily fluids. • electronic equipment, eg mobile phones, desk phones, tablets, desktops and key boards should be cleaned at twice daily. • rooms/areas where PPE is removed must be decontaminated, timed to coincide with periods immediately after PPE removal by groups of staff (at least twice daily) • linen from possible and confirmed COVID-19 patients is managed in line with PHE and other national guidance and the appropriate precautions are taken • single use items are used where possible and according to Single Use Policy • reusable equipment is appropriately decontaminated in line with local and PHE and other national guidance • ensure cleaning standards and frequencies are	• Desk space cleaning record • Decontamination policy • Laundry contract • Standard precautions policy • Decontamination policy • Email confirmation of disposable curtain order • Standard precautions policy • Mandatory training lesson plans • Range of single use items • Mandatory training/Induction • Clean trace • Infection Prevention and Control Policy • SOP for cleaning of visors/goggles and hoods • COVID -19 policy	• The Trust does not have a single use policy	• Refer to appropriate policy during education sessions, signpost to intranet page • Mandatory Health and Safety and induction training addresses single use items • Staff support and education

monitored in non-clinical areas with actions in place to resolve issues in maintaining a clean environment	• Facilities audit outcomes		
• ensure the dilution of air with good ventilation in admission and waiting areas to assist the dilution of air	• Natural ventilation in Ward/OPD Areas	• Windows may not be opened on a regular basis to aid ventilation	• Poster provided to all ward areas
• there is evidence organisations have reviewed the low risk COVID-19 pathway, before choosing and decision made to revert to general purpose detergents for cleaning, as opposed to widespread use of disinfectants	• Not applicable SoChlor/Chlorclean used across all areas.		
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	• Antimicrobial ward round – virtual if required. • Microbiology advice available 24/7 • Antimicrobial audits	• Inconsistency in ward rounds • Medical input variable	• Clinical engagement • Clinical Director review • Review of processes
• mandatory reporting requirements are adhered to and boards continue to	• IPC surveillance • Minutes of Antimicrobial stewardship meetings	• None identified	

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		
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**
• implementation of national guidance on visiting patients in a care setting • areas in which suspected or confirmed COVID-19 patients are being treated in areas clearly marked with appropriate signage and have restricted access • information and guidance on COVID-19 is available on all trust websites with easy read versions • infection status is communicated to the receiving organization or department when a possible or confirmed COVID-19 patient needs to be moved • there is clearly displayed	• Visitors guidance • Patient information leaflets • Social media page • Signage at ward entrance • Transfer form • Posters at entrances and in departments/wards • Pre-operative patient letter • Hand hygiene stations	• None identified	

and written information available to prompt patients' visitors and staff to comply with hands, face and space			
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: • screening and triaging of all patients as per IPC and NICE Guidance within all health and other care facilities must be undertaken to enable early recognition of COVID-19 cases	• Assessment undertaken via telephone pre visit • Face to face Clinics currently reduced • Signage clear at the entrance / reception area and on the Trust website • Temperature/PPE stations at entrance/exits • Screens in place in reception areas • Allocated beds – Chavasse • Bed Managers risk assessment	• Information taken during assessment not being highlighted clearly in the documentation or on PAS.	• Review with Divisional Nurse Directors
• front door areas have appropriate triaging arrangements in place to cohort patients with possible or confirmed COVID-19 symptoms and to segregate them from non COVID-19 cases to minimise the risk of cross-infection as per national guidance	• COVID-19 policy • Staff testing SOP • Liverpool Clinical Laboratories SOP for patient testing. • COVID 19 policy • Protocol for rapid COVID 19 testing • OPD SOP • Patients attending with symptoms will be assessed and confirmed whether they need to go home to self-isolate or be admitted, depending on their	• Transfer time to Chavasse can variable	• Escalated to Director of Operations/acting DIPC for review

• staff are aware of agreed template for triage questions to ask • triage undertaken by clinical staff who are trained and competent in the clinical case definition and patient is allocated appropriate pathway as soon as possible • face coverings are used by all outpatients and visitors. • Face masks are available for patients with respiratory symptoms • provide clear advice to patients on use of face masks to encourage use of surgical facemasks by all inpatients in the medium and high-risk pathways if this can be tolerated and does not compromise their clinical care • ideally segregation should be with separate spaces, but there is potential to use screens, e.g. to protect reception staff.	condition • In all areas • Signage to highlight use of masks and provision of masks provided across all patient pathways • Screens in place	• Delay in results from LCL due to increased numbers being tested • No electronic lab system - Incorrectly labelled	•Labelling of samples discussed at Trust safety huddle •Discussion underway to explore Order Comms

• for patients with new-onset symptoms, isolation, testing and instigation of contact tracing is achieved until proven negative • patients that test negative but display or go on to develop symptoms of COVID-19 are segregated and promptly re-tested and contacts traced promptly • patients that attend for routine appointments who display symptoms of COVID-19 are managed appropriately	• Testing available 24/7 7 days a week • De-escalation protocol • COVID-19 dashboard • Patient pathway document • Enhanced screening programme • OPD SOP • Hygiene stations	samples, potential delay in results due to sample not processed • None identified	system

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: • separation of patient pathways and staff flow to minimise contact between pathways. For example, this could include provision of separate entrances/exits (if available) or use of one-way entrance/exit systems, clear signage, and restricted access to communal areas • all staff (clinical and non- clinical) have appropriate training, in line with latest national guidance to ensure their personal safety and working environment is safe • all staff providing patient care are trained in the selection and use of PPE appropriate for the clinical situation and on how to Don and Doff it safely • a record of staff training is maintained	• Patient pathway Guidance • Floor signage • Back entrance restricted to Staff only • Maximum occupancy notices in break areas • Additional break areas provided • Agile working policy • Education and training • Training records • Signage • IPC walkabouts • Posters • IPC walkabouts • Leaflets • Decontamination policy • Covid-19 policy • No hand dryers in Trust • Staff screening protocol • Outbreak protocol • SBAR • IMARCH Data entry to national outbreak	• Additional public signage required in some areas e.g. lifts	• Communications Team are reviewing and additional signage/sites agreed

• appropriate arrangements are in place that any reuse of PPE in line with the MHRA CAS Alert is properly monitored and managed • any incidents relating to the re-use of PPE are monitored and appropriate action taken • adherence to PHE national guidance on the use of PPE is regularly audited • hygiene facilities (IPC measures) and messaging are available for all patients/individuals, staff and visitors to minimise COVID-19 transmission such as: • hand hygiene facilities including instructional posters • good respiratory hygiene measures • maintaining physical distancing of 2 metres wherever possible unless wearing PPE as part of direct care • frequent decontamination of equipment and	system • Mandatory training records • COVID-19 dashboard • Minutes of outbreak meetings		

environment in both clinical and non-clinical areas • clear advice on use of face coverings and facemasks by • patients/individuals, visitors and by staff in non-patient facing areas • staff regularly undertake hand infection control precautions • the use of hand air dryers should be avoided in all clinical areas. Hands should be dried with soft, absorbent, disposable paper towels from a dispenser which is located close to the sink but beyond the risk of splash contamination as per national guidance • guidance on hand hygiene, including drying should be clearly displayed in all public toilet areas as well as staff areas • staff understand the requirements for uniform laundering where this is not			

provided for on site • all staff understand the symptoms of COVID-19 and take appropriate action (even if experiencing mild symptoms) in line with PHE national guidance and other if they or a member of their household display any of the symptoms • a rapid and continued response through ongoing surveillance of rates of infection transmission within the local population and for hospital organisation onset cases (staff and patients/individuals) • positive cases identified after admission who fit the criteria for investigation should trigger a case investigation. Two or more positive cases linked in time and place trigger an outbreak investigation and are reported. • robust policies and procedures are in place for the identification of and management of outbreaks of infection			

7. 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 and local assessment	• 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	• Non identified	
• 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.	• Non identified	• Managers have been asked to inform their teams regarding updates
• 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	• Potential for transfer letter not being completed	• Discussions with receiving organisation prior to patient leaving the ward

