NHS
The Walton Centre
NHS Foundation Trust

Public Trust Board Meeting

Thursday 9th June 2022

Agenda and Papers

Excellence in Neuroscience

PUBLIC TRUST BOARD MEETING
Thursday 9 June 2022
Boardroom
09:30am - 12.30pm

The Walton Centre NHS Foundation Trust

v = verbal d = document p = presentation

Item	Time	Item	Owner	Purpose
1	09.30	Welcome and Apologies (v)	Chair	N/A
2	09.30	Declaration of Interests (v)	Chair	N/A
3	09.35	Minutes and actions of meeting held on 5th May 2022 (d)	Chair	Decision
4	09.40	Patient Story (v)	Chief Nurse	Information
STRATEGIC CONTEXT				
5	10.00	Chair and Chief Executive's Update (v)	Chief Executive Officer	Information
6	10.10	Communications and Marketing Update (d)	Chief Executive Officer	Assurance
7	10.20	Health and Wellbeing Strategy (d)	Chief People Officer	Approval
INTEGRATED PERFORMANCE REPORT				
8	10.40	Integrated Performance Report (d)	Chief Executive Officer	Assurance
9	10.45	Business Performance Committee: Chair's Assurance Report (d)	Committee Chair	Assurance
10	11.00	Quality Committee: Chair's Assurance Report (d)	Committee Chair	Assurance
BREAK				
QUALITY & SAFETY				
11	11.25	Nurse Staffing Bi-Annual Acuity Review (d)	Chief Nurse	Assurance
12	11.35	Infection Prevention and Control Annual Report (d)	Chief Nurse	Assurance
WORKFORCE				
13	11.45	Freedom to Speak Up Guardian Report (d)	Chief Nurse	Assurance
CHAIR'S ASSURANCE REPORTS FROM BOARD COMMITTEES				
14	12.00	Audit Committee - 17 May 2022 (d)	Committee Chair	Assurance
15	12.05	Neuroscience Programme Board - 12 May 2022 (d) • Terms of Reference (d)	Committee Chair	Assurance
16	12.10	Research, Innovation and Medical Education - 4 May 2022 (d)	Committee Chair	Assurance/ Decision
17	12.15	Strategic BAME (Black, Asian, Minority Ethnic) Advisory Committee - 16 May 2022 (d)	Committee Chair	Assurance
CONSENT AGENDA				
Subject to Board agreement, the recommendations in the following reports will be adopted without debate: • Infection Prevention and Control Board Assurance Framework (d) • Safeguarding Annual Report 2021/22 (d) • Request for Use of Trust Seal (d)				
CONCLUDING BUSINESS				
18	12.20	Any Other Business (v)	Chair	Information

Item	Time	Item	Owner	Purpose
19	12.25	Review of Meeting (v)	Chair	Information

Date and Time of Next Meeting: 9.30am, 7 July 2022, Boardroom, The Walton Centre

UNCONFIRMED

Minutes of the Public Trust Board Meeting

Meeting held via Microsoft Teams

5th May 2022

Present:

Max Steinberg	Chair (C)
Karen Bentley	Non-Executive Director (NED-KB)
Paul May	Non-Executive Director (NED-PM)
Su Rai	Senior Independent Director (SID)
David Topliffe	Non-Executive Director (NED-DT)
Ray Walker	Non-Executive Director (NED-RW)
Mike Burns	Chief Financial Officer (CFO)
Mike Gibney	Chief People Officer (CPO)
Andy Nicolson	Medical Director (MD)
Jan Ross	Chief Executive (CEO)
Lisa Salter	Chief Nurse (CN)
Lindsey Vlasman	Chief Operating Officer (COO)

In attendance:

John Baxter	Corporate Governance Officer (CGO) (minutes)
Katharine Dowson	Corporate Secretary (CS)
Jibril Farah	Consultant Neurosurgeon (CNS) (item 13 only)
Jay Panicker	Consultant Neurologist (CNO) (item 13 only)

Observers:

Nicola Martin	Deputy Chief Nurse (DCN)
Elaine Vaile	Communications and Marketing Manager (CMM)

Apologies:

No apologies were received

1 Welcome and apologies

1.1 The Chair welcomed everyone to the meeting.

2 Declarations of interest

2.1 The Chair declared that he was Chair of both the Shakespeare North Playhouse and the Roy Castle Lung Cancer Foundation and a Board member of National Museums Liverpool.

3 Minutes of the meeting held on 7th April 2022

3.1 The minutes of the meeting held on 7th April 2022 were approved as an accurate record of the meeting.

Action tracker

3.2 There were no outstanding actions to be updated.

4 Patient Story

4.1 CMM introduced the patient story which was a video of the first patient treated utilising transcranial magnetic resonance imaging (MRI) guided focused ultrasound for the

treatment of essential tremor. The patient described their treatment and reported that the outcome had been instant and a success.

4.2 CEO highlighted that the business case had originally been brought to the Executive Directors team and then Trust Board as a time limited business case which had been a challenge.

4.3 MD reported that this treatment would likely not have been procured had the Trust been part of a larger Trust and recognised that this had been the culmination of three years of work. All Neuroscience Units across the North of the country had submitted bids, however the Walton Centre had been best prepared and Board engagement had been highlighted as a positive during the tender process.

4.4 NED-PM highlighted that the Trust was now one of two service providers nationally and this was a reflection on the standing and future profile of the Trust. SID queried how the media exposure had been received and CEO informed that there had been a lot of interest from patients across the country.

4.5 NED-RW questioned how demand and capacity would be managed. COO informed that the Trust had been commissioned to treat 75 patients during the first year and the division was currently reviewing patient lists to identify patients who could potentially benefit from the treatment. MD stated that a lot more patients would be seen in clinics before getting to the point of identifying 75 patients for treatment.

4.6 **The Board recorded their thanks to the patient for sharing their story and all teams involved in the successful bid to implement the service.**

5 Chair & Chief Executive's Report

5.1 The Chair informed that discussions regarding profiling and branding events were ongoing and further comments were to be forwarded to the Chair with comments to be circulated to all.

5.2 The Chair had written to the University of Liverpool to discuss joint working and research opportunities for collaboration.

5.3 CEO updated that Covid continued to have an impact on the Trust and although the national message was about living with Covid there were still challenges across the region. The Trust currently did not have any Covid positive inpatients however staff sickness remained high at approximately 8% between March and May. This was impacting on activity delivery and Trusts across the region were working to balance urgent care, Covid and capacity.

5.4 CEO reported that a new Consultant Anaesthetist had been appointed since the previous meeting and there had been changes within Clinical Director positions.

5.5 CEO attended the recent NHS England (NHSE) CEO meeting and discussed the transition to living with Covid and the lessons learned. Finances were discussed; consideration was required in regard to how Trusts could become more financially efficient. It was reported that Liverpool Health Partnership remained an important central vehicle for how Trusts would function going forward in Liverpool. The Trust was also

continuing to engage with discussions regarding regional priorities.

5.6 The recent Sutcliffe Kerr lecture had been very successful and Professor Lip, Cardiologist, had been very keen to engage in cross-collaborative research on brain and heart in conjunction with Liverpool Heart and Chest Hospital NHS Foundation Trust.

The Board noted the verbal updates.

6 Trust Strategy

6.1 MD presented the Trust strategy and thanked all for feedback already received. It was recognised that the wording required further work to sharpen the message and further comments were welcomed. The Board were asked to approve that the broad content and themes of the strategy were correct as this would enable the approval of the principal strategic risks and other strategies.

6.2 NED-DT felt that some of the deliverables should be strategic objectives, with targets in place prior to the strategy being finalised and SID requested additional focus on outputs and ambitions detailing what the Trust wanted to achieve. CPO recognised the requirement for a balance between ambition and delivery and highlighted the challenge of sharpening the strategy to define what the Trust delivers.

6.3 All agreed to forward comments to MD prior to an updated draft being submitted to the next Board meeting however the broad content and themes were approved.

The Board approved the broad content and themes of the strategy while the content was being further refined.

7 Principle Strategic Risks 2022/23

7.1 CEO presented the principle strategic risks for 2022/23 and highlighted that these tied into the draft Trust Strategy. Twelve strategic risks had been developed and had been colour coded into the crosscutting themes of the strategy and linked to the new strategic ambitions. The Executive risk owner, assurance committee and risk appetite had also been identified. The Board Assurance Framework (BAF) would be developed following agreement of the strategic risks.

7.2 NED-DT queried if BAF001 just related to finance or if this was a wider risk. It was clarified that this was a wider risk about collaboration. It was agreed that this should sit with the CEO as the risk lead. The wording would be amended to provide clarity and agreed with the Chair and Chief Executive.

The Board approved the principle strategic risks for 2022/2,3 pending completion of an amendment to BAF001.

8 Integrated Performance Report

8.1 The CEO informed that check and challenge of the Integrated Performance Report (IPR) had been undertaken at Board Committees and the Chairs of the relevant Committee would present their assurance reports.

8.2 NED-DT provided an update on discussions held at Business Performance Committee (BPC) and highlighted that sickness remained high and was impacting on activity,

particularly within theatres. Activity performance for cancer, diagnostics and activity restoration had met their associated activity plans during March. The number of patients waiting 104 weeks or more had reduced however there had been a slight increase in the number of patients waiting 52 weeks or more.

8.3 Sickness figures were reviewed and it was stated that short term sickness was currently at 3% with long term sickness recorded at 5%, these figures were currently being drilled down into staffing groups to understand them further. There had been a lot of focus on appraisals however little improvement was being made and it was recognised that recovery of this target was slow. The People Group were continuing to focus on this area and the staff who required assistance had been identified and were being given targeted support. CPO recognised that this was an issue and compliance levels were being closely monitored, an action plan was being developed and it was expected that there would be an improvement reported back to BPC within three months.

8.4 An update on the end of year financial position was provided which had been a break even position and capital spend targets had also been met. It was recognised that an area of focus was payment to creditors on time and work was ongoing to improve compliance in this area.

8.5 NED-RW updated on discussions held at Quality Committee and reported that an improvement on mortality rates had been recorded and the Trust performed significantly better than peers. A patient fall with moderate harm had been recorded and the patient had required surgery, duty of candour processes had been followed and a rapid review undertaken which had identified no lapses in care.

8.6 A complaint had been received from a patient relating to disclosure of sensitive information pertaining to gender. This complaint was under review and it was agreed that lessons would be learnt, with future training to be provided.

8.7 Assurances were provided that there had been an increase in the response rate for the Friends and Family test and increased levels of compliance with National Early Warning Scores (NEWS).

8.8 SID queried if visiting was back to pre-Covid levels and CN clarified that visiting was currently limited to two visitors per patient per day. This was a regional approach and dependant on the numbers of Covid within the Trust.

The Board noted the Integrated Performance Report

9 Business Performance Committee Chair's Assurance Report

9.1 NED-DT updated that the final financial plan had been submitted to NHSE on time and approval had been given by BPC as delegated by the Board at the last meeting.

9.2 The bed repurposing project was well advanced and a benefits realisation review would be undertaken when this had been fully implemented.

9.3 The Committee had a line of sight on how the majority of quality improvement plans (QIP) would be delivered and the procurement strategy would be reviewed in line with the QIP programme.

9.4 Two risks had been identified and an overview of these was provided.

9.5 NED-DT informed that BPC priorities had been reviewed and the objectives refreshed to frame the focus moving forward and this would align with the Trust objectives.

The Board noted the Business Performance Committee chair's assurance report.

10 Quality Committee Chair's Assurance Report

10.1 NED-RW reported that the tissue viability report had been received which reported an increase in the number of verified pressure ulcers during 2021/22. The tissue viability nurse had worked to engage with staff on wards and education for the year was planned, with link nurses assigned to each ward.

10.2 A presentation was received by the Neuropsychiatry team which had reported an increase in activity with further increased activity expected during 2022/23.

10.3 The CQC action plan had been closed down at the meeting following assurance that all actions had been closed or moved to business as usual.

The Board noted the Quality Committee chair's assurance report.

11 Annual Nurse Revalidation Report

11.1 CN presented the annual nurse revalidation report and highlighted that table two in the report was incorrect and an updated table had been circulated for information. All nursing staff due for revalidation had successfully revalidated and there were 139 registered nurses who were due for revalidation during 2022/23. It was stated that all staff PINs were checked for compliance to provide assurance.

The Board noted the Annual Nurse revalidation report.

12 Ockenden Report

12.1 CN presented an update on the Ockenden Report. The report noted the poor care delivery at Shrewsbury and Telford Hospitals NHS Trust and identified key learning for all organisations. The Trust had reviewed the findings of the report and risk assessed Trust processes and internal controls for lessons to be learned from the report.

12.2 It was reported that the Trust had good governance processes in place to ensure that incidents were reviewed to a high standard and an overview of the evidence supporting this was reviewed.

12.3 NED-RW queried if there was a process for horizon scanning and CN clarified that information was received from regional CN and CEO meetings and this was reviewed at the informal Executive Team meeting each week where it was discussed if this required escalation to the formal Executive Directors meeting.

The Board noted the assurance provided in relation to findings from the Ockenden Report.

13 Transcranial Magnetic Resonance Guided Focussed Ultrasound Thalamotomy Update

13.1 CNS and CNO joined the meeting to provide a presentation on the implementation of the transcranial magnetic resonance guided focussed ultrasound (tcMRgFUS) thalamotomy service as described in the patient story. CNO highlighted that essential tremor was the most common movement disorder and was difficult to manage. Approximately 50% of patients were managed with medication, other treatments included deep brain stimulation (DBS) however not all patients were eligible for DBS and not all eligible patients chose to undergo the procedure.

13.2 An overview of the patient pathway for the tcMRgFUS service was provided and it was highlighted that two clinics were held per week and patients were also discussed at the multi-disciplinary team meetings.

13.3 CNS informed that the treatment was performed using an MRI scanner with a helmet that focussed ultrasound waves to one point in the brain. The patient's head was shaved and held in a frame linked to the machine with a membrane filled with water around the head as the ultrasound waves are unable to pass through air bubbles. Multiple sources of ultrasound waves were utilised to ensure that the patient's skin or tissue was not burned and these all worked together to burn one singular point. A pre-lesion could be undertaken to heat the area and monitor the patient's response before moving to a full lesion. An MRI scan was performed to identify the specific point to complete the lesion which was approximately 2mm in diameter. CNS confirmed that this was the same planning and target point undertaken for DBS however this treatment was non-invasive.

13.4 NED-PM queried if the system could be used to treat other conditions, CNS stated that it could potentially be used to treat a number of movement disorders however it was currently only commissioned for unilateral treatment of essential tremor. Bilateral treatment of essential tremor was a future possibility, however this would need to be part of a clinical trial. The system also had potential applications for Parkinsons tremor, neuropathic pain, treatment of small tumours and research applications.

13.5 NED-KB questioned why only one side of the patient was treated. CNS explained that if both sides were treated then the risk of speech disruption would increase by 40%. The patient is currently treated on one side and following a period of healing then treated on the second side.

13.6 CEO recognised that the implementation of this treatment had been clinically led and teams had advocated for Board buy-in via Divisional business cases with a multi-disciplinary team approach. CNS highlighted that the whole Trust had worked together to implement the service as a collective approach.

13.7 SID queried the impact on the patient, how long the procedure had taken and what the recovery period was. CNS informed that planning was undertaken the day before the procedure and the time from shaving the patients head to treatment was two to three hours dependant on how successful the planning was. If planning changed then this would add time to the procedure however it was felt that two cases could be treated per day initially and then three cases per day in approximately six months. The patient was discharged the following day.

13.8 SID questioned how many Consultants could operate using the equipment and it was confirmed that CNS was the only Consultant currently certified in use of the equipment however it was planned that certification would be provided to other Consultants in a cascade approach in due course.

13.9 The Chair thanked CNO and CNS for an inspiring presentation.

The Board noted the update on the implementation of Transcranial Magnetic Resonance Guided Focussed Ultrasound Thalamotomy.

14 Trust Operational Plan

14.1 CFO provided an update on the Trust operational plan and reported that this had been submitted to NHSE on 28th April 2022 and further work had since been completed with the Trust now forecasting a surplus of £1.4m for 2022/23. An overview of the risks to delivery was provided and this included cost improvement requirements of 3% of the Trust turnover. Elective Recovery Fund (ERF) income of £4.1m had been assumed and the Trust was required to achieve 104% of pre-Covid activity to access this funding. It was reported that no funding for NICE approved devices had been currently allocated and lower capital allocations than requested had been received.