8. Provide or secure adequate isolation facilities			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure: • restricted access between pathways if possible, (depending on size of the facility, prevalence/incidence rate low/high) by other patients/individuals, visitors or staff	• Ward RAG rating for placement of patients • All side rooms have en-suite facilities • All positive patients nursed within the same area • COVID-19 Dashboard	• None identified	
• areas/wards are clearly signposted, using physical barriers as appropriate to patients/individuals and staff understand the different risk areas	• Minutes of divisional group meetings • Command and control log • IPC walkabouts	• None identified	
• patients with suspected or confirmed COVID-19 are isolated in appropriate facilities or designated areas where appropriate	• Management of multi drug resistant organism policy • Isolation policy • SOP for side room allocation • IPC daily escalation email / ward visits • Decontamination policy	• Limited side rooms	• IPCT have daily communication with bed managers/matrons
• areas used to cohort		• None identified	
• patients with suspected or confirmed COVID-19 are isolated in appropriate facilities or designated areas where appropriate			
• areas used to cohort patients with suspected or			

confirmed COVID-19 are compliant with the environmental requirements set out in the current PHE national guidance • patients with resistant/alert organisms are managed according to local IPC guidance, including ensuring appropriate patient placement	• Daily infection list/review		
9. 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: • ensure screens taken on admission given priority and reported within 24hrs • regular monitoring and reporting of the testing turnaround times • with focus on the time taken from the patient to time result is available • testing is undertaken by competent and trained individuals • patient and staff COVID-19 testing is undertaken	• SOP for testing • LCL guidance on testing and packaging of samples • SOP for staff testing • COVID -19 policy • MDRO policy • Quarterly audits undertaken • MRSA policy • BSC • HCAI surveillance • CPE policy • Outbreak screening guidance • Pre-op screening	• Turnaround time may fluctuate • SBAR identified admission/5day screening not robust	• Daily email for day 5 screens

promptly and in line with PHE and other national guidance • regular monitoring and reporting that identified cases have been tested and reported in line with the testing protocols (correctly recorded data) • screening for other potential infections takes place			
10. 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 • any changes to the PHE national guidance on PPE are quickly identified and effectively communicated to staff • all clinical waste related to confirmed or suspected COVID-19 cases is	• Mandatory health and safety training • Induction training • Ward manager meetings / IPC Committee / PNF • COVID -19 policy • PPE posters • COVID 19 intranet page • Communicated via Command and Control/daily COVID-19 comms • COVID -19 policy • Waste audits • Health and safety committee minute	• Non adherence to policy • Non adherence to policy • Noncompliance to correct waste segregation	• Refer to appropriate policy during education sessions, signpost to intranet page • Discussion at Trust safety huddle • Staff support and education • Mandatory Health and Safety • Discussion at Trust safety huddle

handled, stored and managed in accordance with current national guidance • 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/Tactical Meeting/Safety huddle daily	• None identified	• Staff support and education • Mandatory Health and Safety
11. 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 • that risk assessment(s) is (are) undertaken and documented for any staff members in an at risk or shielding groups, including Black, Asian and Minority Ethnic (BAME) and pregnant staff	• Staff COVID risk assessment • COVID – 19 staff support helpline • Shiny minds • Numerous emails sent to staff highlighting health and wellbeing initiatives • Occupational health • Staff risk assessment Proforma • Fit testing is being delivered as per protocol and recorded centrally in	• Staff do not wish to engage with support • None identified	• 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 and held centrally • staff who carry out fit test training are trained and competent to do so • all staff required to wear an FFP respirator have been fit tested for the model being used and this should be repeated each time a different model is used • a record of the fit test and result is given to and kept by the trainee and centrally within the organization • for those who fail a fit test, there is a record given to and held by trainee and centrally within the organisation of repeated testing on alternative respirators and hoods • for members of staff who fail to be adequately fit	database • Accredited fit tester training • As previous sections • Inputted on database • SOP for staff testing • COVID -19 staff support helpline • Return to work assessment • Occupational health • HR COVID policy • Hoods/reusable (personal issue) respirators provided	• Ad hoc communication	

tested a discussion should be had, regarding re deployment opportunities and options commensurate with the staff members skills and experience and in line with nationally agreed algorithm • a documented record of this discussion should be available for the staff member and held centrally within the organisation, as part of employment record including Occupational health • following consideration of reasonable adjustments e.g. respiratory hoods, personal re-usable FFP3, staff who are unable to pass a fit test for an FFP respirator are redeployed using the nationally agreed algorithm and a record kept in staff members personal record and Occupational health service record • boards have a system in place that demonstrates how, regarding fit testing, the organisation			

maintains staff safety and provides safe care across all care settings. This system should include a centrally held record of results which is regularly reviewed by the board • consistency in staff allocation should be maintained, reducing movement of staff and the crossover of care pathways between planned/elective care pathways and urgent/emergency care pathways as per national guidance • all staff should adhere to national guidance on social distancing (2 metres) if not wearing a facemask and in non-clinical areas • health and care settings are COVID-19 secure workplaces as far as practical, that is, that any workplace risk(s) are mitigated maximally for everyone • staff are aware of the need to wear facemask when moving through	• Communication bulletins • Minutes of safety huddle • IPC Walkabouts • Implementation of regional directive for all staff to wear masks	• Staff noncompliance with rest areas • Ongoing assessment of COVID-19 secure areas	• Daily bed/staff escalation • Estates department reviewing scope for additional areas • Desk dividers • Managers to ensure communication is shared with all members of their teams • Managers and teams and occupational health available to support staff. FTSUG

COVID-19 secure areas • staff absence and well-being are monitored and staff who are self-isolating are supported and able to access testing • staff who test positive have adequate information and support to aid their recovery and return to work	• ESR records • Testing provided 7 days per week • Information available to all staff who test positive • Access to psychological support • IPC Champions enabled to talk with staff		in place

The Walton Centre NHS Foundation Trust

The Walton Centre NHS Foundation Trust

REPORT TO THE TRUST BOARD
Date: 10th June 2021

Title	**Governance Annual (Quarter 4) Report 2020/21**
Sponsoring Director	**Name:** Lisa Salter **Title:** Director of Nursing and Governance
Author (s)	**Name:** Lisa Gurrell **Title:** Head of Patient Experience **Name:** Tom Fitzpatrick **Title:** Head of Risk **Name:** Kate Bailey **Title:** Clinical Governance Lead
Previously considered by:	• Quality Committee

Executive Summary:

The purpose of the report is to:

1. A comparison of annual governance data between 2019/20 and 2020/21 in order to identify themes and trends.
2. A review of governance activity in Quarter 4 (Q4) 2021.
3. Assurances that robust actions are in place to mitigate risk, reduce harm and ensure that learning is embedded.
4. Assurance to the Board that issues are being identified and managed effectively.

Related Trust Ambitions	• Best practice care • Be recognised as excellent in all we do
Risks associated with this paper	The risk of the failure to inform committee of the board of the risk profile of the organisation.
Related Assurance Framework entries	• None
Equality Impact Assessment completed	• No
Any associated legal implications / regulatory requirements?	• Yes – Failure to comply with CQC/HSE regulations
Action required by the Board	• To receive and note

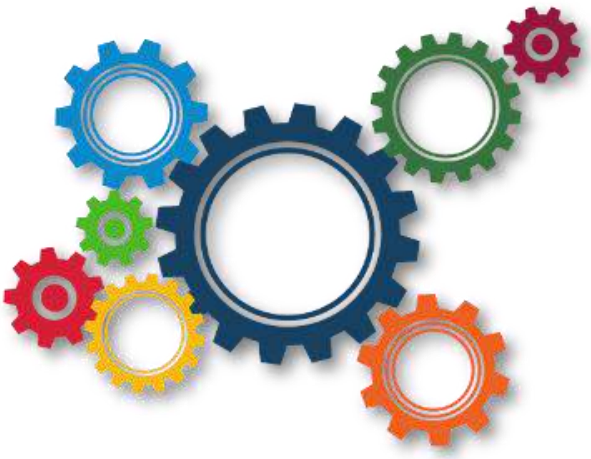
The Walton Centre
NHS Foundation Trust

Excellence in Neuroscience

Governance, Risk and Patient Experience Department

Annual Report for 2020/21

(Including Q4 data)



"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 (including Quarter 4 data) provides an overview of activity for patient safety, incident management, patient experience, complaints, claims, volunteering, risk management, resilience and health and safety.

The report has been compiled using a collaborative approach with inputs from across the Trust, including Nursing, Human Resources, Information Governance, Quality and Divisional Management to ensure that themes and trends are identified, escalated, actioned and lessons learnt as appropriate. Emerging themes and trends inform the Governance Assurance Framework (GAF).

1.1. <u>The purpose of this annual report is to provide:</u>

1. A comparison of annual governance data between 2019/20 and 2020/21 in order to identify themes and trends.
2. A review of governance activity in Quarter 4 (Q4) 2021.
3. Assurances that robust actions are in place to mitigate risk, reduce harm and ensure that learning is embedded.
4. Assurance to the Board that issues are being identified and managed effectively.

The data is accurate from the date the reports were generated. Should incidents, complaints or claims be withdrawn, those figures will appear in subsequent reports.

2. Executive Summary

Throughout the past year, the Risk Team has supported the Trusts Covid-19 response by:

- supporting the health, safety and welfare of staff
- implementing the command and control structure to support the Trust's strategic response
- implementing a programme of fit testing in accordance with HSE guidance
- redeploying staff to oversee the patient vaccination programme
- supporting the above whilst covering existing roles

There has been a particular emphasis on the management of violent and aggressive (V&A) patients in 2020/21. There has been a focus on supporting staff to ensure that timely interventions are put in place to reduce harm to staff and patients from V&A as well as providing debriefing sessions for staff.

Throughout the past year, the Patient Experience Team has:

- continued to listen to and support patients thereby effectively resolving enquiries and concerns before they escalate to formal complaints
- provided support to families unable to visit their loved-ones during Covid-19 and for the families of the bereaved
- continued to support and engage with volunteers
- reviewed and enhanced the complaints management process including implementing a local resolution pro-forma and responded to all concerns and complaints within a timely manner
- proactively engaged with families/clinical staff by being involved at the earliest opportunity at best interest and multi-disciplinary meeting prior to discharge

3. Governance Assurance Framework (GAF)

The following themes have been added to the GAF log in Q4:

- Ref 310 - Pressure Ulcers (added 24th March 2021)

- Ref 311 - Theatre Ventilation system (added 5th May 2021)

The following GAF themes are requested to be closed:

- Ref 302 - Safeguarding (added 09th July 2019)
- Ref 307 - Medication Incidents (added 14th July 2020)

4. Incident Management

4.1. Serious Incident (SI):

- 0 serious incidents were reported in Q4 compared with 0 in Q3
- overall 3 serious incidents were reported in 2020/21 compared with 8 in 2019/20

4.2. Moderate (& above incidents):

- 37 moderate incidents were reported in Q4 compared with 20 in Q3, 21 of these incidents were due to Covid 19 Walton Centre acquired infections[1]
- overall 92 moderate incidents were reported in 2020/21 compared with 63 in 2019/20

4.3. Duty of Candour (DoC):

- 37 moderate incidents were reported in Q4, 3 incidents did not meet the requirement for reporting under DoC, as they were staff related incidents
- 92 moderate incidents were reported in 2020/21 compared with 63 in 2019/20

4.4. Incident themes by category:

4.4.1 Infection Control Incidents:

- 59 incidents reported in Q4 compared with 38 in Q3
- 184 incidents reported in 2020/21 compared with 112 in 2019/20

4.4.2 Communication Incidents (GAF Entry 304):

- 75 incidents reported in Q4 compared with 112 in Q3
- 442 incidents reported in 2020/21 compared with 429 in 2019/20

4.4.3 Information Governance Incidents:

- 17 incidents reported in Q4 compared with 44 in Q3
- 0 externally reportable incidents to the Information Commissioners Office (ICO) in Q4 compared with 2 in Q3
- 122 incidents reported in 2020/21 compared with 213 in 2019/20

4.4.4 RIDDOR:

- 3 reported incidents (staff affected) reported in Q4 compared with 2 in Q3
- 8 reported incidents (staff affected) reported in 2020/21 compared with 12 in 2019/20

4.4.5 Violence & Aggression:

- 90 incidents reported in Q4 compared with 107 in Q3
- 341 incidents reported in 2020/21 compared with 272 in 2019/20

4.5. Risks

There has been significant work undertaken to review risks throughout the year and develop a COVID risk register in year.

[1] These incidents are currently under review via the recently approved Covid Investigation SOP process. This will determine severity and requirement for written notification under the Duty of Candour Regulations.

4.6. Complaints and Concerns

- there has been a dramatic reduction in formal complaints received and responded to during 2020/21 (67) compared to 2019/20 (129)
- there has been a significant increase in concerns and enquiries more than doubled but were effectively dealt with and responded to by PET before escalating in 2020/21 in comparison to 2019/20
- the response time for formal complaints has considerably reduced from an average of 57 working days in 2019/20 to an average of 23 working days in 2020/21, which is less than the required response time of 25 working days demonstrating a robust management process
- we aim to continue to reduce the numbers of formal complaints in 2021/22 by continuing to embed actions and lessons learnt and proactively resolving enquires and concerns at the very earliest opportunity – in addition we aim to maintain the improved response time

4.7. Compliments

There were 203 compliments received in 2020/21 compared to 287 received in 2019/20.

4.8. Claims

There were 4 claims in Q4 compared with 9 in Q3. No claims were reopened.

4.9. Patient Experience

Friends and Family Test was on hold until Q4 but numbers remain low.
New digital platforms have been introduced to support and improve the numbers captured going forward and this has improved slightly towards the end of Q4. As a result of the digital platform, a high rate for outpatients has been received, as patients can now provide digital feedback following all virtual appointment via Attend Anywhere.

5. Recommendation

Quality Committee is asked to receive and note this report.

6. Governance Assurance Framework (GAF) Log – Q4 2020/21

6.1. Items for closure:

Theme	Context	Analysis	Action	Recommendation
Ref 302 Safeguarding 09th July 2019	Increase in safeguarding incidents reported both internally and externally to the commissioner in 2019/20, which has continued into 2020/21, as a result of the implementation of new safeguarding section in Datix. **Lead:** Safeguarding Matron (Quality Committee)	Following the implementation of enhanced training for staff, there was a significant increase in the identification of incidents of abuse/neglect/safeguarding concerns. There is also an increase in the reporting of DoLS breaches due to untimely Local Authority assessment of the applications.	1. 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. 2. To await further guidance regarding changes to DoLS (i.e. Liberty Protection Safeguards), due for implementation 2022.	**Recommendation:** Discontinue monitoring of this theme via GAF.
Ref 307 Medication Incidents 14th July 2020	Increase in medication incidents. **Lead:** Safer Medication Group	Added following a significant increase in medication incidents in Q2. Incidents statistics have increased from 72 in Q3 to 80 in Q4.	1. Stock discrepancies will continue to be monitored via Safer Medication Group. 2. Pharmacy Risk register reviewed to ensure increase in reoccurring incidents is noted.	Agreement to increase discrepancy reporting threshold from 1 – 5 mls, following discussions with MIAA. This should see a reduction in incidents reported. **Recommendation:** Discontinue monitoring of this theme via GAF.

6.2. Items for continued monitoring:

Theme	Context	Analysis	Action	Recommendation
Ref 287 Violence & Aggression 9th October 2017	The Trust is part of the Mersey Major Trauma & Critical Care and Cheshire and Merseyside Rehabilitation Network. The Trust now treats more complex and challenging patients. Feedback from incidents, staff and staff surveys highlight a higher risk of injury to staff whilst caring for challenging patients who lack capacity. There are often difficulties and delays experienced whilst trying to discharge or transfer complex patients. **Lead:** LSMS (Health Safety & Security Group).	During Q4 a slight reduction of V&A incidents was evident; reducing from 107 in Q3 to 90 in Q4 (bed occupancy in 2020/21 has been lower than usual). There were 341 incidents reported in 2020/21 compared with 272 in 2019/20.	1. Develop a violence & aggression management assurance plan (complete). 2. Develop a Strategy to implement the National Violence & Reduction standards. 3. Undertake a risk profiling exercise and review of risk control measures. 4. Review of Trust TNA in regards to personal safety training. 5. Continue to provide debriefing sessions for staff. 6. Review the frequency of meetings for the Violence & Aggression working group (complete, group to meet bi-monthly). **Lead:** LSMS / Head of Risk. Timescale Q3.	It is recommended that this remains on the GAF for further monitoring. **Recommendation:** Continue to monitor.