14.2 COO updated that a 10% increase in activity from 2019/20 levels had been forecast and a break down of these plans was provided. Patient Initiated Follow Up (PIFU) targets were on track and there continued to be a focus on long waits with the Trust forecasting that there would be no 104 week waiters by the end of June and no 78 week waiters by the end of September.

14.3 National planning guidance had required the Trust to plan for no impact from Covid however it was highlighted that Covid was still impacting activity delivery across the Trust, due to staff sickness.

14.4 NED-PM noted the requirement for a 25% reduction on outpatient activity and questioned if there was any mitigation in moving to virtual follow ups. It was clarified that this was not the case and it would be challenging to meet this target. The Trust was exploring other mitigations and a piece of work was underway to review Did Not Attend (DNA) rates along with follow-up waiting lists and Patient Initiated Follow Up (PIFU) lists. CEO informed that it was nationally recognised that this target would be particularly difficult for Specialist Trusts to achieve.

14.5 CFO stated that plans continued to be reviewed in line with national planning guidance and updates would be presented if any changes in guidance were published.

The Board approved the Trust operational plan update.

15 Board Effectiveness Review

15.1 CEO presented the Board effectiveness review report for information and highlighted that it was good practice to review the effectiveness of Board on a regular basis. Responses received had reported that the Board was moving in the right direction however further improvements could be made. Feedback received was detailed in the report and an overview of responses was presented for discussion and this would be utilised to further develop the Board.

15.2 NED-KB queried succession planning for senior roles and the CEO stated that the focus would initially be on business-critical roles and a methodology was in place, this would then be rolled out to all roles.

15.3 NED-DT questioned if this would be integrated with the well led review and it was confirmed that this would be the case. Succession planning had been discussed at Remuneration Committee in August 2021 and Remuneration Committee was responsible for succession planning assurance in line with the terms of reference.

The Board noted the results from the Board effectiveness review.

16 Audit Committee Chair's Assurance Report and Terms of Reference

16.1 SID provided an update from the recent Audit Committee and highlighted the annual review of 2021/22 and plans for 2022/23. It was noted that a letter had been received from the regional CFO regarding the Trusts compliance with Better Payments Practice Code (BPPC) which requested an action plan to bring the Trust in line with the code, this action plan would be monitored at Audit Committee.

16.2 A number of audit reports had been received by the committee and it was highlighted that two audits had reported 'moderate assurance'. Work was underway to resolve the actions highlighted as part of the audits and assurances were provided that gaps in controls were being addressed and timescales for completion of outstanding actions had been agreed. The overall audit opinion for the Trust for 2021/22 was 'substantial assurance' and an overview of this opinion was provided.

16.3 The committee approved audit fees for 2022/23 however it was noted that there had been a large increase in the audit fees for external audit following completion of the most recent tender process for external audit services. There were no changes reported in the work required to audit value for money and it was noted that the Trust had agreed that quality accounts would be audited by the internal auditors as it was no longer a requirement for external auditors to complete this.

16.4 NED-KB queried the timeliness of submission of evidence for outstanding actions on the cyber security audit and it was confirmed that progress against these actions had been made and evidence submitted but this had been submitted following publication of the audit recommendations report and had therefore not been included in the report.

16.5 The committee reviewed the terms of reference and noted that minor amendments had been made and the format refreshed. Information Governance had been included as an area of focus for the committee along with additional focus on clinical aspects of assurance.

The Board noted the Audit Committee chair's assurance report and approved the terms of reference.

17 Walton Centre Charity Committee Chair's Assurance Report

17.1 SID provided an update from the recent Walton Centre Charity Committee (WCCC) and noted that there had been a number of changes in the way that the WCCC had operated in recent years. NHS Charities Together had helped to fill gaps in fundraising during the

pandemic and it was highlighted that implementation of the updated Charity strategy would follow the new Trust Strategy with an aim to improve the strength of governance. There was a need to be aware of the dynamic between specific Trust fundraising and fundraising for NHS Charities Together and concerns were noted on fundraising due to the increase in cost-of-living pressures.

17.2 It was highlighted that the two investment funds were warning that the value of current investments may decrease due to the financial climate. The Committee had reviewed the reserves policy and approved an increase in reserves to £296k to cover the costs of the next 12 month period, this would be reviewed annually.

17.3 An update on fundraising activities had been provided including the Walk for Walton event, the Jan Fairclough Ball and golf event.

17.4 The fundraising strategy had also been presented; it was recognised that there was a need to change how the Trust approached digital fundraising with discussions underway to explore the potential for recruiting a digital fundraiser at a cost of £40k per annum. Benchmarking would be put in place for the post and costs for the post would be reviewed against income generated.

17.5 NED-KB noted that funding for the Violence and Aggression app had not been approved and requested an update regarding this. It was stated that the Violence and Aggression strategy had been presented to Board in April 2022 and the app was not part of the strategy. The charity had not approved funding however had agreed to support bids for regional funding.

The Board noted the Walton Centre Charity Committee chair's assurance report.

18 Any Other Business

18.1 NED-PM highlighted that a committee effectiveness review had been undertaken of the Research, Innovation and Medical Education Committee and it had been agreed to form a working group to undertake a root and branch review of the agenda structure and associated sub-committees. This would clarify relationships between committees and identify any conflicts of interest.

Review of Meeting

19 Those present agreed the agenda covered a lot of ground, that the meeting was open,
19.1 strategic and well chaired with a good level of debate.

There being no further business the meeting closed at 12.45

Date and time of next meeting - Thursday 9th June 2022 at 09:30 Boardroom

Trust Board Attendance 2022-23										
Members:	Apr	May	Jun	Jul	Sept	Oct	Nov	Dec	Feb	Mar
Max Steinberg	✓	✓								
Karen Bentley	✓	✓								
Paul May	✓	✓								
Su Rai	✓	✓								
David Topliffe	✓	✓								
Ray Walker	✓	✓								
Mike Burns	A	✓								
Mike Gibney	✓	✓								
Andy Nicolson	✓	✓								
Jan Ross	✓	✓								
Lisa Salter	✓	✓								
Lindsey Vlasman	✓	✓								

TRUST BOARD
Matters arising Action Log
May 2022

	Complete & for removal
	In progress
	Overdue

Date of Meeting	Item Ref	Agenda item & action	Lead	Update	Deadline	Status
03/03/22	11.3	**Infection Prevention and Control Board Assurance Framework** An update on air handling units was scheduled to be submitted to the Executive Directors meeting for discussion in April and this would then be fed back to the Board.	CN		June 22	

Actions not yet due

Date of Meeting	Item Ref	Agenda item & action	Lead	Update	Deadline	Status
03/02/22	11	**Reducing the Burden and Releasing Capacity** Board to review the continuation of emergency powers.	CS		July 22	

The Walton Centre NHS Foundation Trust

Report to Trust Board
9 June 2022

Report Title	Communications and Marketing update – Social media at The Walton Centre
Executive Lead	Jan Ross, Chief Executive
Author (s)	Elaine Vaile, Communications and Marketing Manager
Action Required	To note

Level of Assurance Provided

☐ **Acceptable assurance** Systems of controls are suitably designed, with evidence of them being consistently applied and effective in practice	☐ **Partial assurance** Systems of controls are still maturing – evidence shows that further action is required to improve their effectiveness	☐ **Low assurance** Evidence indicates poor effectiveness of system of controls

Key Messages

- Social media is a vital element of the communications mix for any organisation
- At The Walton Centre, we have taken a fresh focus on using social media to raise the profile of the Trust and Charity
- This paper, part of a regular series to update and inform about the work of Communications and Marketing, outlines the changes made over the past year in our social media work, key highlights and the way forward

Next Steps

- Communications and Marketing to continue its work in social media, taking on board any recommendations or suggestions from Board members

Related Trust Strategic Ambitions and Themes	**Impact**		
Leadership	Not Applicable	Not Applicable	Not Applicable

Strategic Risks

Not Applicable	Choose an item.	Choose an item.

Equality Impact Assessment Completed

Strategy ☐	Policy ☐	Service Change ☐

Report Development

Committee/ Group Name	**Date**	**Lead Officer (name and title)**	**Brief Summary of issues raised and actions agreed**
n/a			

The Walton Centre
NHS Foundation Trust

Excellence in Neuroscience

Social media at The Walton Centre

Elaine Vaile
Communications and Marketing Manager

www.thewaltoncentre.nhs.uk

That Facetwit thing…..

The Walton Centre NHS Foundation Trust

Excellence in Neuroscience

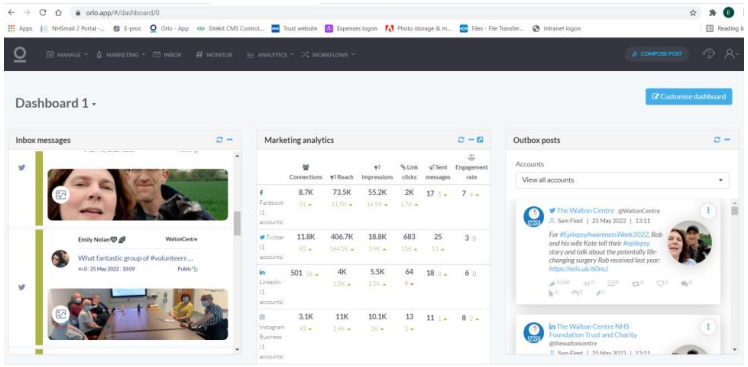
- Why is social media important?
- Likes v the ‘gram’ v the ‘professional one’
- A year ago….
  - Twitter 11,097
  - Facebook 8,444
  - Instagram 2,627
  - LinkedIn 208 (new page)

A fresh approach

The Walton Centre NHS Foundation Trust

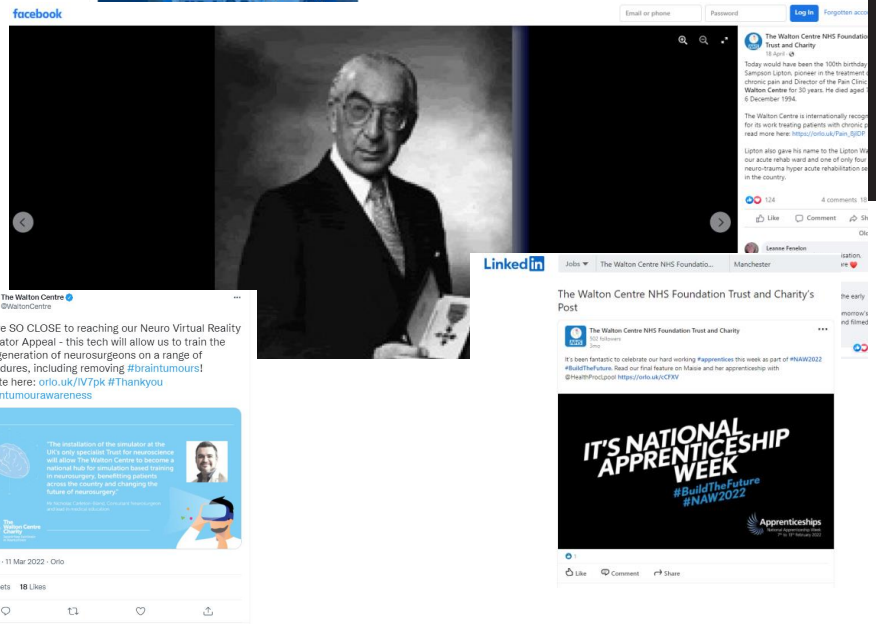
Excellence in Neuroscience

- Social media management platform
- Emerging from the pandemic – refocus content
- Do we know where we're going, and why?



Just a pretty picture?

- What works? What doesn't?
- Do we actually know?!
- 'Evergreen' content v news
- Keeping it fresh



A numbers game

The Walton Centre NHS Foundation Trust

Excellence in Neuroscience

- A year on, our numbers are going in the right direction:

	Followers	Organic reach (by clicks)
Twitter	11,848 (+751)	4m
Facebook	8,711 (+267)	862.4k
Instagram	3,062 (+435)	135.8k
LinkedIn	501 (+293)	31.7k

Where it's gone right…

NHS
The Walton Centre
NHS Foundation Trust

Excellence in Neuroscience

The Walton Centre NHS Foundation Trust and Charity
Published by Orlo · Yesterday at 12:02 ·

New diagnostic guidelines for fibromyalgia syndrome have been published. Dr Andreas Goebel, pain consultant, a lead author, "We hope they mean more effective and efficient diagnosis to enable patients to access the right treatment at an earlier stage."

THEWALTONCENTRE.NHS.UK
New guidelines launched for fibromyalgia syndrome
New guidelines for the diagnosis of fibromyalgia syndrome (FMS) have been pu...

5,557	1,147	–	Boost post
People reached	Engagements	Distribution score	

102 43 comments 53 shares

The Walton Centre NHS Foundation Trust and Charity
Published by Orlo · 18 May at 15:12 ·

How lovely is this? Ben, who has a brain tumour and is being looked after here at The Walton Centre, surprised his wife Janet on their 40th anniversary with help from their son Daniel and staff. #ThankYou for letting us be a part of your special day.

6,409	857	–	Boost post
People reached	Engagements	Distribution score	

260 14 comments 10 shares

The Walton Centre
@WaltonCentre

Meet Jade. She's spoken at many of our Walton Willow events as a donor recipient. Make sure you talk to your loved ones about your #organdonation choices this week. @NHSBT @NHSOrganDonor #LeaveThemCertain #ODW #ODW2021

11:08 AM · Sep 22, 2021 · Orlo

View Tweet analytics Promote

13 Retweets **21** Likes

NHS
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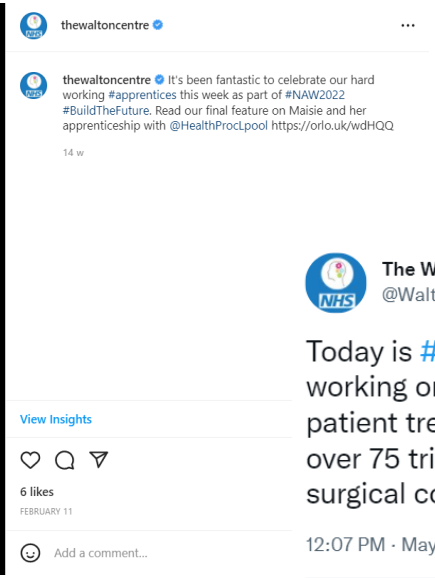
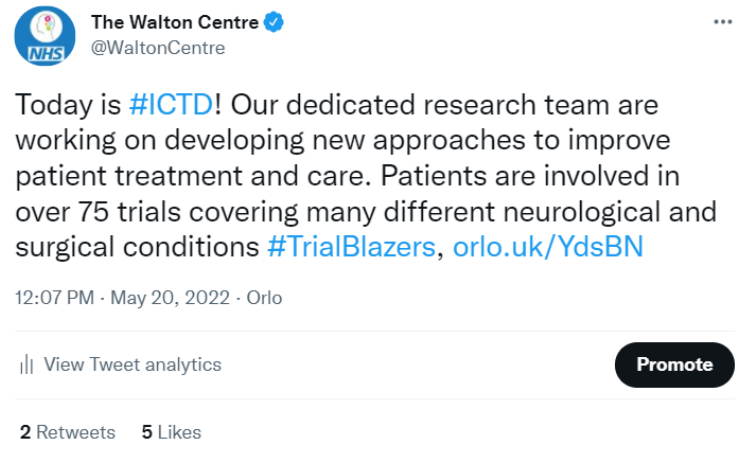
Where it's gone wrong…

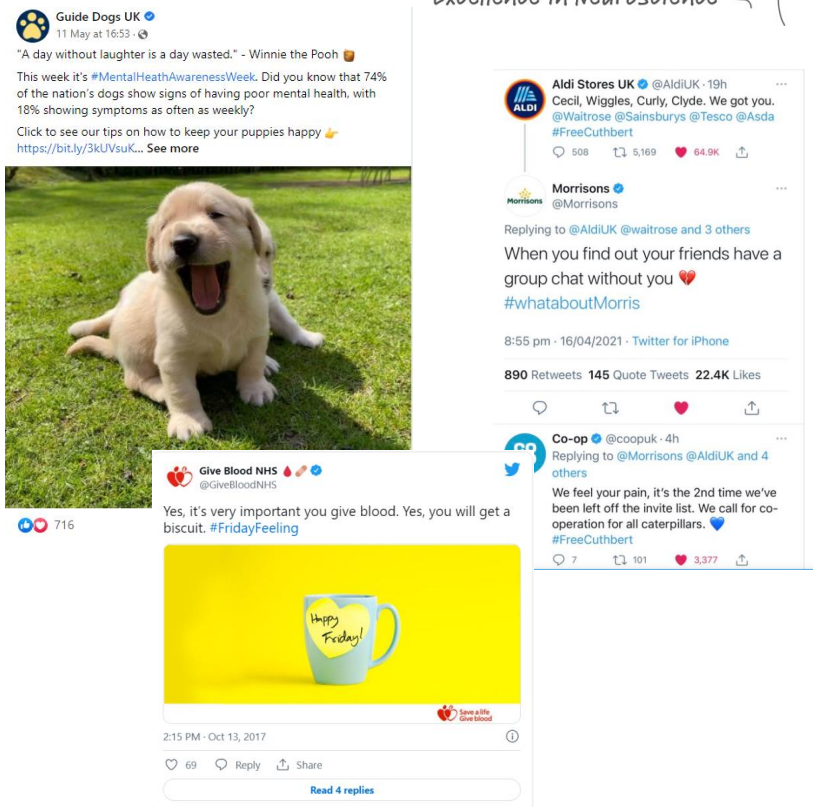




The *next* brave new world

NHS
The Walton Centre
NHS Foundation Trust
Excellence in Neuroscience

- Imitation is the sincerest form of flattery
- Keeping fresh
- Content is king
- Chipping away



Any questions?