Theme	Context	Analysis	Action	Recommendation
Ref 286 Appointments Cancellations/Delays 16th January 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 Patient Access Centre (PAC) on the telephone to book/cancel appointments. It is anticipated that there will be a significant increase in Do Not Attends (DNAs), complaints and this will affect staff/patient experience and patient outcomes going forward. **Lead:** Patient Access and Performance Director.	There has been an increase in concerns received in 2020/21, regarding appointment issues. Increase in issues in 2020/21, relating to patients unable to get through via telephone or to cancel appointments	1. MITEL IT/telephony in-depth management training planned for 30/03/21 (complete). 2. The cancellation and delays with patient's appointments and the overall backlog for follow up review has increased further due to the Covid-19 pandemic. However, Covid-19 recovery and restoration plans are being devised and been submitted. 3. Recruitment of 2 additional Band 2 permanent staff members has taken place as opposed to continuous use of Admin Bank and overtime (complete). 4. Continuous review of patient concerns and complaints. 24 concerns were due to patients unable to get through to PAC 01/03/20 - 16/03/2021 compared to 51 from 01/03/19 - 28/02/20, this will continue to be monitored. 5. Implementation of Synertec hybrid mail solution planned for April 2021 (this is currently in its final stages). 6. Data Quality report set up to highlight potential incorrect letters.	It is recommended that this remain on the GAF to monitor improvements in patient and staff experience to ensure that both are sustained. **Recommendation:** Continue to monitor.

Theme	Context	Analysis	Action	Recommendation
Ref 300 Rejection Of Pathology samples by LCL 2nd October 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)	Rejection data reports now received monthly from LCL. Approximately 60 samples a month 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 are the highest affected locations. Rejections may increase in the near future when samples will be rejected if time of collection is not included following a Serious Untoward Incident in LCL.	1. IT to prepare a paper and recommendations for an order comms system based on the vision of the Cheshire and Merseyside network in terms of IT and connectivity. **Lead:** Head of IMT. Timescale: December 2021	Incidents to be monitored through Datix. **Recommendation:** Continue to monitor.
Ref 304 – Communication 19th December 2019	Communication issues have been identified via a number of sources, including the staff survey (2019/20), incidents, concerns and complaints. **Lead:** Head of Patient Experience/Divisional Director for Neurology/Neurosurgery.	There continues to be a visible reduction in incidents evident on review of quarterly statistics, decreasing from 112 Q3 to 75 in Q4. Also the theme communication seems to be a recurrent theme amongst Incident investigations. Communication continues to be a theme in complaints and concerns.	1. Complaints continue to be monitored via the Board KPI Report and bi-monthly at Executive Team. 2. Divisions continue to closely monitor concerns and complaints via weekly meetings with Patient Experience Team (PET). 3. Continue to log actions/learning from concerns/complaints which are monitored at weekly PET/Divisional meetings.	Although there is a visible reduction in incident statistics it suggested we continue to monitor this theme via complaints and concerns. **Recommendation:** Continue to monitor in Q1 2021/22.

Theme	Context	Analysis	Action	Recommendation
Ref 309 – E.coli Bacteraemia Incidents 7th January 2021	Healthcare associated infections can cause substantial patient morbidity, complicate treatment and increase cost to the NHS. A number of these infections are preventable through better application of good practice. The thematic review of 2019/20 investigations, identified that there has been 15 E-coli bacteraemia, against an internal trajectory of 9. This represents an increase of 5 since 18/19. Review of the subsequent investigations has shown 13 cases were related to urosepsis, a further 2 were as a result of abdominal sepsis. The presence of a urinary catheter in situ was identified in all cases. This increase reflects the national position; the government have set a goal to reduce healthcare associated gram negative blood stream infections by 50% by 2020/21. **Lead:** Lead Nurse Infection Control and Prevention	The Trust infection control policies and procedures reflect the NICE Quality standard (QS 61). Quality Standard 4 states people who need a urinary catheter should have their risk of infection minimised by the completion of specific procedures necessary for the safe insertion and maintenance of the catheter and its removal as soon as it is no longer needed. This is important in terms of both infection prevention and patient comfort and experience. Previous reviews of catheter care (2017) have resulted in improvements in practice and education. The increase in E Coli bacteraemia suggests it is necessary to raise the profile of catheter care and ensure the guidance and education is relevant and robust.	1. Infection Control/Service Improvement & MDT to undertake an A3 Quality Improvement Project (QIP) monitored via the Executive Team to reduce the complications associated with indwelling urinary catheters with the aim of reducing the incidence of E Coli bacteraemia. 2. The QIP measures are: • avoid unnecessary urinary catheters • all insertions to be undertaken with aseptic technique and managed in line with guidelines • all catheters to be reviewed daily and removed promptly in line with clinical requirements • theatre / recovery - review the criteria for the need for insertion, together with technique and commence the removal plan • acute ward team - ongoing care, daily review (plan for removal) • IPC / Specialist nurses - review of specialist needs (Neurogenic bladder) including review of policy / education	Continue to work through all actions and monitor in Q1, if reduction continues as expected, monitor via the IPR. **Recommendation:** Continue to monitor in Q1 with a view to closing in Q2.

Theme	Context	Analysis	Action	Recommendation
Ref 310 - Pressure Ulcers 24th March 2021	There have been a number of incidents reported via Datix of patients developing hospital acquired pressure ulcers. This could potentially lead to moderate/severe patient harm and a poor patient experience. **Lead:** Tissue Viability Specialist Nurse.	1. Between Q1 2020 & Q4 2021 there has been 7 category 2 pressure ulcers (PU), 1 category 3 PU (evolved from unstageable pressure ulcer), 0 category 4 PU, 3 (4) deep tissue injuries & 2 unstageable PU (x1 then verified as category 3 & x1 evolved from deep tissue injury as per 'watch and wait' guidance). This equates to 15 hospital acquired PU. 2. Lack of TVN in post and oversight of tissue viability in clinical areas until November 2020.	1. 12 month PU training plan for all staff. 2. Establish tissue viability link nurses for each ward/dept. 3. Update immediate post incident PU documentation & ensure 72 hour completion, including pressure ulcer flow sheets. 4. Update wound assessment charts (Ep2). 5. Introduction of SSKIN bundles for all wards. 6. Update Pressure Ulcer Policy to reflect changes. 7. Monitor attendance numbers for PU training. 8. Ensure link nurses attend training sessions to cascade up to date information/training to their team/dept. 9. Identify and monitor themes and trends.	Continue to work through all actions and monitor. **Recommendation:** Continue to monitor.

Theme	Context	Analysis	Action	Recommendation
Ref 311 Theatre Ventilation System – 05th May 2021	**NEW.** Theatres 1 – 5 do not meet the required level of air changes per minute as required by Health Technical Memorandum (HTM) 2025 guidance. **Lead:** Estates Manager (BPC).	During the annual validations of Theatre ventilation system (1 - 5) it has been identified there are not sufficient air change rates. Recent intervention work has taken place which has provided improvements, but fails to meet HTM standards. The National Infection Rate for Theatres does not indicate a high prevalence of infection which is an indicator of a clean environment. Additionally, it is known that the air cascade, as prescribed in HTM 2025 is correct.	1. Provide options to neurosurgical division, Infection Prevention & Control Team and consultant microbiologist to agree most appropriate way forward. 2. Engage with design consultants to evaluate preferred options. 3. Prepare paper with detail from above for discussion and capital investment.	**Recommendation:** Continue to monitor and work through all actions. Review at end of Q2.

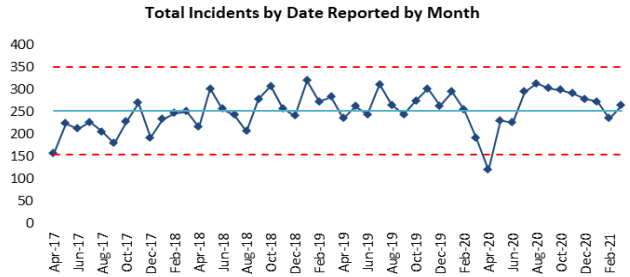
Theme	Context	Analysis	Action	Recommendation
Ref 301 Fire Safety Compliance 17th January 2018	Following the Outpatient Department fire in 2018, and Merseyside Fire Service investigation and inspection of the Trust, legislative breaches were identified. **Lead:** Estates Manager (BPC).	1. The Fire Service identified serious breaches in the OPD/NRC fire compartment lines post fire. 2. These gaps were as a result of the original building works not being inspected and signed off as being compliant. 3. The registered fire compartmentation contractor has now completed the works.	1. Undertake a validation audit of completed works to establish efficacy of contractual works. 2. Any areas of non-compliance from survey to be reported and remedied. 3. Areas that cannot be remediated, due to access difficulties, to have bespoke risk assessments and be included on the Trusts passive fire register (for diligence purposes). 4. Continue to manage staff & contractors works that affect compartment lines. 5. Head of Risk to provide regular update reports to Executive Team.	**Recommendation:** Continue to monitor with a view to closing in Q2 2021/22.

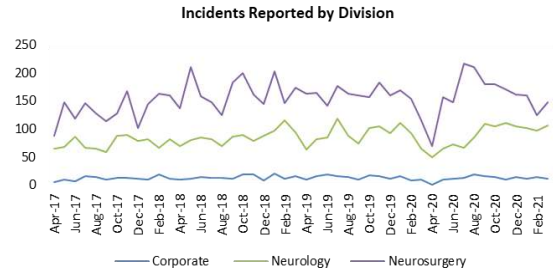
Theme	Context	Analysis	Action	Recommendation
Ref 305 – Legionella 19th December 2019	Legionella positive samples found in water outlets in some clinical areas in the Trust. **Lead:** Estates Manager (BPC).	There has been an improvement over recent months of the circulation of hot water temperatures which are now in line with HSE Guidance.	1. Undertake meeting with Estates Manager, Head of Risk, Consultant Microbiologist, Infection Prevention & Control Team (IPCC), Director of Nursing and Trust's external water treatment chemist to establish options for future chlorination and treatment of the water pipework. 2. Establish a process for re-balancing, treatment and testing that will lead towards the future removal of all point of use filters. 3. Continue programme of temperature testing to ensure stability of circulation. 4. Maintain flushing and regime via Compass water management system. 5. Water Safety Group / IPCC to monitor results of above. 6. Prepare a paper with options and potential capital implications for a system wide chemical treatment of the water system.	**Recommendation:** Continue to monitor and work through all actions. Review at end of Q2 2021/22 with view to closing.

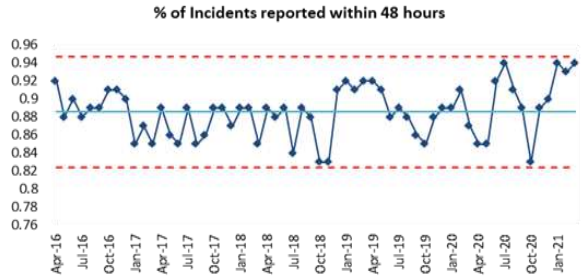
7. Safety and Risk

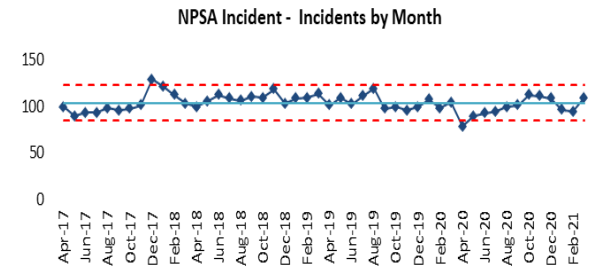
This section provides a detailed report of the number and type of incidents reported during Q4 and throughout 2020/21, there is a number of SPC charts to reflect reporting trends over the past 2 years. The Trust is committed to maintaining a high standard of health, safety and welfare of patients, their families, visitors, contractors and staff. Accurate reporting of incidents and near misses is essential in order to reduce risks and avoid untoward incidents.

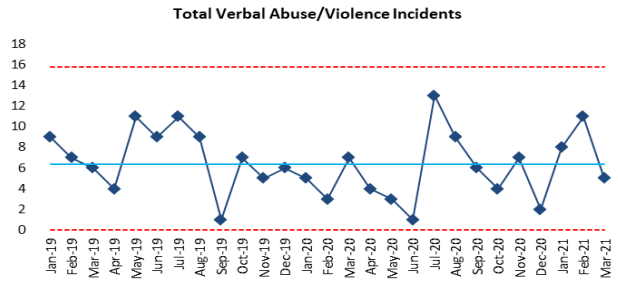
7.1. Incident Management Overview

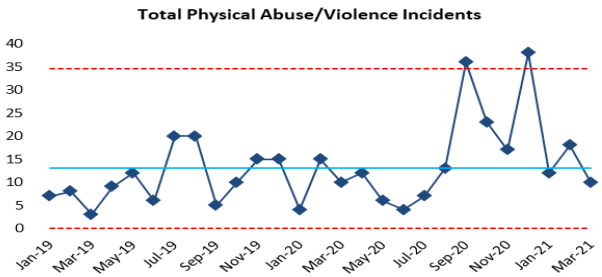


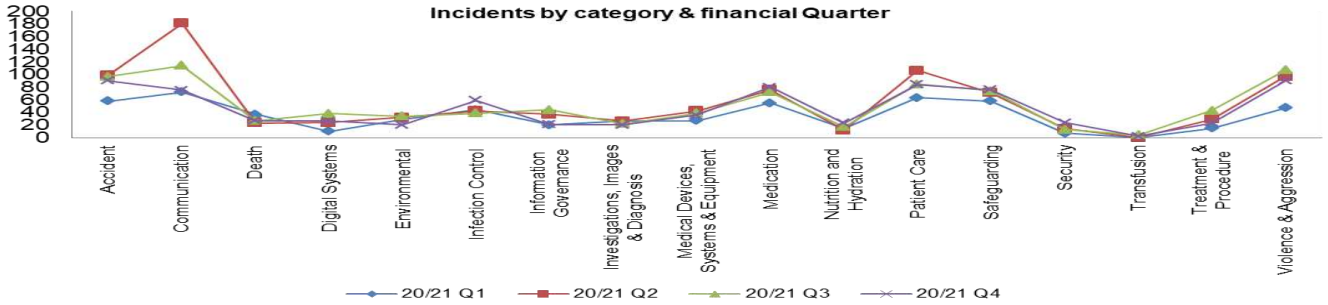












7.1.1 Moderate & above incidents:

- 0 serious incidents were reported in Q4
- 37 moderate incidents were reported in Q4 compared with 20 in Q3
- 92 moderate incidents were reported in 2020/21 compared with 63 in 2019/20

7.1.2 Duty of Candour (DoC) audit outcome:

- full compliance was recorded
- develop an electronic DoC form within EP2, action complete
- DoC is continually reviewed and monitored within the Risk Team

7.1.3 Communication Incidents (GAF Entry 304):

- 75 incidents reported in Q4 compared with 112 in Q3
- 442 incidents reported in 2020/21 compared with 429 in 2019/20

7.1.4 Infection Control Incidents:

- 59 incidents reported in Q4 compared with 38 in Q3
- 184 incidents reported in 2020/21 compared with 112 in 2019/20

7.1.5 Safeguarding Incidents and Concerns (GAF Entry 302):

- 76 incidents reported in Q4 compared with 74 in Q3, 44 incidents related to Deprivation of Liberty (DoLS) breaches
- 279 incidents reported in 2020/21 compared with 247 2019/20, 107 incidents related to DoLS breaches

7.1.6 Information Governance Incidents:

- there were 17 reported incidents in Q4 compared with 44 in Q3
- there were 0 externally reportable incidents to the Information Commissioners Office (ICO) in Q4 compared with 2 in Q3
- 122 incidents reported in 2020/21 compared with 213 in 2019/20
- there were no breaches of Subject Access or Freedom of Information requests in Q4

7.1.7 Medication incidents:

- 80 incidents reported in Q4 compared with 72 in Q3
- 283 incidents reported in 2020/21 compared with 284 in 2019/20