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Report to Trust Board
9 June 2022

Report Title	Health & Wellbeing Strategy
Executive Lead	Mike Gibney, Chief People Officer
Author (s)	Matt Holt-Rogers, Wellbeing4Business
Action Required	To approve

Level of Assurance Provided *(do not complete if not relevant e.g. work in progress)*

☐ **Acceptable assurance**	☐ **Partial assurance**	☐ **Low assurance**
Systems of controls are suitably designed, with evidence of them being consistently applied and effective in practice	Systems of controls are still maturing – evidence shows that further action is required to improve their effectiveness	Evidence indicates poor effectiveness of system of controls

Key Messages *(2/3 headlines only)*

- The Trust Health and Wellbeing Strategy has been reviewed following the Pandemic, a number of national drivers and a survey carried out in November 2021
- The aim of the strategy is to create a safe, supportive, healthy and resilient workforce
- The need to make this one of the trusts top priorities is reinforced on a daily basis not least, through the cost of living crisis.
- The result is an accessible strategy with a clear brand, commitment and programme of support.

Next Steps (*actions to be taken following agreement of recommendation/s by Board/Committee)*

- To promote the strategy across the Organisation
- To implement the actions within the Strategy
- To measure performance through the Wellbeing Dashboard.

Related Trust Strategic Ambitions	**Impact** *(is there an impact arising from the report on any of the following?)*		
Innovative Culture	Workforce	Equality	Finance

Strategic Risks *(tick one from the drop down list; up to three can be highlighted)*

005 Recruitment and Retention of Staff	001 Impact of Covid 19 on delivery of strategic objectives	002 Meeting operational performance standards

Equality Impact Assessment Completed *(must accompany the following submissions)*

Strategy ✓	Policy ☐	Service Change ☐

Report Development *(full history of paper development to be included, on second page if required)*

Committee/ Group Name	**Date**	**Lead Officer (name and title)**	**Brief Summary of issues raised and actions agreed**
Staff Partnership Committee	February 2022	Jane Mullin, Deputy Chief People Officer	Strategy agreed
Business Performance Committee	April 22	Matt Holt-Rogers, Wellbeing4Business	Strategy recommended for approval at Board

Health & Wellbeing Strategy 2022-23

Executive Summary

1. Every employer understands that prioritising the health and wellbeing of its employees promotes the best working environment, underpins productivity and strengthens retention. In many ways the Walton Centre has been a trail blazer in this field prior to the pandemic. The challenge is now further exacerbated through international events that have resulted in a cost of living crisis.

2. Financial institutions, thought leaders and political pundits are pessimistic about the long term inflationary pressures, economic uncertainty and the prospects for global growth. These are all drivers in the need to sustain health and wellbeing as an organisational priority.

3. The strategy itself responds to a number of drivers including the national NHS agenda and direct feedback from the trust employees. This has resulted in a number of commitments to demonstrate the aspirations of the Walton Centre. The ambition is supported by a new 'Walton Wellbeing' brand, engagement and a dedicated wellbeing dashboard. There are a series of discrete component parts that make up the Staff Wellbeing Charter 2022, the Wellbeing Service Level Agreement 2022 and the programme of activity.

4. It is important for the Board to note that the health and wellbeing strategy has been approved by Business Performance Committee and is presented to Board to raise awareness and to demonstrate the priority of this agenda amongst the trust leadership team.

Background and Analysis

5. The Walton Centre has a proud commitment to staff wellbeing that has been invested in for over 20 years. It has been built upon partnership working between management and staff side with both parties fully committed. This can be validated through the achievement of the Investors in People standard (gold) twice and the stand along Investors in People Health & Wellbeing award, twice.

6. The global pandemic placed the spotlight firmly upon the wellbeing agenda and this is reflected in the national NHS focus upon health and wellbeing for all our staff. This clearly is the national driver however, locally its particularly important to refresh the offer, target issues as they emerge and revitalise communication/engagement.

7. Wellbeing survey data has identified areas to celebrate but also highlighted areas for further work. Areas of challenge to emerge include mental wellbeing, diet, sleep, stress and lifestyle choices (i.e. alcohol, smoking etc).

8. The new strategy was developed in response to a number of factors and inputs culminating in five overall commitments for 2022/23. They are:
    - Commitment 1 – Employee Health & Wellbeing will be represented at Board and Divisional Level and demonstrate visible organisational support
    - Commitment 2 – All employees will receive appropriate occupational health support whilst at work
    - Commitment 3 – Management will be responsible for the safety and management of employee wellbeing

- Commitment 4 – All employees will have access to a proactive wellbeing programme and personal support
- Commitment 5 – We will measure the effectiveness of health and wellbeing programmes

9. The strategy is supported by the wellbeing model and dashboard to enable effective implementation and monitoring. The component parts are:
    - Mental and emotional wellbeing
    - Physical wellbeing
    - Workplace wellbeing
    - Social wellbeing
    - Financial wellbeing

    To enable effective communication of the strategy and its offer, the trust has developed a staff wellbeing charter to signal its commitment and a Service Level Agreement describing the offer. The strategy includes a calendar of the monthly programme.

Conclusion

10. The case for this organisation to prioritise the Health & Wellbeing of its people is evident. The offer needs to continuously adapt to the changing needs of the workforce and have the ability to provide support to individuals based on their need. This strategy expands the offer to Walton staff, offers a new brand and an enhanced programme.

11. Through the Wellbeing Charter and Service Level Agreement the Trusts offer is coherent, comprehensible and highly accessible to all staff.

Recommendation

- To approve the Health & Wellbeing Strategy 2022-23

Author: Mike Gibney
Date: 31.5.22

Appendix 1 – Health & Wellbeing Strategy 2022-23 / Slide deck
Appendix 2 - Health & Wellbeing Strategy 2022-23 / Strategy
Appendix 3 – Staff Wellbeing Charter 2022
Appendix 4 – Wellbeing Service Level Agreement 2022
Appendix 5 – Equality Impact Assessment

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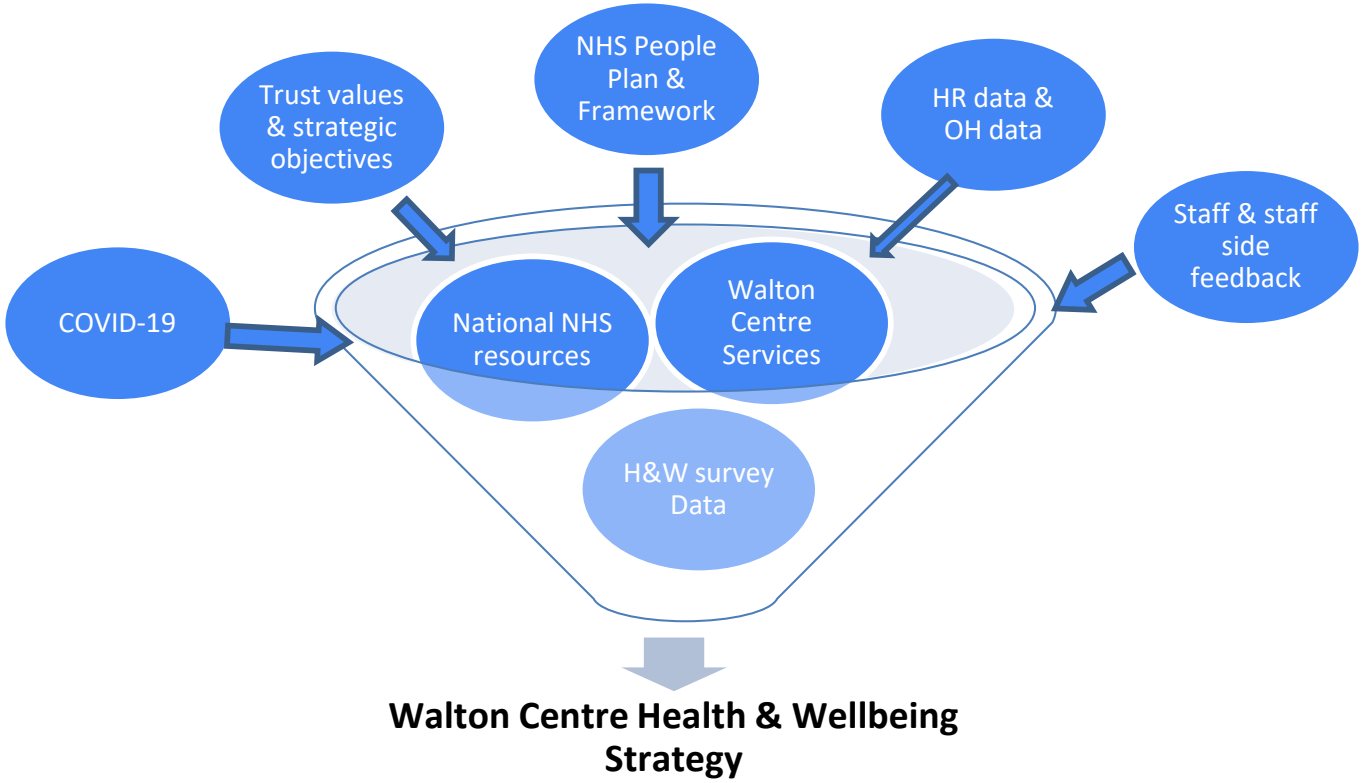
Health & Wellbeing Strategy 2022/23

Factors Influencing The New Strategy



Our vision and mission

Vision

To create a best practice staff wellbeing programme that engages the Trust, it's leaders and staff in creating a vibrant, safe, supportive, healthy and resilient workforce.

Mission

To deliver a visible, accessible, personalised, well managed and sustainable programme linked to Trust and National requirements. To encourage employee ownership of their personal wellbeing through a core annual plan involving education, behaviour change programmes and support by targeted local initiatives.

Brand name

'Walton Wellbeing'

Our commitment

Commitment 1

Employee Health & Wellbeing will be represented at Board and Divisional Level and will demonstrate visible organisational support

- A member of the executive team will have responsibility for Employee Health & Wellbeing.
- A Wellbeing Steering Group will develop and monitor the Wellbeing Strategy and develop an annual action plan in consultation with key stakeholders .
- Each work area will develop a 'Wellbeing team' who will be responsible to deliver the strategy at a local level
- All employees will have access to a copy of the Wellbeing Strategy

Commitment 2

All employees will receive appropriate occupational health support whilst at work.

- Health surveillance will be carried out in accordance with policies to manage risk, incidence and exposure
- Immunisations, risk assessments and screening programmes will be provided in accordance with national programmes and clinical guidelines
- Self and management referrals will be managed using early intervention where possible and in accordance with medical best practice
- Employee assistance programmes will offer personal, emotional and critical incident support

Our commitment

Commitment 3

Management will be responsible for the safety and management of employee wellbeing

- All managers will comply with regulatory requirements to reduce risks and ensure a safe, healthy and balanced working environment
- All managers will conduct wellbeing conversations & receive guidance and/or training on holding wellbeing conversations
- All managers will comply with conduct return to work interviews with staff to enable effective management of attendance.
- Occupational Health Services, EAP and appropriate counselling services will provide advice to managers in support of new and existing employees, who may have ill health or disability, to manage their condition at work or off work more effectively and will also proactively support and assist with return to work and vocational rehabilitation.
- Occupational Health Services will support managers in associated areas of risk management.
- Management will receive relevant education and guidance in relation to management of Health and Wellbeing at work

Our commitment

Commitment 4

All employees will have access to a proactive wellbeing programme and personal support

- All employees can access Occupational Health services
- All employees have access to a mental health first aiders and wellbeing advocates.
- All employees will have access to a confidential support and counselling service helpline 24/7/365 and access to further support if applicable (counselling and psychotherapy) and employee benefits service
- All employees will have access to a core wellbeing programme that will:
    - Be delivered consistently throughout the year
    - Build on and strategically encompasses the existing wellbeing activities
    - Be data driven
    - Can be accessed online - self help as well as face to face
    - Encourage people to adopt healthy behaviours
- All employees will have access to targeted programmes run locally within their work area

Our commitment

Commitment 5

We will measure the effectiveness of health and wellbeing programmes

- Wellbeing Surveys will run bi-annually.
- Service level agreements and KPI's will be developed and reported on.
- All wellbeing initiatives will provide feedback to the steering group at least quarterly.
- Key Performance Indicators will be regularly discussed at a senior level to recognise achievement, identify areas for improvement and consider variations to service provision.

Our strategic model

The 2021 NHS Health & Wellbeing Framework

The proactive interventions and services that empower our NHS people to manage their own health and wellbeing. Sections cover:
– mental and emotional wellbeing
– physical wellbeing
– healthy lifestyle

The ways our teams work together with care and compassion. Sections cover:
– supporting each other
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How our work at the NHS inspires our NHS people, and how we support their growth and passion. Sections cover:
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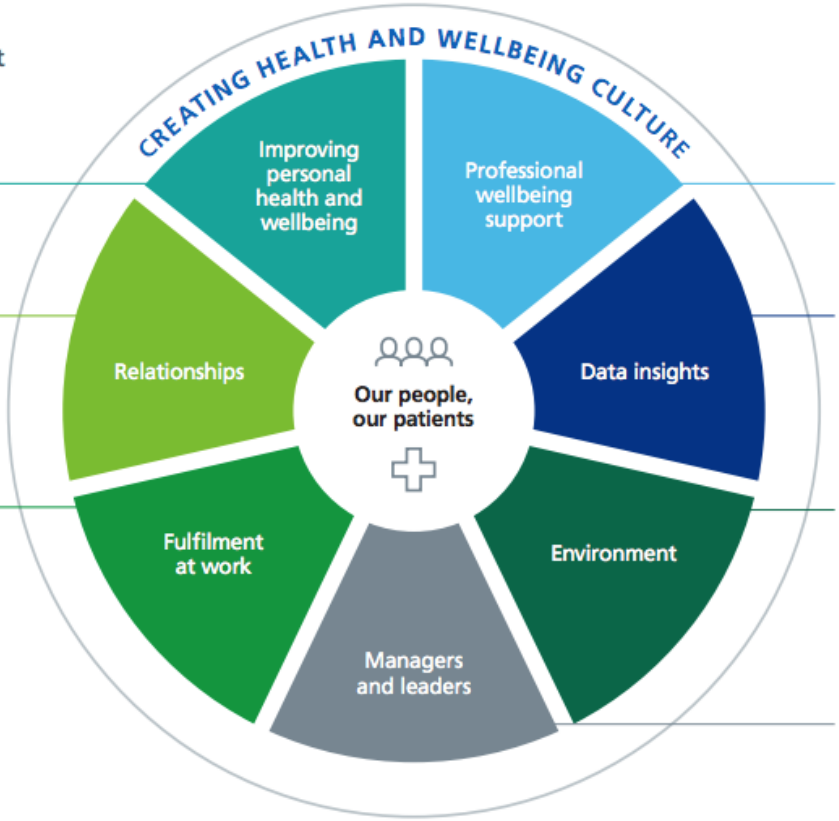

The teams and services, like occupational health, available to support organisation and people in their health and wellbeing. Sections cover:
– support services and partners
– organisation design and policy
– interventions overview

Our approach to understanding our health and wellbeing needs and then measuring our effectiveness in supporting them

Physical work spaces and the facilities available to our people to rest, recover and succeed

How our leaders and managers across all levels of the NHS provide health and wellbeing support as part of their role. Sections cover:
– senior manager responsibilities
– healthy leadership behaviours
– skilled managers

Applying the framework - our wellbeing model

Our 5 core areas will be reflected in everything we do.