7.1.8 RIDDOR (staff more than 7 day absence):

- member of staff tripped over the bottom drawer of a faulty office drawer unit, the drawer was noted to be faulty before the incident occurred, member of staff sustained ligament injury to their ankle
- member of staff was assisting a confused patient who became aggressive, patient grabbed the member of staff by the wrist, twisting it and causing injury to their wrist
- member of bank staff was assisting a confused patient who became aggressive, patient grabbed the member of staff by the wrist, twisting it and causing a fracture

7.2. <u>Violence & Aggression:</u>

- reduction from 107 incidents in Q3 to 90 in Q4
- 341 incidents reported in 2020/21 compared with 272 in 2019/20
- significant reduction in physical assault incidents against staff from 78 in Q3 to 40 in Q4 (all incidents in Q4 patients lacked capacity)
- 2 patients were responsible for 19 of the physical assault (patient on staff)
- GAP analysis completed for the new 'Violence prevention and reduction standards', this will lead to a Strategy for the management of violence and aggression in Q3

- de-briefs held with staff on Cairns and Chavasse Wards
- introduction of:
- "Safety pods," this is in essence a large bean bag, which provides a seated area where care can be undertaken and allowing a patient to go down to a lower elevated area, this provides a more safe and dignified response as opposed to a patient falling to the floor and the continued management of the patient on the ground
- ultra-low beds to assist in the reduction of harm to staff following learning from previous incidents

7.3. Fire safety:

- 7 unwanted fire signals were reported in Q4 compared with 5 in Q3, 1 incident resulted in the attendance of the fire service, this was caused by a contractor working out of hours in the High Dependency Unit
- an audit of fire compartmentation work is ongoing
- existing fire alarm physical link to Aintree Hospital site now severed, new arrangements have been put in place to move to a Red Care link (an external telephone line) that carries a fire alarm signal to a remote fire monitoring service
- mandatory training has improved from 85 to 88% in Q4, this is due to the Fire Safety Advisor & L&D working collaboratively to target bespoke training sessions e.g. to ward and night staff
- fire risk assessments continue to be reviewed, findings discussed with all relevant parties

7.4. Moving and Handling (M&H):

- classroom training reviewed to ensure it is compliant with Covid-19 guidance
- M&H assessments - a total of 6 Moving and Handling assessments were undertaken during Q4:
- 1 for a patient requiring specialised equipment
- 1 for a staff member requiring specialised equipment as a reasonable adjustment
- 3 for staff members with known musculoskeletal disorders
- 1 for introduction of new equipment and attendant competency statement
- Quality Improvement / Equality and Diversity - Moving and Handling Advisor / Therapists / Estates Manager have investigated the possibility of providing a safe space for changing / toileting outpatients who are wheelchair users and require a hoist transfer onto a toilet or changing plinth.
- ward support - Support provided with complex need patients utilising appropriate PPE for the ward and patient status

7.5. DATIX:

- Datix incident training has been provided throughout 2020/21 via MS teams
- the bimonthly governance feedback poster was reinstated during 2020/21, with further development work to be carried out in the new financial year of 2021/22
- risk register refresher training will be a focus for 2021/22 ensuring there is a consistent approach to risk management within the Trust

7.6. Health and Safety:

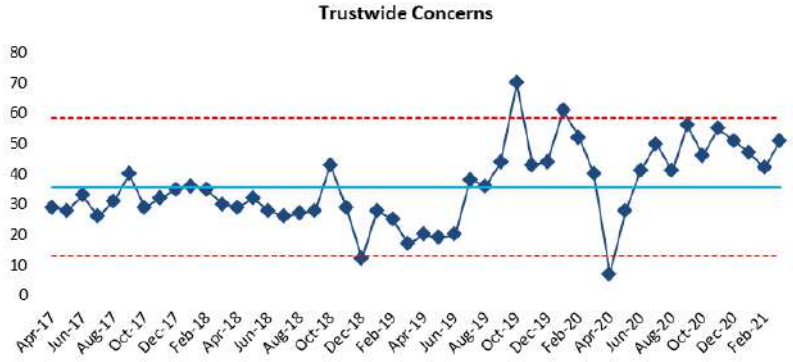
The Head of Risk has developed an online health and safety audit compliance tool with the IT Department in year. This audit covers general health and safety management compliance, including risk assessments and action planning. The tool has been updated to include Covid secure questions from HSE guidance. The Deputy Head of Risk is supporting identified safety leads across the Trust to complete the audit, actions and associated risk assessments. The outcomes of the audit and actions will be monitored by the Health Safety and Security Group.

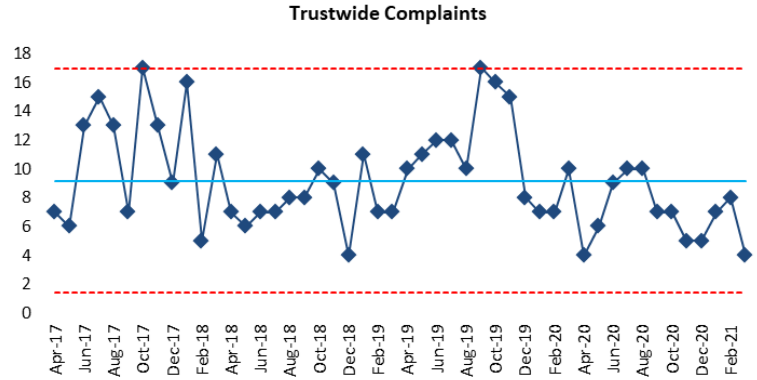
A number of First Aid at Work training courses have been delivered in year. The arrangements have been reviewed for signage and first aid kits have been replaced throughout the Trust.

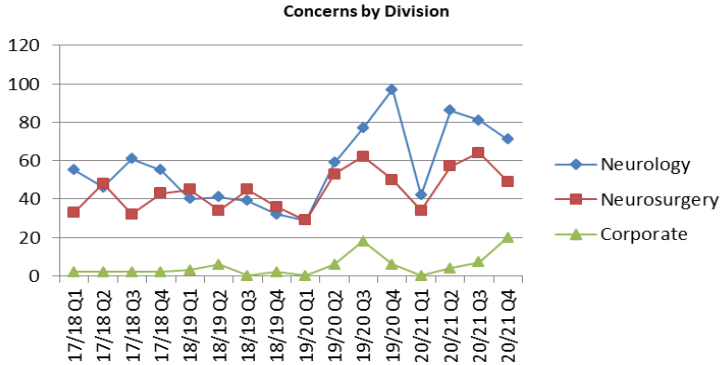
The Trust has trained 30 fit testers in year, and have fit tested over 1,200 staff in year for FFP 3 masks.

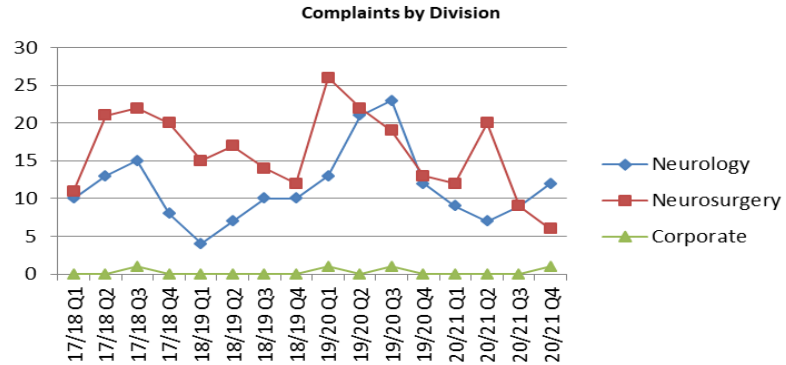
8. Complaints & Concerns

The Patient Experience Team (PET) receives a wealth of information surrounding the experience of patients and their families. The Trust use the positive feedback to share and promote good practice and this information can be found in the table below. This section focuses on the areas of concern raised by patients and their families. This information helps us to improve services and learn lessons to improve the care and service we provide to our patients. This section analyses the complaints and concerns raised with the Patient Experience Team.









8.1. <u>Concerns and Complaints:</u>

8.1.1 Quarter 4:

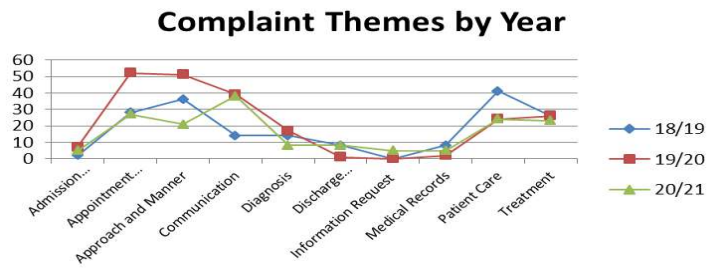
- 12 complaints received in Q4 compared to 16 in Q3

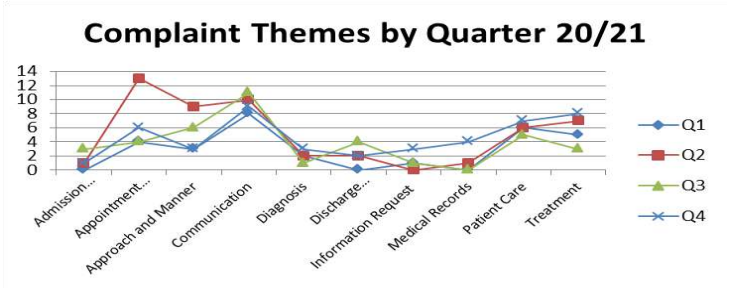
- 7 complaints were re-opened as further clarity was sought. A deep-dive review into this concludes that this is not as a result of the quality of the investigation and response but a difference of opinion in relation to the factual/clinical information provided
- 20 complaints were closed in Q4; 1 upheld, 6 partially upheld and 13 not upheld
- 100% of complaints received in Q4 were acknowledged and responded to within the negotiated timeframe
- The average response time was 22 working days for formal complaint response, this is an over achievement in line with the policy as we aim is to respond within 25 working days
- A reduction was noted within Neurosurgery; 6 (including 4 re-opened) in Q4 compared to 9 (0 re-opened) in Q3, whilst Neurology increased with 12 (including 3 re-opened) in Q4 compared to 8 (including 1 re-opened) in Q3
- The number of concerns reduced slightly fom Q3 to Q4 with 152 received in Q3 and 140 received in Q4
- In addition to concerns, 85 enquiries were received, in comparison to 35 received in Q3; themes relate to the referral process and general hospital enquiries

8.1.2 Annual:

- 67 formal complaints were received in 2020/2021, which is a 48% decrease from 129 in 2019/20
- 14 complaints were re-opened during the year as further clarity was requested. A deep-dive review into these re-opened complaints reveals that this is not as a result of the quality of the investigation and response but a difference of opinion in relation to the factual/clinical information provided. There was no trend in area, individual or theme of subject of complaint.
- 515 concerns were received and resolved in 2020/21, which is a 5% increase from 487 in 2019/20
- 221 enquiries were received and responded to in 2020/21, which is a 131% increase from 46 received within 2019/20, main themes relate to appointment arrangements and communication
- 88 formal complaint cases were closed in 2020/21; 5 upheld, 28 partially upheld and 55 not upheld. There were also 10 additional responses sent which were in relation to re-opened cases. The outcome of these cases did not change as a result of further investigation which is reassuring.
- 100% of complaints received in 2020/21 were acknowledged and responded to within the negotiated timeframe with our average response time at 23 working days for those closed. This is an 60% reduction in time taken to respond from an average of 57 working days in 2019/20.

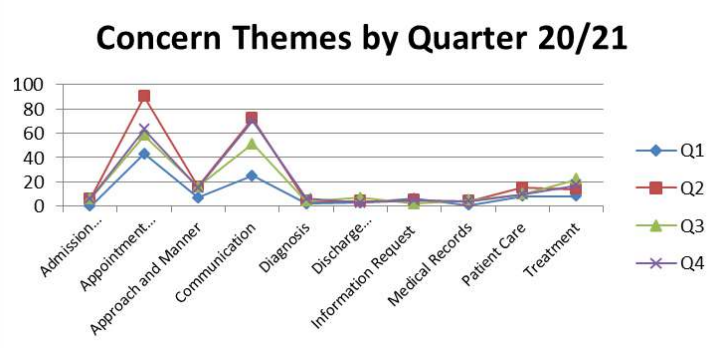
8.1.3 Key themes for formal complaints:

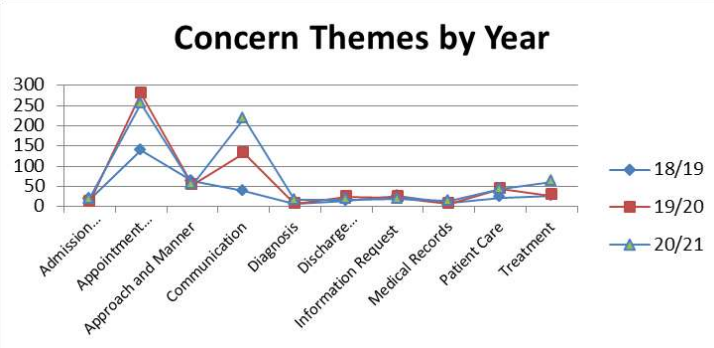




- Communication is the highest theme both in Q4 and annually
- Approach and Manner as a subject of complaints have significantly reduced in comparison to previous years
- Appointment arrangement complaints remain as the second highest theme; with the majority being raised in Q2 following the first National Lockdown for Covid-19, but again a reduction can be seen in numbers compared to previous years.

8.1.4 Key themes for concerns:





- Appointment arrangement concerns remain the highest theme for concerns with communication as a close second
- As with complaints, appointment arrangement concerns peaked during Q2

8.2. Protected Characteristics:

8.2.1 Quarter 4:

There were 2 concerns which were raised in relation to:

- Disabilities – Claustrophobia – patient's father queried why he was informed that patient could not have MRI scan under general anaesthetic and felt the Trust were delaying urgent and necessary treatment by not arranging this – *Closed, clinical discussion to provide clarity and plan next steps*
- Racism – patient raised concerns about appointment and clinic letters not being available in their first language- Romanian – *Closed, Secretarial Team immediately actioned this request and noted for future appointments*

8.2.2 Annual:

For 2020/21 we received 5 concerns and 1 complaint in relation to protected characteristics detailed below:

8.3. Concerns:

- Disabilities – Claustrophobia – Not upheld - as detailed under Q4 information above, decision made in line with clinical discussion
- Racism – Upheld – as detailed under Q4 information above, information not provided in desired format but this has been actioned
- Disabilities – Mental Health – Not upheld – patient did not fit criteria for ambulance transport and the reasons for this were explained

- Disabilities – Parkinson's Disease – Upheld – staff member not did intend to cause offense with the term of phrase used, they recognised in retrospect why this was unacceptable, reflected on their approach and a personal apology was provided.
- Age – Not upheld – CT scan unable to be arranged earlier due to coronavirus restrictions not as a result of the patient's age, explanation provided

8.4. Complaint:

- Age and Nationality – Not upheld – further investigations not clinically indicated and this decision was not based upon the patient's age or Nationality

8.5. Compliments:

- there were 58 compliments in Q4 compared with 53 in Q3
- there were 203 compliments received in 2020/21 compared to 287 received in 2019/20

8.6. Police/Coronial Requests:

8.6.1 Quarter 4:

- Number of police request remains the same with 11 received in both Q3 and Q4 for police statements/case notes
- There was a slight decrease in Coroner's requests with 5 in Q4 compared to 7 in Q3

8.6.2 Annual:

- There were a total of 45 police requests received in 2020/21 compared to 30 received in 2019/20; an increase of 50%
- A total of 21 coroner's requests were received in 2020/21 compared to 12 in 2019/20; an increase of 75%

8.7. Volunteers:

There was limited volunteer activity within Q4 as volunteers supported collating LAMP testing kits. Despite volunteers not being on site, the team have continued engagement with them throughout this time via virtual coffee mornings, quizzes, welfare telephone calls, and newsletters.

8.8. Summary:

In 2020/21 - 88 formal complaints were closed, 532 concerns were resolved and 220 enquiries received and responded to.