Our icons will promote each aspect of the ‘Walton Wellbeing’ brand.

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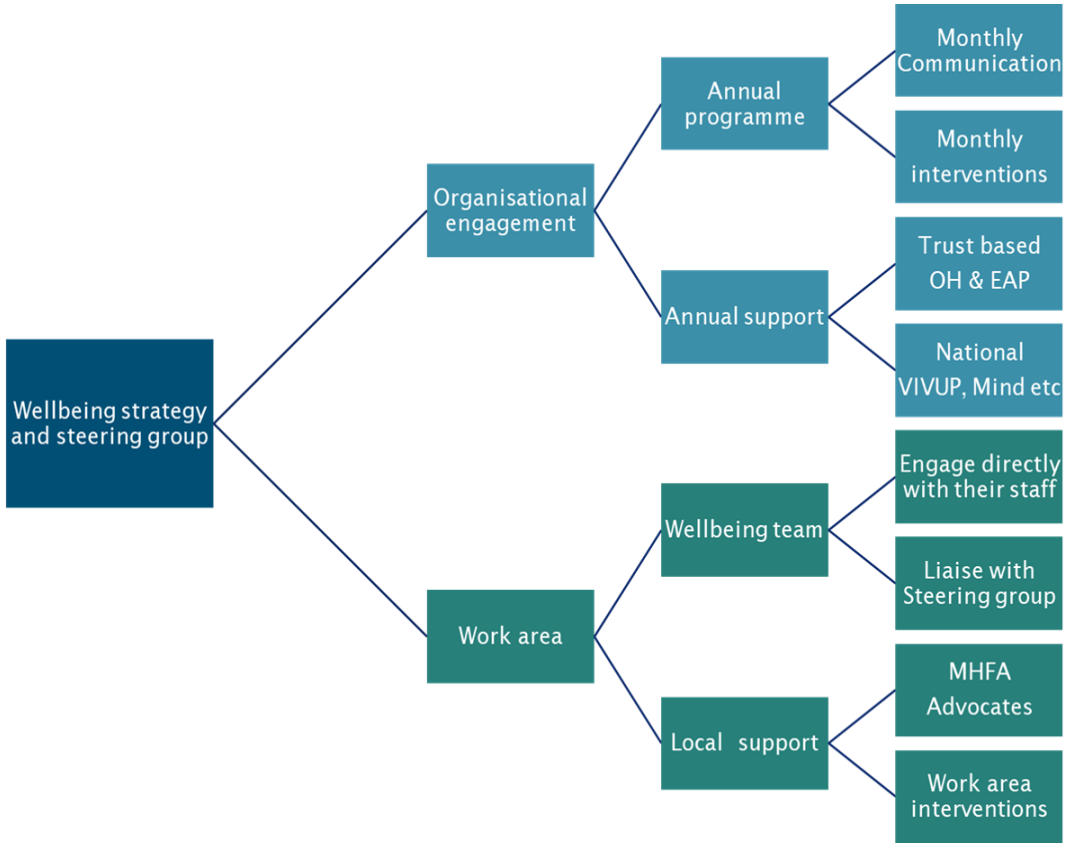
Logo/icons

Engagement

Our strategy will engage at an organisational and local level.



The organisational engagement programme will provide a core programme that everyone can access. Each month there will be a different focus based on key issues.

Each work area will set up a wellbeing team with the following members:

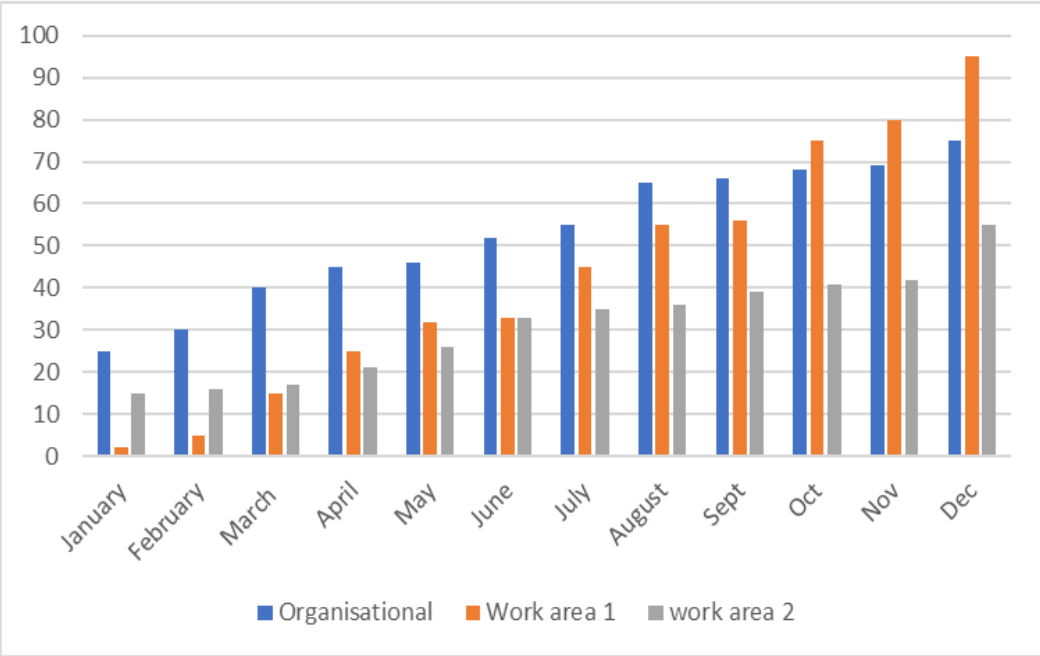
- Mental health first aider
- Wellbeing advocate
- Staff side member
- Employee
- Manager

The wellbeing team will drive the organisation engagement and has the flexibility to arrange their own local support/programmes.

The organisation and work area programmes will capture intervention data and report against kpi's.

Wellbeing Dashboard

Our strategy will populate a ‘Wellbeing Dashboard’ at both organisational and work area level



Data will be used to review the effect of interventions:

- Uptake
- Behaviour change

Data will report on the success of wellbeing teams:

- Number of Mental health first aider
- Number of Wellbeing advocate
- Work area uptake
- Work area behavior change

Component parts

Mental and emotional wellbeing

According to the World Health Organization, mental health is a state of wellbeing in which an individual realises their own abilities, can cope with the normal stresses of life, can work productively and is able to contribute to their community. Mental health conditions are consistently the highest reason for sickness absence in the NHS. Even at its lowest level in 2020, it accounted for 21% of sickness absence, c472,000 FTE days lost in a single month. Poor mental health at work costs the NHS upwards of £3bn per annum

Management support

- Introduce training at board level to familiarise about some of the key stress management concepts.
- We will supply managers with quick health guides and checklists to manage mental wellbeing/stress and links to valuable information and resources
- We will develop a senior management resilience programme.
- We will promote discussions about mental health

Mental health support

- We will train 1 MHFA trained member of staff per 50 staff in each work area
- We will provide self referral and management referral access to telephone counselling/EAP/Face to face counselling and mediation/conciliation support
- We will provide critical incident/trauma support programme

Risk management

- The Management of Health and Safety at Work (MHSW) Regulations 1999 require all employers and the self-employed to assess the risks from their work on anyone who may be affected by their activities. The Regulations require employers to carry out a systematic examination of their work activities and record the significant findings of the Assessment
    - We will ensure that where an incident of stress/anxiety or depression has occurred and is identified as work related that a risk assessment is undertaken of the specific role and the work environment to identify risks.
    - We will ensure that risks identified are reduced or eliminated where practicable in consultation with the employee affected by carrying our risk assessments.

Proactive programmes

- We will provide self help information to managers and employees
- We will provide workshops to build on existing platform of MHFA training

Staff Wellbeing Charter and SLA

We have developed a staff wellbeing charter to demonstrate our commitment to wellbeing in association with our Wellbeing strategy and a Service Level Agreement describing our services.

Staff Wellbeing Charter 2022

The Walton Centre NHS Foundation Trust

Physical Wellbeing | Mental Wellbeing | Workplace Wellbeing | Social Wellbeing | Financial Wellbeing

Developed in association with our 2022 Wellbeing strategy

Trust Committment

Your health and wellbeing is really important to us. As such, we will ensure wellbeing is represented at executive level. That our wellbeing strategy and action plans are open to all and easily available to.

We will work hard to make sure you have a healthy and safe working environment and will actively listen to and engage with all staff, encouraging full participation in our wellbeing programmes.

Wellbeing Culture

Through our plans and actions we will embed the value of good health and wellbeing in the workplace. Supporting you through illness and/or disability; promoting a positive work life balance, encouraging greater participation with us in your personal health care and with general wellbeing promotions. And by liaising and consulting with you on wellbeing issues as they affect you

Staff Committment

In turn with our genuine commitment to you, we ask you to look after your health, get involved in health and wellbeing activities whenever possible and to support others in doing likewise. We also ask that you do your best to work safely too. Help us to create the kind of healthy work environment we all aspire to, and when work is done, return home safe and sound.

Monthly Engagement

We will assist by providing quality information through a monthly communication programme. We will run coordinated challenges, activities and wellbeing events will help us to listen and respond to your needs.

A network of wellbeing advocates and trained Mental Health First Aiders will be available in each work area to listen and signpost you to dedicated support.

Personal Support

Our support services and professional staff will be there to help you manage life's more difficult or unexpected personal events. All our services are guaranteed private and confidential, so you can approach us with absolute confidence. Our medical and occupational health services supports will help keep you fit for work, or assist in any rehabilitation you may need.

Management Support

Line managers will hold "wellbeing conversations" with their team members and we hope staff feel comfortable discussing aspects such as mental wellbeing, alcohol and more. We will support managers with information, guidance and training in dealing with certain wellbeing issues.

Wellbeing Service Level Agreement 2022

The Walton Centre NHS Foundation Trust

Developed in association with our 2022 Wellbeing strategy

Service Level Agreement

This Service Level Agreement (SLA) specifies the provision of a comprehensive Staff wellbeing service. The delivery of the service is underpinned by the following principles:

- Strong focus on a high quality, data driven, evidence-based service.
- An equitable and accessible service.
- Impartial, approachable and engaging.
- Contribute to improved organisational productivity.
- Work in partnership with internal departments, stakeholders, staff side representatives, external organisation's and within the community.
- Underpinned by NHS national programmes, innovation and efficiency.

Our Core Occupational Health Programmme

Our core OH services provide a clinically led services which can be accessed by all staff:

- Employment screenings
- Immunisation
- Risk assessments
- Health surveillance
- Management referrals
- Ill health retirement
- Medical opinion and support

Core Confidential Counselling and Support

Our core support services can be accessed by all staff.

- 24/7/365 telephone counseling
- Face to face counseling
- MHFA onsite employee welfare support
- Management support
- National support e.g. Mind, Resilience HUB

Core Wellbeing Interventions

Our core programme is something that everyone can access. All interventions will aim to cover the five aspects in our wellbeing model.

- Wellbeing Calendar Communication
- Wellbeing Website Resources
- Wellbeing Advocates
- Wellbeing Challenges
- Management training
- Wellbeing conversations
- Wellbeing coaching
- Wellbeing workshops
- Wellbeing surveys and screening

Local Services

We will enable work areas to approved run local initiatives. Each work area will create a "wellbeing team" led by advocates to drive core services and explore bespoke services:

- Locally purchased wellbeing services
- Locally organised activities/events
- Charity initiatives

Programme Management and Metrics

The overall programme will be centrally led by HR and will provide:

- A dedicated programme manager
- Quarterly reports will be produced in relation to performance against (KPIs) and measure of service usage

2022 - Health Calendar Monthly Programme

	JANUARY	FEBRUARY	MARCH	APRIL	MAY	JUNE
PHYSCIAL WELLBEING	Energy Levels	Menopause	Cardiovascular Health	Sleep	Weight Management	Physical Activity
MENTAL WELLBEING	Anxiety	Depression	Stress & Pressure	Finding Help	Eating Disorders	Mindfulness
WORKPLACE WELLBEING	Goal Setting	Healthy Leadership	Communication	Life Balance	Vision & Purpose	Motivation
SOCIAL WELLBEING	Pressures of a New Year	Lonliness	Positive Relationships	Volunteering	Making a Connection	Self-Care
FINANCIAL WELLBEING	Financial Support	Spending	Budgeting	Understanding Living Costs	Debt Management	Saving
WORKSHOPS	• Anxiety • Energy Levels	• Depression • Menopause	• Stress • Budgeting	• Sleep • Life balance	• Debt • Weight loss	• Physical Activity • Mindfuilness

The Walton Centre NHS Foundation Trust

Health & wellbeing strategy 2022/23

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Written By: Matthew Holt-Rogers - Wellbeing4business Ltd. & Jane Mullin - Deputy Hr Director - The Walton Centre NHS Foundation Trust
Date: 5th January 2022

Document Intention

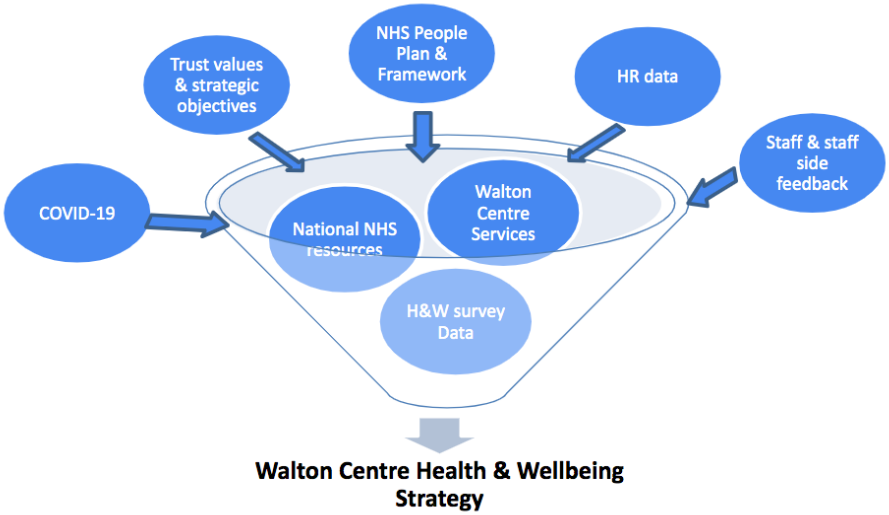
We consider our staff to be our greatest resource. We want each member of staff to enjoy good physical and mental health and wellbeing, within the workplace and in their personal life.

This wellbeing strategy policy document, incorporating our Staff Wellbeing Charter; describes our organisation's approach to the management of health and wellbeing for our staff. Through a series of objectives, our wellbeing strategy aims to make a recognisable and tangible difference to our employees' health; their attitudes to, and personal ownership of, health and wellbeing issues.

It has been developed in accordance with the most recent NHS Health & Wellbeing Framework, NHS People Plan/pledge and specific Walton Centre NHS Trust needs.

Developing the strategy

Factors Influencing The New Strategy



Current situation

The Walton Centre has invested in staff wellbeing for a number of years and currently offer the following services to staff:

- Wellbeing strategy and steering group
- Employee Assistance Programme – NOSS
- Employees benefits – VIVUP
- In-house coaches
- PDR - Wellbeing conversations lead by management staff
- Wellbeing page on intranet and communication/section in Walton Weekly
- 28 trained Mental Health First Aiders
- Pre-covid history of onsite classes
- Occupational health service
- Many departments run their own health campaigns
- Investor in People award for health & wellbeing

Prior to the global pandemic, within the NHS, reducing sickness absence was seen as the leading indicator of improved health and wellbeing. Emphasis has now changed nationally to thinking that if we focus on the health and wellbeing of our NHS people, they would be better placed to care for our patients and service users, therefore creating a culture of wellbeing that focuses on prevention and culture change.

From discussions with staff and stakeholders the following factors were considered important when designing the new strategy:

- Senior management buy-in and managers are comfortable having conversations about wellbeing.
- Staff want things to do, not read; a visible programme aimed at our diverse population's real needs.
- It is difficult engaging certain members of staff e.g.ward staff due to work commitments. Future programmes must be able to be accessed by everyone.
- Covid continues to affect staff wellbeing and the effect on staff should be monitored regularly and factored into programme design
- A more personalised approach linked to real lifestyle/trust issues. Everyone is different.
- Staff would like to be involved in promoting the strategy and have a voice in developing the strategy.

Wellbeing Survey Data

The data emphasised the importance of how both a proactive and reactive approach to wellbeing should be developed in future strategy and programme development:

- 69% rated their overall wellbeing as excellent/good. This is very positive and is maintained through proactive programmes.
- 10.53% rated their mental wellbeing as poor, (31.58% fair) and 4.68% rated physical wellbeing as poor (28.07% fair) the Trust should provide visible support and ensure staff are successfully signposted to resources and services.

Reviewing lifestyle data concluded that:

- Most people eat a fairly healthy diet. There are caffeine and hydration issues for some.
- 42% rarely sleep well.
- 43% have fatigue issues all of the time and 44% some of the time. Energy and fatigue are major issues for the Trust to manage due to their effect on performance and safety.
- 63% of staff enjoy their job even though it's stressful.
- Personal life and finance are important aspects to focus on. 24% worry about finance all the time and 39% some of the time.
- Inactivity and obesity are important aspects to focus on whilst alcohol and smoking are less important.
- Musculoskeletal problems and work-related stress affect over half the population.

The effect of Covid-19 on wellbeing.

- The data shown demonstrates that whilst the majority of staff feel no difference, over 30% of colleagues are feeling a negative effect.
- The effect COVID has had on staff appears to vary widely amongst staff and highlights the importance of a more personalised approach to wellbeing in future.

Workplace influence on wellbeing:

- Safety and discrimination are issues for some staff. 24% have experienced violent or abusive behaviour at work and 15% have experienced discrimination at work.
- The majority of staff are knowledgeable about the wellbeing strategy and 61% feel that the organisation supports employees who experience mental health problems.
- Breaks and adequate rest areas are worth considering (especially as fatigue is a major issue).
- When looking at work-related pressure 17**%** are in the strain zone which exacerbates tiredness and fatigue. 0.6% are in the panic zone where they feel severely stressed and are at risk of serious health problems.

Staff pledges to improve their wellbeing concluded that the following subjects were the most popular aspects to focus on: sleep, eating healthier, losing weight, becoming more active, managing work-related stress, mental health (depression, anxiety), home life issues, finances and musculoskeletal problems.

Vision, Mission & Commitments

Our vision and mission

Vision

To create a best practice staff wellbeing programme that engages the organisation, its leaders and staff in creating a vibrant, safe, healthy and resilient workforce.

Mission

To encourage employee ownership of their personal wellbeing through a core annual plan involving education, behaviour change programmes and support by targeted local initiatives. To deliver a visible, accessible, personalised, well managed and sustainable programme linked to Trust and National requirements.

Brand name

'Walton Wellbeing'

Our commitments

Commitment 1

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    - Encourage people to make pledges to adopt healthy behaviour
- All employees will have access to targeted programmes run locally within their work area

Commitment 5

We will measure the effectiveness of health and wellbeing programmes

- Wellbeing Surveys will run bi- annually.
- Service level agreements and KPI's will be developed and reported on.
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Our strategic model

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Excellence in Neuroscience

Logo's/Icons

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Our strategy will engage at an organisational and local level.

The organisational engagement programme will provide a core programme that everyone can access. Each month there will be a different focus based on key issues.

Each work area will set up a wellbeing team with the following members:

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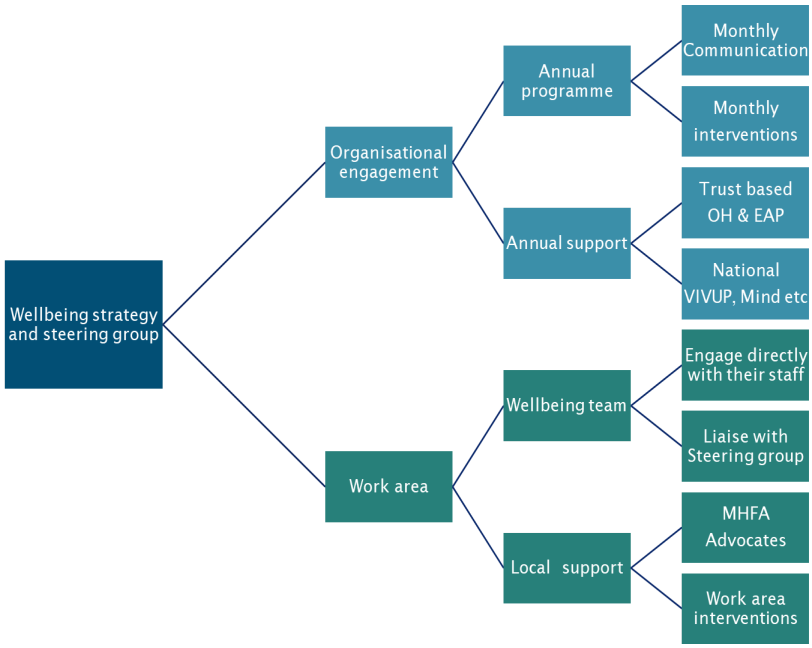


Wellbeing Dashboard

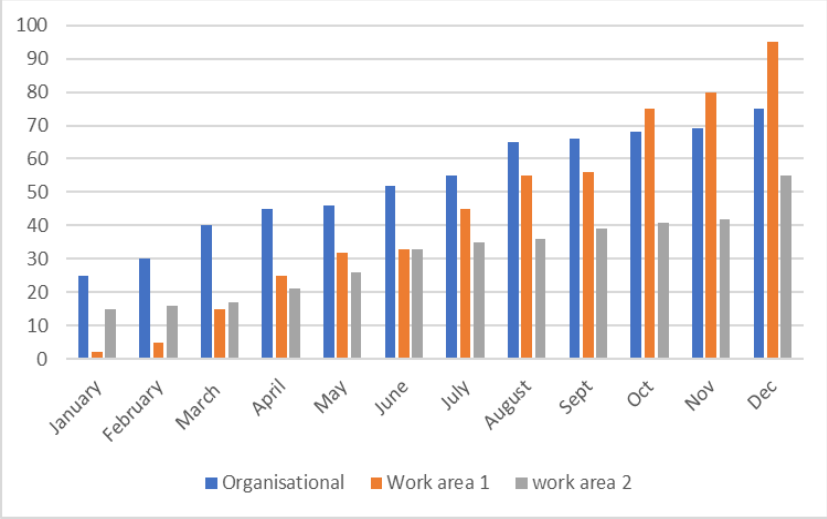
Our strategy will populate a 'Wellbeing Dashboard' at both organisational and work area level

Data will be used to review the effect of interventions:

- Uptake
- Behaviour change

Data will report on the success of wellbeing teams:

- Number of Mental health first aider
- Number of Wellbeing advocate
- Work area uptake
- Work area behaviour change



Component parts

Mental & Emotional Wellbeing

According to the World Health Organisation, mental health is a state of wellbeing in which an individual realises their own abilities, can cope with the normal stresses of life, can work productively and is able to contribute to their community. Mental health conditions are consistently the highest reason for sickness absence in the NHS. Even at its lowest level in 2020, it accounted for 21% of sickness absence, c472,000 FTE days lost in a single month. Poor mental health at work costs the NHS upwards of £3bn per annum

Management support

- Introduce training at board level to familiarise with some of the key stress management concepts.
- We will supply managers with quick health guides and checklists to manage mental wellbeing/stress and links to valuable information and resources
- We will develop a senior management resilience programme.
- We will promote discussions about mental health

Mental health support

- We will train 1 MHFA trained member of staff per 50 staff in each work area
- We will provide self-referral and management referral access to telephone counselling/EAP/Face to face counselling and mediation/conciliation support
- We will provide a critical incident/trauma support programme

Risk management

- The Management of Health and Safety at Work (MHSW) Regulations 1999 require all employers and the self-employed to assess the risks from their work on anyone who may be affected by their activities. The Regulations require employers to carry out a systematic examination of their work activities and record the significant findings of the Assessment
    - We will ensure that where an incident of stress/anxiety or depression has occurred and is identified as work-related that a risk assessment is undertaken of the specific role and the work environment to identify risks.
    - We will ensure that risks identified are reduced or eliminated where practicable in consultation with the employee affected by carrying out risk assessments.

Proactive programmes

- We will provide self-help information to managers and employees
- We will provide workshops to build on the existing platform of MHFA training

Physical Wellbeing

Physical health is defined as is the condition of the body. Good physical health is when your body is functioning as it was designed to function. Musculoskeletal health interventions by occupational health services have been shown not only to return employees to work up to five weeks earlier than under normal care but also to reduce the recurrence of back pain in the following year by up to 40%. 69% of nursing staff do not take breaks, compared to 56% of hospital staff. Fatigue and sleep deprivation affect error rates, quality of care and personal safety.

Managing musculoskeletal health

- We will establish a fast track system for the physiotherapist as part of the case management process for MSDs. The OH service should be the main gatekeeper for a referral.
- Occupational physiotherapists will provide ergonomic advice. This is to avoid what is called “re-infection” where an employee who has suffered a musculoskeletal injury at work is returned to the same occupation without any re-adjustment to the working environment that subsequently causes a return of the original condition.
- Physical activity programmes will be promoted as they are essential in the management of musculoskeletal disorders.

Managing physical energy and fatigue

Employees and leaders need the energy and stamina to meet challenging goals, create value and inspire performance. Energy fuels engagement, excellence and leadership.Fatigue influences safety and performance.

- We will establish a fatigue management programme
- We will provide proactive programmes on eating/drinking well, being fit and active, sleeping and recuperating
- We will aim to provide adequate facilities that promote healthy breaks

Managing key modifiable health risks and issues

- We will promote health checks – know your numbers, assessment, links with national campaigns/charities
- We will provide proactive programmes on Cancer, Heart Disease, Diabetes, IBS, Menopause

Workplace Wellbeing

Workplace wellbeing is essentially managing the effect of health on work and the effect of work on health. It involves establishing a safe working environment, complying with legislation, managing sickness absence, pandemics and crisis's and fostering good working relationships, high levels of self-awareness, team morale and personal engagement.

Managing occupational health

- Each business unit working environment is different and carries varied risks.
- Our occupational health specialists will support businesses in managing work-related physical risk e.g: Chemicals and Dangerous Substances, Driving and Transport, Use of Display Screen Equipment (VDU's), Manual Handling, Biological and Infectious Diseases
- We will manage sickness absence, pandemics and crisis's in a structured people-centred way

Managing violence, bullying, harassment

- We will address levels of bullying and harassment by creating a compassionate and inclusive culture
- We will aim to foster good working relationships, high levels of self-awareness, team morale and personal engagement.
- We will recognise the value of differences in people and how a diverse set of backgrounds and experiences enriches the NHS as an organisation.
- We will ensure policies are in place to manage risks

COVID-19

- We will continually survey the effect of COVID 19 on staff and intervene where possible
- We will ensure staff have the correct PPE etc to keep themselves safe
- We will support national guidelines and objectives

Social wellbeing

Forward
The sense of family within the NHS, through mutual concern for each other, extends from our company into the home and personal lives through work-life balance programmes, personal or family support, advice or guidance and where necessary, positive and targeted interventions.

Work-life balance

- We will provide information and challenges to prompt staff to balance work and life
- We will implement changes as applicable

Personal life issues

- We will aim to support staff having personal life issues such as caring, bereavement, housing etc
- Provide signposting information to enable staff to find support, quickly and efficiently
- Provide awareness workshops and training programmes on key aspects

We will provide information on volunteering, climate change and Covid-19.

Financial wellbeing

Forward
Personal money management, budgeting courses and talks will remain a part of our efforts to assist staff. One to one consultations with financial professionals may also be available in certain circumstances.

Policy

- We will build a financial wellbeing policy

Financial wellbeing support

- We will promote free, confidential and independent money and debt advice from the government's Money and Pensions Service.
- We will ensure staff are fully aware of all the employee benefits currently on offer and how to make the most of them.

Programmes

- We will provide information awareness workshops and programmes on aspects such as budgeting, financial awareness

Staff Wellbeing Charter & SLA

We have developed a staff wellbeing charter to demonstrate our commitment to wellbeing in association with our Wellbeing strategy and a Service Level Agreement describing our services.

Images are for viewing only - Copies of these documents can be found separately

Staff Wellbeing Charter 2022

The Walton Centre NHS Foundation Trust

Physical Wellbeing | Mental Wellbeing | Workplace Wellbeing | Social Wellbeing | Financial Wellbeing

Developed in association with our 2022 Wellbeing strategy

Trust Committment

Your health and wellbeing is really important to us. As such, we will ensure wellbeing is represented at executive level. That our wellbeing strategy and action plans are open to all and easily available to.

We will work hard to make sure you have a healthy and safe working environment and will actively listen to and engage with all staff, encouraging full participation in our wellbeing programmes.

Wellbeing Culture

Through our plans and actions we will embed the value of good health and wellbeing in the workplace. Supporting you through illness and/or disability; promoting a positive work life balance, encouraging greater participation with us in your personal health care and with general wellbeing promotions. And by liaising and consulting with you on wellbeing issues as they affect you

Staff Committment

In turn with our genuine commitment to you, we ask you to look after your health, get involved in health and wellbeing activities whenever possible and to support others in doing likewise. We also ask that you do your best to work safely too. Help us to create the kind of healthy work environment we all aspire to, and when work is done, return home safe and sound.

Monthly Engagement

We will assist by providing quality information through a monthly communication programme. We will run coordinated challenges, activities and wellbeing events will help us to listen and respond to your needs.

A network of wellbeing advocates and trained Mental Health First Aiders will be available in each work area to listen and signpost you to dedicated support.

Personal Support

Our support services and professional staff will be there to help you manage life's more difficult or unexpected personal events. All our services are guaranteed private and confidential, so you can approach us with absolute confidence. Our medical and occupational health services supports will help keep you fit for work, or assist in any rehabilitation you may need.

Management Support

Line managers will hold "wellbeing conversations" with their team members and we hope staff feel comfortable discussing aspects such as mental wellbeing, alcohol and more. We will support managers with information, guidance and training in dealing with certain wellbeing issues.

Wellbeing Service Level Agreement 2022

The Walton Centre NHS Foundation Trust

Developed in association with our 2022 Wellbeing strategy

Service Level Agreement

This Service Level Agreement (SLA) specifies the provision of a comprehensive Staff wellbeing service. The delivery of the service is underpinned by the following principles:

- Strong focus on a high quality, data driven, evidence-based service.
- An equitable and accessible service.
- Impartial, approachable and engaging.
- Contribute to improved organisational productivity.
- Work in partnership with internal departments, stakeholders, staff side representatives, external organisation's and within the community.
- Underpinned by NHS national programmes, innovation and efficiency.

Our Core Occupational Health Programmme

Our core OH services provide a clinically led services which can be accessed by all staff:

- Employment screenings
- Immunisation
- Risk assessments
- Health surveillance
- Management referrals
- Ill health retirement
- Medical opinion and support

Core Confidential Counselling and Support

Our core support services can be accessed by all staff.

- 24/7/365 telephone counseling
- Face to face counseling
- MHFA onsite employee welfare support
- Management support
- National support e.g. Mind, Resilience HUB

Core Wellbeing Interventions

Our core programme is something that everyone can access. All interventions will aim to cover the five aspects in our wellbeing model.