This demonstrates a robust complaint management process and excellent collaborative working between PET and Divisions. The complaints tracker which includes all open complaints and actions is presented to Execs on a bi-monthly basis to offer the executive team assurance of the process and learning. In addition, a new process for Local Resolution meetings was introduced in 2020 and these have continued to take place in line with covid-19 safety precautions.

It is encouraging to note that the number of formal complaints have greatly reduced in 2020/21 whilst an increase has been noted in the numbers of concerns and enquiries received and resolved, demonstrating that our teams are working in partnership to swiftly resolve issues informally before they escalate. A significant reduction in response times to complaints has been noted which again is a testament of collaborative working. The team are working in the same vicinity and partnership with the Matrons in order to proactively reach out to patients and families who have concerns before these are raised directly for example, being involved in best interest meetings and complex multi-disciplinary discharge meeting to support both patients and staff.

The complaints management process will be reviewed and strengthened further over the next 12 months following the implementation of the NHS Complaint Standards which are being piloted in 2021 and will be implemented in 2022. The Standards aim to support organisations in providing a more streamlined approach to complaint handling with the focus on early resolution and well trained staff. Early resolution has been the focus for the Trust in 2020/21 and the team continue to build on this.

9. Claims / Legal

TRUST WIDE	Q1 20/21	Q2 20/21	Q3 20/21	Q4 20/21
Claims				
Total new claims received	5	9	9	4
Neurosurgery claims	5	6	5	1
Neurology claims	0	1	2	3
Corporate claims	0	2	2	1
Total number of pre-action protocols in quarter – contact made prior to submitting a claim	13	7	7	7
Number of closed claims in quarter	4	5	3	3
Value of closed claims - Public liability	£0	£0.00	£0.00	£5,000
Value of closed claims - Employer liability	£0	£0.00	£0.00	£0.00
Value of closed claims - Clinical Negligence	£2,715,964.73	£3,203,388.52	£209,929.13	£128,261.21

9.1.1 All staff involved in claims/coronial reviews or inquests receive full support throughout the process.

9.1.2 No Re-opened Claims in Quarter 4.

9.2. <u>Lessons Learnt:</u>

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

9.2.1 Treatment and documentation:

- The claimant was prescribed medication to be administered the night before surgery but this was not given due to the inexperience of the nurse. The surgery was cancelled and emergencies the following day meant that the surgery could not go ahead. The patient was then discharged with a plan to follow up in OPD clinic. Due to administrative failings the patient was lost in the system. After a further OPD consultation, a pre-op appointment and a request for follow up scan, the patient suffered a SAH and was admitted to WCFT where the patient sadly died on 26/01/2018.
- Several lessons have been learned from this case including review of neurovascular service, Bed Management Policy, pre-op drug administration guidance and development of MDT process.

9.2.2 Communication:

- The claimant was reviewed in clinic with significant back pain following surgery 4 months earlier. The consultant requested an urgent MRI although the correct process was not followed for urgent MRI requests from OPD and the claimant did not receive a scan until 10 days after the request.
- Clinical Lead has sent an email to remind medical/clinical staff of the referral process to radiology from OPD clinic.

9.2.3 Treatment:

- The claimant had cannula removed but part of it was left insitue. The patient was not informed of the advantage/disadvantage of immediate surgery to remove this. The patient suffered an infection, unnecessary attempt to remove it surgically, has been left with a scar and suffers ongoing psychological distress.
- Monitoring and removal competency training has now been introduced.

9.2.4 Thematic Review:

Poor documentation and allegations relating to informed consent is an ongoing theme which runs through many of the claims that the Trust receives. This is always highlighted to medical staff during induction and mandatory training sessions to raise awareness.

9.3. <u>CNST Trials:</u>

The Trust has 4 clinical negligence trials coming up over the next 5 months. It is possible that some of these may be settled before trial start dates. Divisional and Clinical Management have been made aware of these cases so that they, along with the claims team can offer support to staff during this difficult time. The Claims Manager will attend the trials with the staff to provide ongoing support.

9.4. <u>Coroners Inquests:</u>

9.4.1 Neurology:

A 28 year patient with a long standing history of seizures was admitted on 19/02/18 for monitoring of epilepsy with an aim to adjust treatment in order to improve seizure control. The patient's condition deteriorated despite maximal efforts and, following admission to ITU, the patient suffered a cardiac arrest on 08/04/18. Despite input from a consultant cardiologist, which was futile, the patient suffered a further cardiac arrest and sadly died at 20:03 hours.

Following a formal complaint from the family regarding care, treatment and the cause of death, the family have met with the Trust on two occasions and referred their concerns to the CQC and HM Coroner. As part of the complaint an independent review was undertaken by the RCP. Recommendations have been included in an action plan which is managed by the neurology division and was reviewed by the CQC. The CQC have now completed their investigation and found no failings with the treatment provided by the Trust. Directions were received from the Coroner and the Trust attended a first pre inquest review (PIR) on 28/07/20 with legal representation. The family also have legal representation. The next PIR was scheduled for 11/11/20 but this was re-scheduled to 12/05/21. This has since been re-scheduled again to a later date.

9.4.2 Neurology

Patient was admitted to Hyperacute Specialist Rehabilitation on 06/11/2019 following a cardiac arrest on 16/09/2020 and a period on intensive care at Aintree University Hospital. The patient was transferred to Oakvale Gardens on 06/04/2020 and sadly died on 08/05/2020. Concerns were raised by the family in relation to the discharge from the Trust to the care home and the details surrounding the death.

A Pre-Inquest Review (PIR) took place on 22/09/2020 and a further on 22/01/2021. At present we do not feel legal representation is required for the Inquest, however, this will be kept under review.

9.4.3 Neurosurgery

Patient transferred from Isle of Man to WCFT on 30/08/2020 following a spontaneous intracerebral bleed. Surgery performed on 30/08/2020 and required post-operative ITU care. Patient was due to be repatriated on 23/09/2020. On 22/09/2020 the patient's tracheostomy dislodged in the early hours whilst being turned resulting in hypoxic cardiac arrest and patient death.

An initial rapid review report was provided to HM Coroner and an RCA has been provided. Before the Inquest the Trust received a pre-action request for medical records. The Inquest was held on 15/03/2021. The Coroner was not critical of the care and treatment provided by the Trust in his summary. The Trust awaits any further correspondence following the conclusion of the Inquest. There was, however, no indication that any of the issues raised amounted to a breach of duty.

9.4.4 Neurosurgery

The patient known to the Trust had a first posterior fossa decompression on 23/06/2017; post-operatively the patient suffered a cardiac arrest due to a build-up of CSF (hydrocephalus) which required insertion of an external ventricular drain (EVD). As the patient's symptoms had deteriorated, the patient was admitted in July 2020, for re-exploration of the post-fossa. The patient was discharged 5 days later but developed problems with the wound shortly after discharge. The patient was readmitted on the 25/7/2020 with CSF leak and hydrocephalus. Between July 2020 and January 2021, the patient remained in hospital and had ongoing problems with EVD failure CSF infection leading to two periods in ITU. Following the first admission to ITU, the patient was transferred back to the ward where they had a witnessed cardiac arrest. CPR was successfully given and post arrest the patient was transferred to ITU. On 15/1/2021 the patient had a further deterioration and her pupils were fixed and dilated. CT showed brain swelling and no hydrocephalus. Brain stem testing was carried out with consent from family. The patient sadly died on 16/01/2021.

The Coroner has opened a file on this matter. A PIR has been scheduled for 22/06/2021. A SI Mortality Report has been completed and the Trust Solicitors have now provided this to the Coroner on 08/04/2021.

We have reported the case to NHSR and requested Inquest funding which has now been granted. HD has now been instructed to represent the Trust in this case.

The Patient Experience Team (PET) has remained in regularly contact with the family from the time of the patient's death to offer support. A meeting was planned with them 08/04/2021 but this has now been cancelled by the family. The draft Mortality Report was shared with the family who expressed their dissatisfaction with the report as they do not feel that their concerns have been addressed, although all concerns raised to the Coroner were addressed within. The Trust offered to re-schedule the meeting but the family submitted additional concerns to the Coroner and were responded to via a Coroner's Statement. Further Directions from the Coroner are awaited.

9.5. Staff Education and support:

Training continues to be provided to all junior doctors at induction and to consultants during annual health and safety training.