- Wellbeing Calendar Communication
- Wellbeing Website Resources
- Wellbeing Advocates
- Wellbeing Challenges
- Management training
- Wellbeing conversations
- Wellbeing coaching
- Wellbeing workshops
- Wellbeing surveys and screening

Local Services

We will enable work areas to approved run local initiatives. Each work area will create a "wellbeing team" led by advocates to drive core services and explore bespoke services:

- Locally purchased wellbeing services
- Locally organised activities/events
- Charity initiatives

Programme Management and Metrics

The overall programme will be centrally led by HR and will provide:

- A dedicated programme manager
- Quarterly reports will be produced in relation to performance against (KPIs) and measure of service usage

2022 - Health Calendar Monthly Programme

	JANUARY	FEBRUARY	MARCH	APRIL	MAY	JUNE
PHYSCIAL WELLBEING	Energy Levels	Menopause	Cardiovascular Health	Sleep	Weight Management	Physical Activity
MENTAL WELLBEING	Anxiety	Depression	Stress & Pressure	Finding Help	Eating Disorders	Mindfulness
WORKPLACE WELLBEING	Goal Setting	Healthy Leadership	Communication	Life Balance	Vision & Purpose	Motivation
SOCIAL WELLBEING	Pressures of a New Year	Lonliness	Positive Relationships	Volunteering	Making a Connection	Self-Care
FINANCIAL WELLBEING	Financial Support	Spending	Budgeting	Understanding Living Costs	Debt Management	Saving
WORKSHOPS	• Anxiety • Energy Levels	• Depression • Menopause	• Stress • Budgeting	• Sleep • Life balance	• Debt • Weight loss	• Physical Activity • Mindfuilness

Staff Wellbeing Charter 2022

The Walton Centre NHS Foundation Trust
Excellence in Neuroscience

Developed in association with our 2022 Wellbeing strategy

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The Walton Centre NHS Foundation Trust

Equality Impact Assessment (EIA) Form

For the purpose of this form 'document/activity' will refer to policies, procedures, strategies, projects, CIPs and service changes. *For further support please refer to the EIA Guidance on the Equality and Diversity section of the Intranet.*

Part 1 must be completed for **all** documents/activities when created, updated or reviewed. This must be done at the **development stage** i.e. before ratification or approval.

Part 2 must be completed only where the proposed document/activity will have an impact and further consultation is needed.

Part 1

1. Person(s) Responsible for Assessment:

2. Contact Number:

3. Department(s):

4. Date of Assessment:

5. Name of the document/activity (policy/procedure/project/CIP/service change) being assessed:

6. Is the document/activity new or existing?

New Existing

7. Who will be affected by the document/activity (*please tick all that apply*)?

Staff Patients Visitors Public

8. How will these groups/key stakeholders be consulted with?

9. What is the main purpose of the document/activity?

10. What are the benefits of the document/activity and how will these be measured?

11. Is the document/activity associated with any other policies, procedures, guidelines, projects or services? *If yes, please give brief details*

12. What is the potential for discrimination or disproportionate treatment of any of the protected characteristics? *Please specify specifically who would be affected (e.g. patients with a hearing impairment or staff aged over 50*

Protected Characteristic	**Positive Impact *(benefit)***	**Negative *(disadvantage or potential disadvantage)***	**No Impact**	**Reasons to support your decision and evidence sought**	**Mitigation/adjustments already put in place**
Age					
Sex					
Race					
Religion or Belief					
Disability					
Sexual Orientation					
Pregnancy/maternity					
Gender Reassignment					
Marriage & Civil Partnership					
Carers					
Other					

If you have identified no negative impact for all please explain how you reached that decision and provide reference to any evidence (e.g. reviews undertaken, surveys, feedback, patient data etc.)

13. Does the document/activity raise any issues in relation to Human Rights as set out in the Human Rights Act 1998? *See Guidance for more details (NB if an absolute right is removed or affected the document/activity will need to be changed. If a limited or qualified right is removed or affected the decision needs to be proportional and legal)*

If you have identified negative impact for any of the above characteristics, for which there is no mitigation in place you MUST complete Part 2.

If you have not identified any negative impacts, or for those you have are able to completely eliminate this by the mitigation/adjustments already in place, please go straight to the Declaration Section.

Part 2

1. Who (specifically) is expected to benefit from the proposed change?

2. What is the overall cost of implementing the document/activity?

3. Have you carried out a Privacy Impact Assessment?

Yes No

4. Do different groups have different needs, experiences, issues and priorities in relation to this document/activity? *If yes please give brief details*

5. Is there public concern (including media, academic, voluntary or sector specific interest) about actual, perceived or potential discrimination about a particular community?

6. What consultation has taken place so far and what is planned, and with who? *Consultation includes; meetings, formal consultations, communications etc.*

7. How have you/do you plan to include the protected characteristics and other affected groups in the consultation process (e.g. young people, Black, Asian and minority ethnic communities, refugees, asylum seekers, travellers or gypsy communities)?

8. Date consultation started and planned end date? *This should be 12 weeks*

9. What was the outcome of this consultation?

10. Have any changes been made as result of consultation?

11. Do these changes remove all negative impact and maximise positive impact whilst still achieving the aims?

12. Provide examples to demonstrate how equality is currently considered within this area (e.g. making reasonable adjustments for patients with disabilities)?

13. Have any complaints been received in relation to this service/area of work, within the last 3 years, which involve equality issues? *If yes give brief details*

Action Plan & Monitoring

14. If you consider there to be actual or potential adverse impact or discrimination please detail what broad actions you are taking to address the issues. The responsibility for establishing and maintaining the monitoring arrangements of the EIA action plan lies with the service/team completing the EIA. Consider what arrangements/actions will you take to monitor the impact and/or address any disadvantage and promote equality of outcome for individuals? *Please ensure any remedial actions are Specific, Measureable, Achievable, Realistic, and Timely (SMART)*

Action	Lead	Timescales	Review Date

Declaration

I am satisfied this document/activity has been satisfactorily equality impact assessed and the outcome is:

No major change needed – EIA has not identified any potential for discrimination/adverse impact & all opportunities to promote equality have been taken

Adjust the document/activity to remove barriers identified by EIA or to better promote equality
Please provide an explanation

Adverse impact but continue with document/activity
Please provide an explanation that clearly sets out your justification for continuing with the document/activity. You should consider whether there are sufficient plans to reduce the negative impact and/or plans to monitor the actual impact.

Stop and remove the document/activity – EIA has shown actual or potential unlawful discrimination

Name: Date:

Signed:

The Walton Centre NHS Foundation Trust

Report to Trust Board
9 June 2022

Report Title	Integrated Performance Report
Executive Lead	Lindsey Vlasman - Interim Chief Operating Officer
Author (s)	Mark Foy - Head of Information & Business Intelligence
Action Required	To note

Level of Assurance Provided *(do not complete if not relevant e.g. work in progress)*

☐ **Acceptable assurance** Systems of controls are suitably designed, with evidence of them being consistently applied and effective in practice	✓ **Partial assurance** Systems of controls are still maturing – evidence shows that further action is required to improve their effectiveness	☐ **Low assurance** Evidence indicates poor effectiveness of system of controls

Key Messages *(2/3 headlines only)*

- See summary for performance overview

Next Steps (*actions to be taken following agreement of recommendation/s by Board/Committee)*

- Ongoing

Related Trust Strategic Ambitions	**Impact** *(is there an impact arising from the report on any of the following?)*		
	Choose an item.	Choose an item.	Choose an item.

Strategic Risks *(tick one from the drop down list; up to three can be highlighted)*

002 Meeting operational performance standards	001 Impact of Covid 19 on delivery of strategic objectives	Choose an item.

Equality Impact Assessment Completed *(must accompany the following submissions)*

Strategy ☐	Policy ☐	Service Change ☐

Report Development *(full history of paper development to be included, on second page if required)*

Committee/ Group Name	**Date**	**Lead Officer (name and title)**	**Brief Summary of issues raised and actions agreed**

Integrated Performance Report

Executive Summary

1. This report provides assurance on all Integrated Performance Report measures aligned to the Business & Performance and Quality Committee's. Performance is based on four aspects; performance in month, trend/variation, whether the target is within variation and external benchmarking. The below table highlights indicators by those which are High Performing (achieving target or improvement), Opportunity for Improvement (improving but not hitting target, or underperforming compared to peers, and Underperforming (not hitting target consistently or performance significantly decreasing).

Operations & Performance Indicators

High Performing
Cancer Standards
Diagnostics
Referral to Treatment - Long Waits
28 Day Emergency Readmissions

Opportunity for improvement
Theatres
Referral to Treatment - Waits
Activity Restoration

Underperforming
N/A

Workforce Indicators

High Performing
N/A

Opportunity for improvement
Mandatory Training
Turnover

Underperforming
Appraisal Compliance
Sickness/Absence

Quality Indicators

High Performing
Complaints
CAUTI
VTE
Hospital Acquired Pressure Ulcers
Risk Adjusted Mortality
Friends and Family Test
Moderate Harm Falls

Opportunity for improvement
Infection Control

Underperforming
N/A

Finance Indicators

High Performing
Income and Expenditure (subject to audit):
- In month - £3k behind plan
- YTD - £3k behind plan

Cash balance £41.8m equivalent to 104 days operating expenses
Capital:
- For the year £315k behind plan

Opportunity for improvement
BPPC (by value) – Target 95%:
- Non-NHS – 93.4%
- NHS – 79.8%
- Total – 91.6%

Conclusion

2. As listed above the majority of indicators are high performing either against a set target, local improvement or external benchmarking.

Recommendation

3. To note the compliance against key performance indicators and the assurance or mitigations in place

Author: Mark Foy – Head of Information & Business Intelligence
Date: 23/05/2022

The Walton Centre
NHS Foundation Trust

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Board KPI Report
June 2022

Data for April 2022 unless indicated

The Walton Centre NHS Foundation Trust

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Explanation of SPC Charts and Assurance Icons

SPC charts are widely used in this report int order to provide increased assurance, insight and an indication of future performance. However SPC charts are not relevant for every indicator. Where there are not enough data points, numbers too small or very unstable, or the indicator is to provide knowledge rather than show an improvement then an alternative visualisation will be used.

To maximise insight the charts will also include any targets and benchmarking where applicable.

All SPC charts will follow the below Key unless indicated

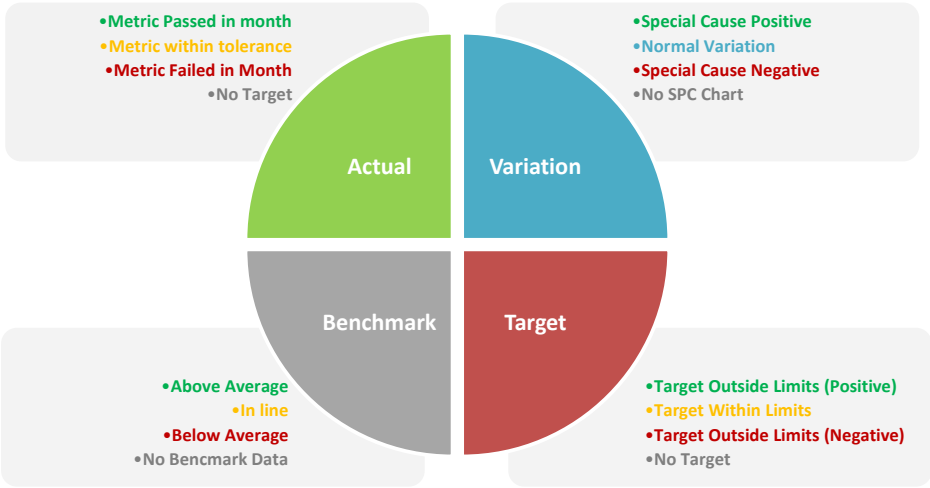
Actual — UCL — Average — LCL — National Average — Target

= Part of Single Oversight Framework

= Mandatory Key Performance Indicator

Assurance Icons (Colour Key)

All metrics now have an Assurance Icon consisting of 4 components. These give assurance on; in month performance against target, whether any SPC variation rules have been triggered, whether the target is achievable, and how the organisation compares to benchmarked data.



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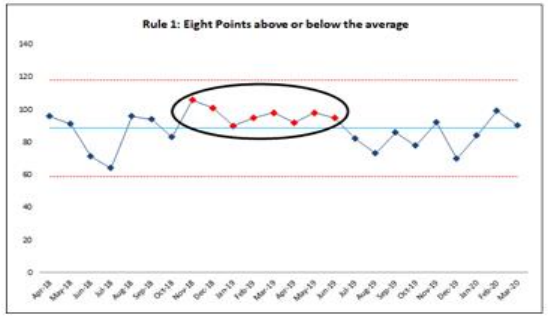
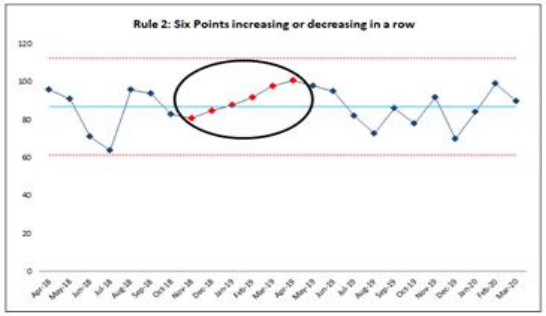
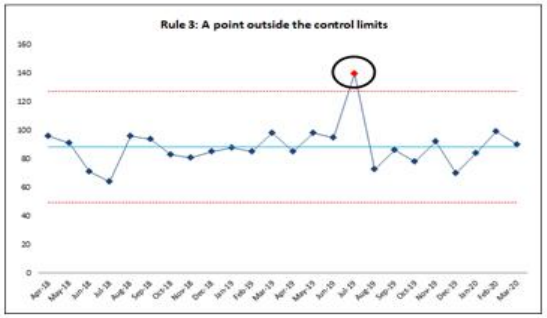
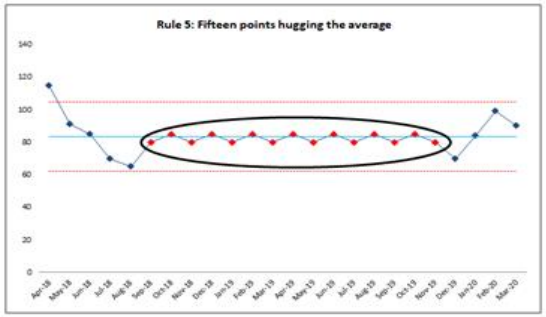
SPC Chart Rules

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).









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Operations & Performance Indicators

Operational

Responsive - Cancer Standards

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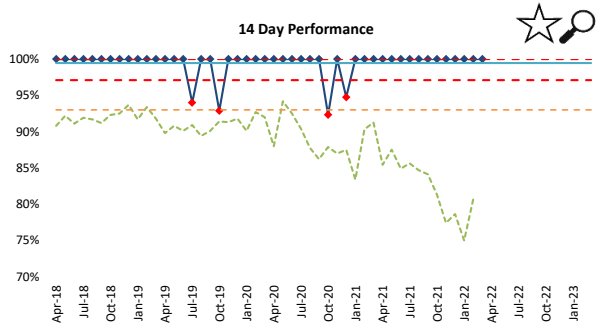
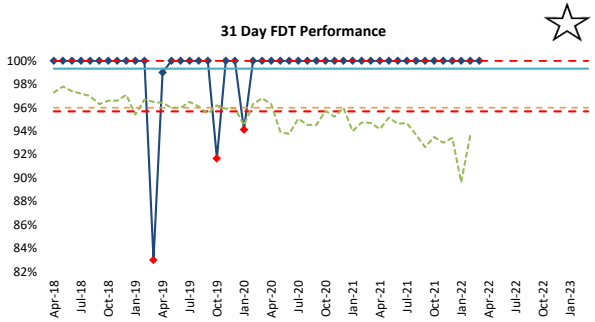
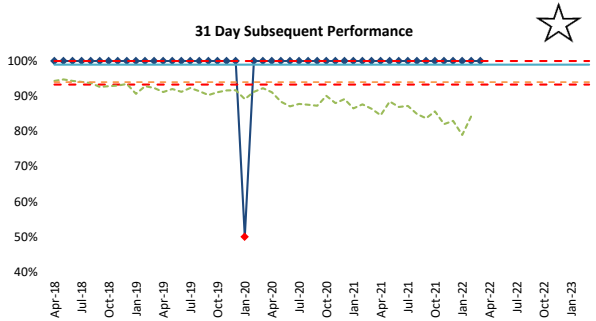
Responsive - Access Standards	Target	Actual	Assurance
Cancer TWW	93%	100%	
Cancer 31 Day FDT	96%	100%	
Cancer 31 Day Sub	94%	100%	
Cancer 62 Day Standard	85%	100%	
28 Day Faster Diagnosis Standard	70%	100%	

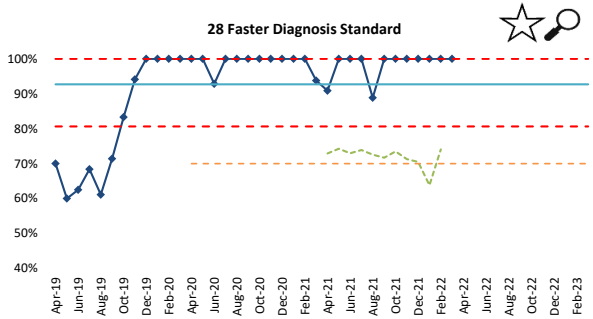
The Trust has continued to see and treat all cancer patients as these patients are designated as urgent, therefore COVID-19 has not impacted their care and treatment.

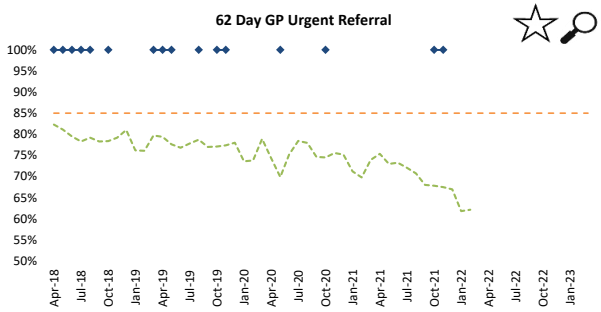
Associated Risks
001 - Covid-19
003 - Performance Standards

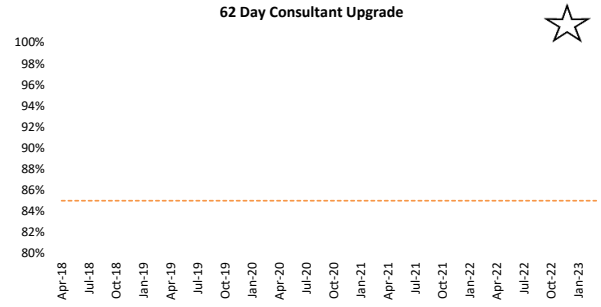












Operational

Responsive - Diagnostics

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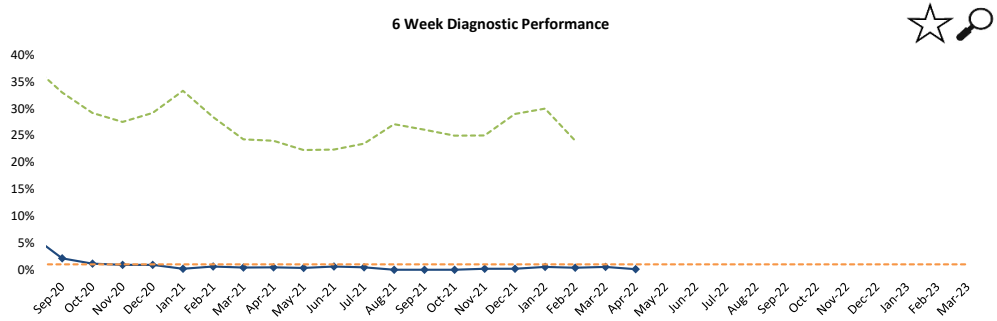
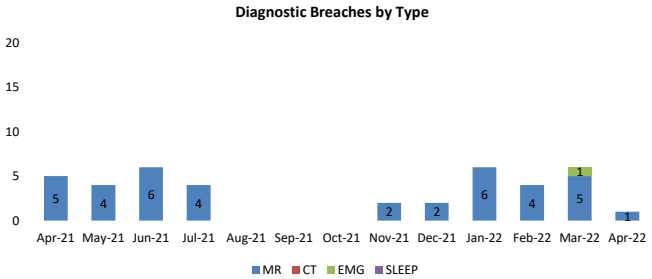
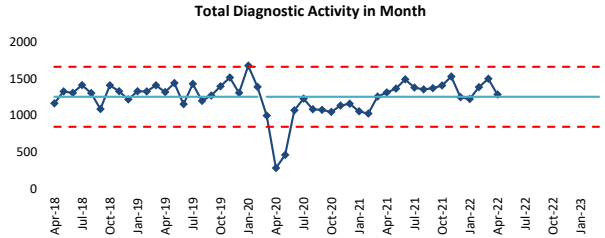
Responsive - Access Standards	Target	Actual	Assurance
Diagnostic 6 Week Performance	1%	0.10%	

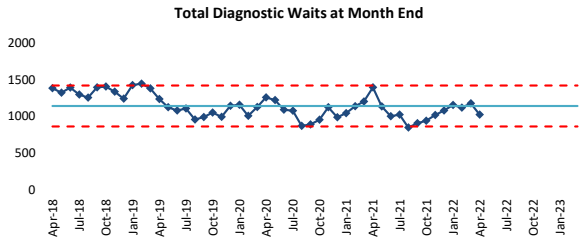
Associated Risks
001 - Covid-19
003 - Performance Standards

Achievement against the Diagnostic 6 week standard has been met in month. There was one 6 week breach in month.









Operational

Effective - Theatres

The Walton Centre NHS Foundation Trust

Excellence in Neuroscience

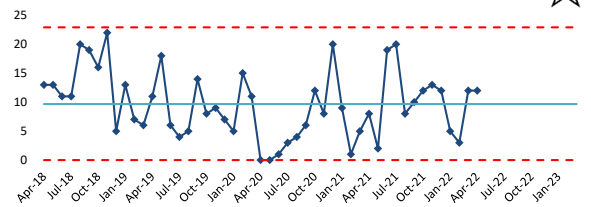
Effective - Theatres	Target	Actual	Assurance
No. Non Clinical Cancelled Operations	-	12	
% Cancelled operations non clinical on day	0.80%	1.16%	
28 Day Breaches in month	0	1	

Non Clinical Cancellations

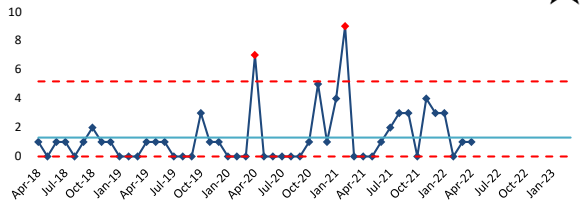
There were 12 patients cancelled at last minute for non-clinical reasons in April 2022, the reasons for the cancellations were replaced by more urgent case (3), Staff unavailable (4) and List overran (3) and no ITU Beds (2).

The Trust is in line with the national average for the % of non clinical cancelled operations based off latest published data .

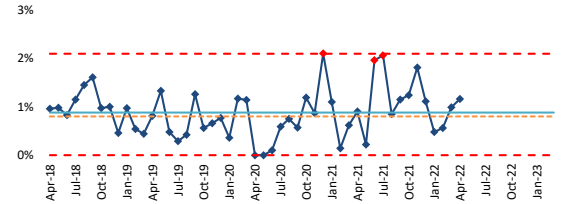
Number of Cancelled operations non clinical (on day)



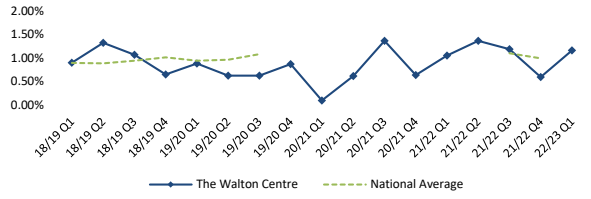
Number of cancelled operations not re-admitted within 28 days



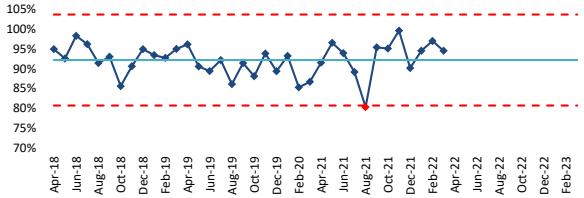
% of Cancelled operations non clinical (on day)



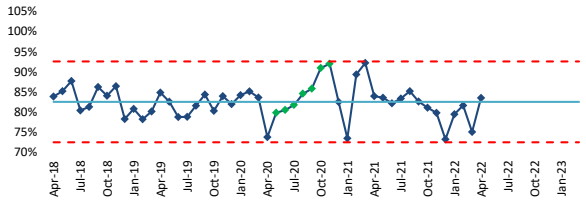
Non Clinical Cancelled Ops as a % of Elective Admissions



Theatre utilisation of Elective Sessions



Theatre utilisation of in Session Time



Operational

Effective - Activity Recovery Plan

The Walton Centre NHS Foundation Trust

Excellence in Neuroscience

April 22 Overall Activity Performance

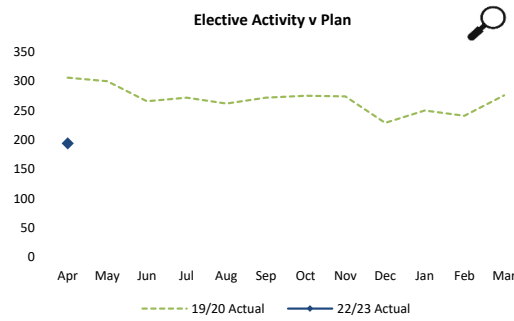
POD	Actual 22/23	Plan 22/23	Actual (% of 19/20)	Target (% of 19/20)
Daycase	847	826	112.8%	104%
Elective	194	318	63.4%	104%
Elective & Daycase Total	**1041**	**1144**	**98.5%**	**104%**
Non Elective	158	-	100.6%	-
New Outpatients	3190	4100	80.9%	104%
Follow Up Outpatients	7516	7467	100.7%	100%

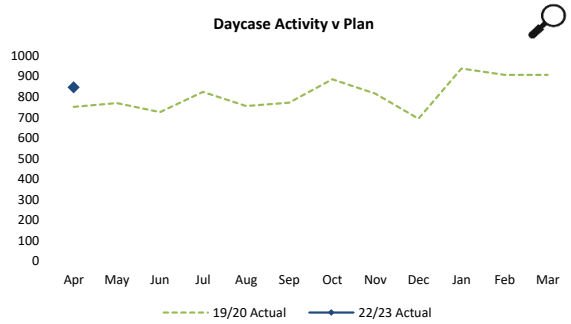
Operational planning for 2022/23 requires trusts to achieve 104% of new outpatient appointments compared to 2019/20 and an ambition for Trusts to deliver 110% of Elective and Daycase activity by March 2023. However ERF levels have been set to 104% of 2019/20.

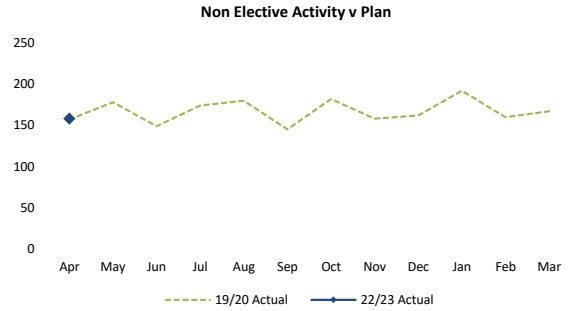
Trusts are also asked to achieve the ambition of reducing follow up outpatient appointments compared to 2019/20.

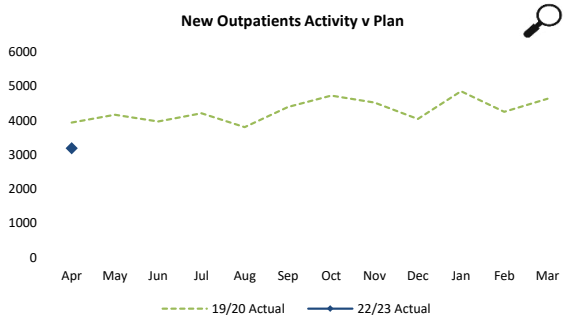
There is no target set against Non Elective activty.

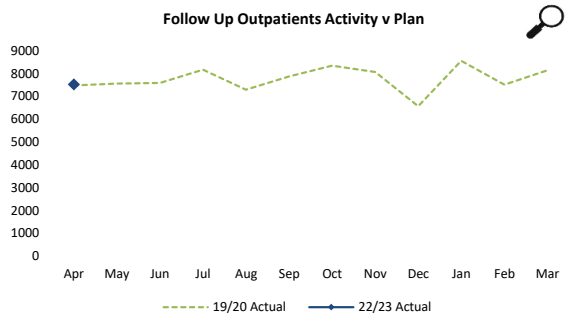
The information on this slide is for all Walton Centre patients.











Operational

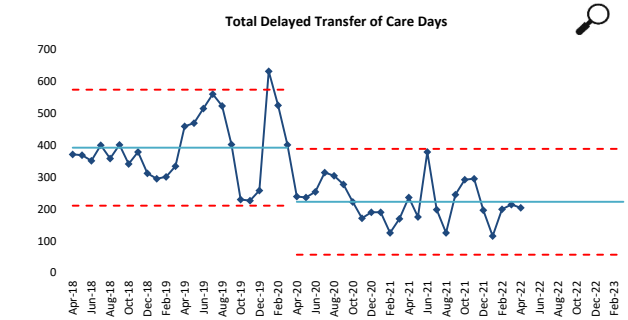
Effective - Flow

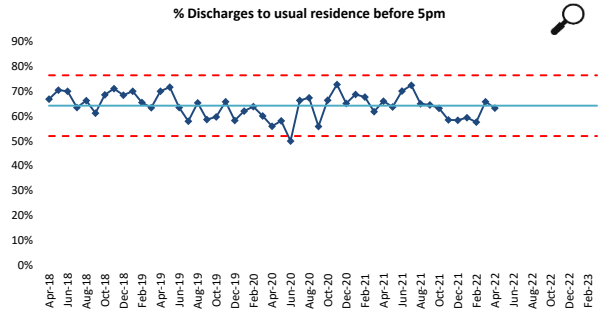
The Walton Centre NHS Foundation Trust

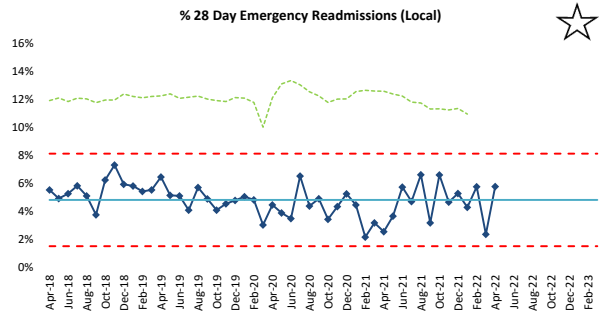
Excellence in Neuroscience

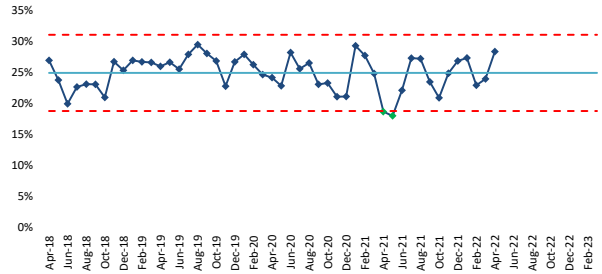
Effective - Flow	Target	Actual	Assurance
% 28 Day Emergency Readmissions (Local)	-	5.76%	
Total Delayed Discharge Days	-	204	
% Discharges by 5pm	-	63.24%	
% 14 Day Stranded Patients	-	28.35%	

All indicators are stable and within normal variation. These indicators form part of Patient Flow Transformation and are monitored through that workstream.









Operational

Effective - Outpatient Transformation

The Walton Centre NHS Foundation Trust

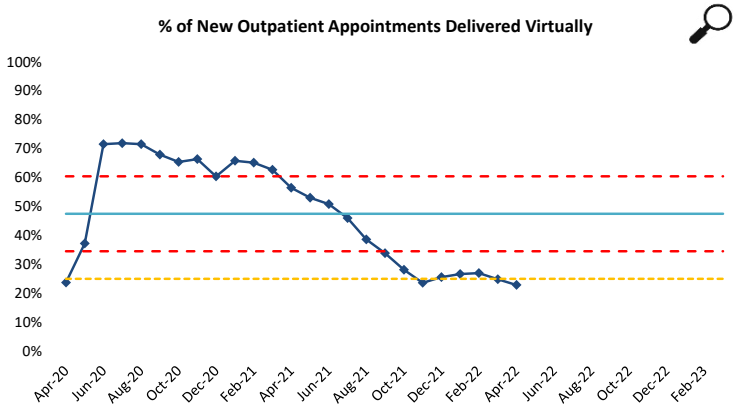
Excellence in Neuroscience

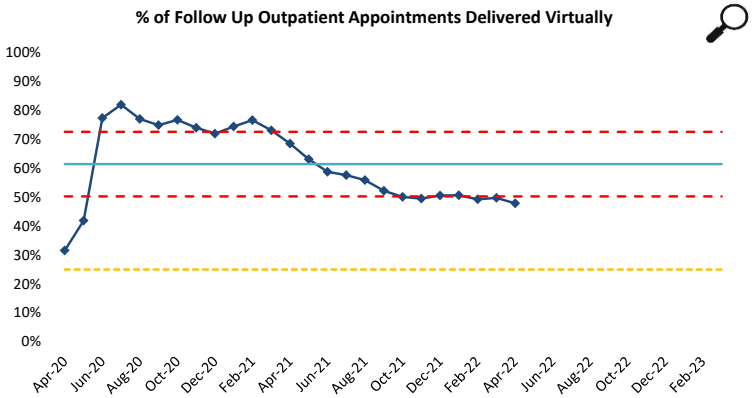
Virtual Appointments

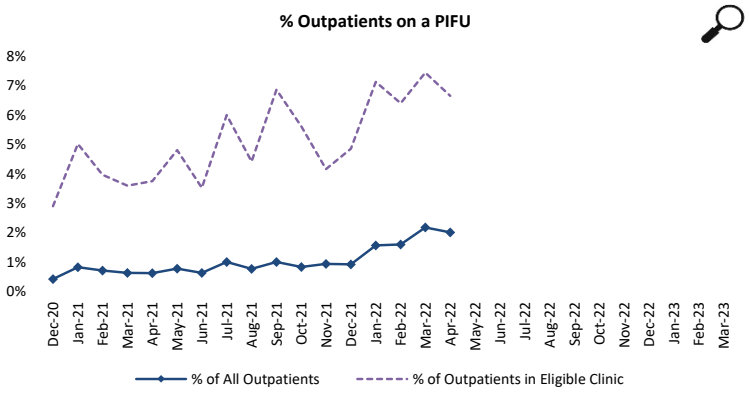
The Trust is required to deliver a minimum of 25% of its total outpatient appointments virtually. We are currently above this target. Following a switch to deliver mainly virtual appointments during Covid-19 the Trust is reverting appropriate clinics back to face to face where clinically necessary but is expected to remain above the target.

Patient Initiated Follow Up (PIFU)

As part of national Outpatient Transformation schemes the Trust the guidance is to work towards 5% of our total outpatients on a Patient Initiated Follow Up by March 2023. In April 22 2.01% of total outpatients were on a PIFU. Of the patients in eligible clinics the rate is 6.65%.







The Walton Centre
NHS Foundation Trust
Excellence in Neuroscience

Workforce Indicators

Workforce

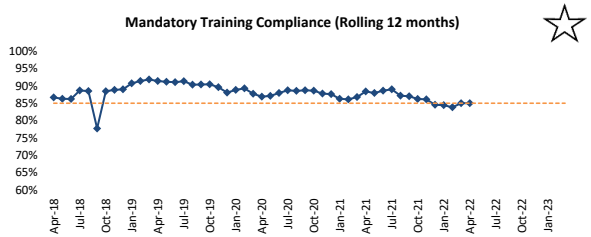
Well Led - Workforce KPIs

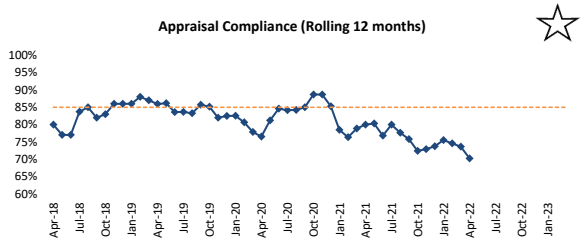
The Walton Centre NHS Foundation Trust
Excellence in Neuroscience

Well Led - Workforce	Target	Actual	Assurance
Appraisal Compliance	85%	70.24%	
Mandatory Training Compliance	85%	85.00%	

Appraisal Compliance

Training & Development have continued to send monthly reports to Department Heads and separately chase individual departments with low (below 85%) appraisal compliance. Whilst there is understanding of the impact staff sickness has on departments being able to complete mandatory training and appraisals, as a result of the continuous decline in appraisal compliance across the organisation, the Senior Education Manager is in the process od directly contacting all department heads with any out of date PDRs. Any department which does not respond will be escalated to the relevant Executive Director. Assuming appraisals are still below target at the end of May reporting period, a similar process will be followed in June where the Senior Education Manager will directly contact the Department Heads with any out of date appraisals, copying in the relevant Executive Director, and requesting a plan of how they will reach the Trust PDR target by the end of August.





Workforce

Well Led - Workforce KPIs

The Walton Centre NHS Foundation Trust
Excellence in Neuroscience

Well Led - Workforce	Target	Actual	Assurance
Sickness / Absence	4.75%	7.12%	
Trust Turnover	-	16.72%	
Nursing Turnover	10%	13.71%	
Other Staff Turnover	-	17.61%	

Sickness/Absence

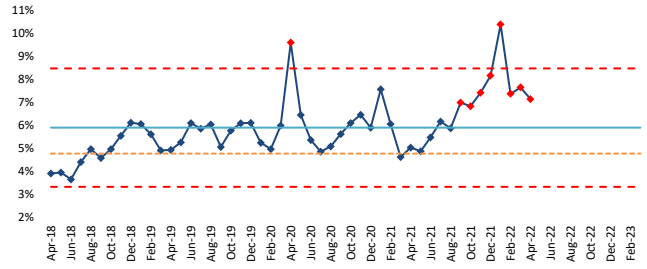
The Trust has seen a significant increase in Sickness/Absence levels which is above the 4.75% target.

Turnover

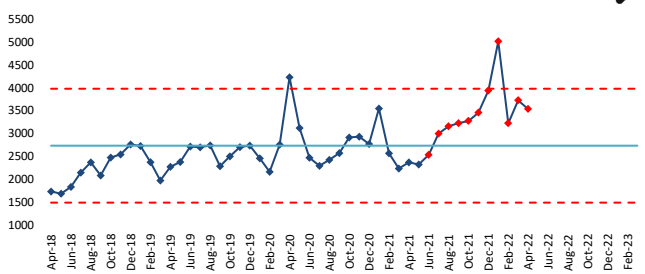
Overall Turnover for the Trust has significantly increased recently, largely driven by Corporate Services and Non Nursing Staff within Divisions.

Nursing Turnover has remained consistent despite a period of recruitment and internal progression.

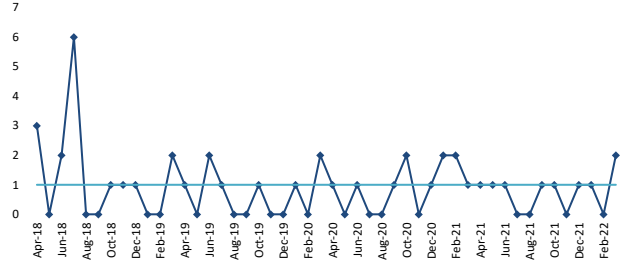
Sickness/Absence (Monthly)



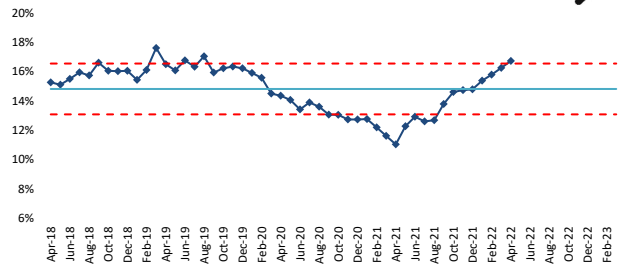
Lost Days due to Sickness/Absence (Monthly)



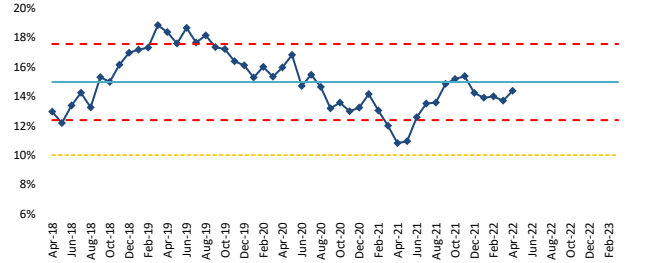
Medical Leavers



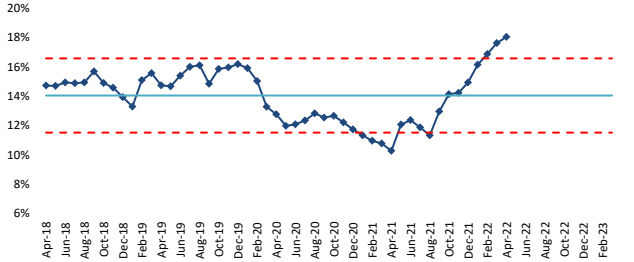
Trust Turnover (Rolling 12 months) - All Staff Groups



Nursing Turnover (Rolling 12 months)



Other Staff Turnover (Rolling 12 months)



The Walton Centre
NHS Foundation Trust
Excellence in Neuroscience

Quality Indicators

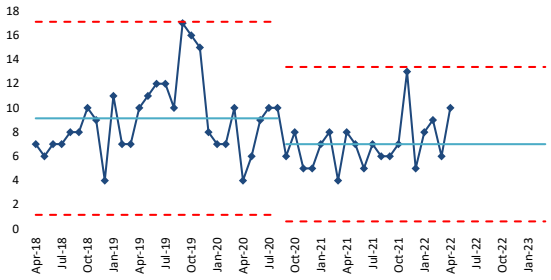
Quality of Care

Caring - Complaints

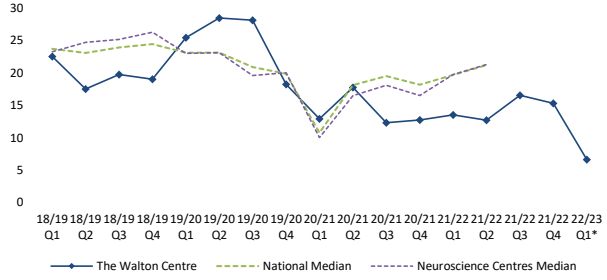
The Walton Centre NHS Foundation Trust

Excellence in Neuroscience

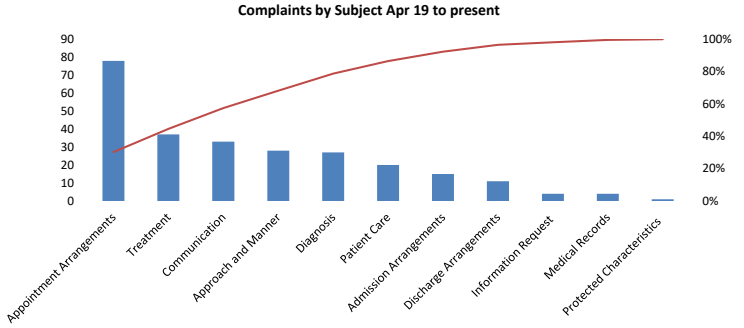
Total New Complaints Received in month



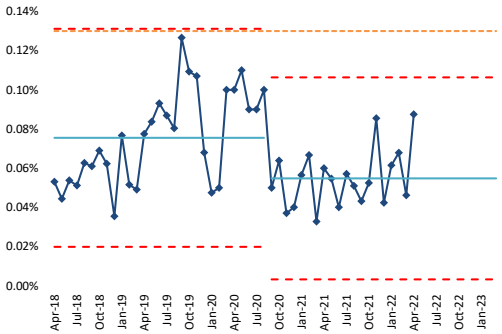
Quarterly Complaints per 1000 WTE



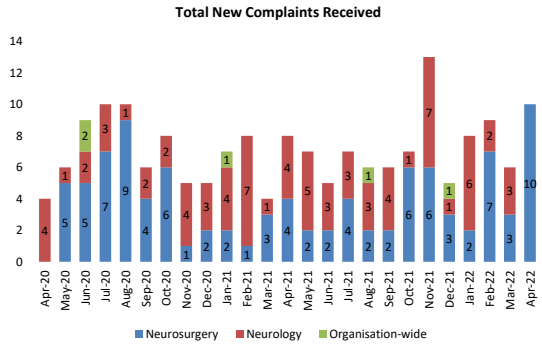
Complaints by Subject Apr 19 to present



% New Complaints Received against Activity



Total New Complaints Received



Complaints by Outcome

	Not Upheld	Partial Upheld	Upheld
19/20	53	41	20
20/21	41	21	5
21/22	42	19	10
22/23	-	-	-

In April 2022 the Trust received 10 new complaints and 5 reopened; 3 Neurology and 12 Surgery. Of the 15 complaints received; 4 related to admission or discharge arrangements and 8 related to treatment or care and 1 to Protected Characteristics

The number of complaints the Trust receives has a wide variation range meaning the expected numbers range from 0 to 13 at an average of 6 per month. The number of complaints received has significantly dropped during recent months.

Due to the reduction seen the Trust is now below the national average and neuroscience centres average up the latest published period of Q2 2021/22.

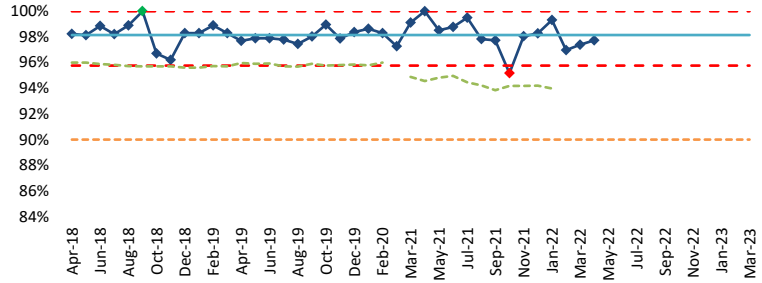
Quality of Care

Caring - Friends & Family Test

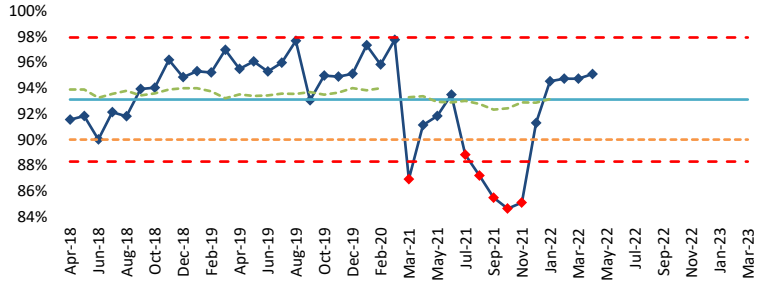
The Walton Centre NHS Foundation Trust

Excellence in Neuroscience

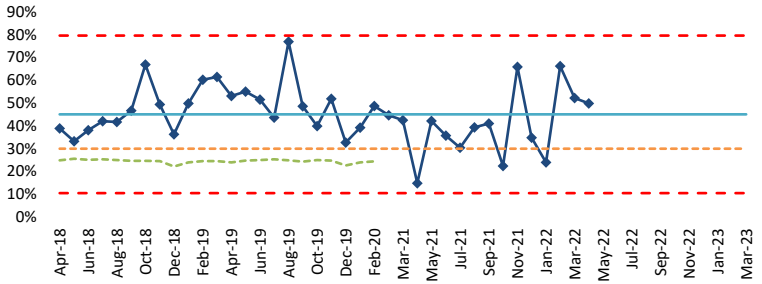
Inpatient FFT % Likely to Recommend



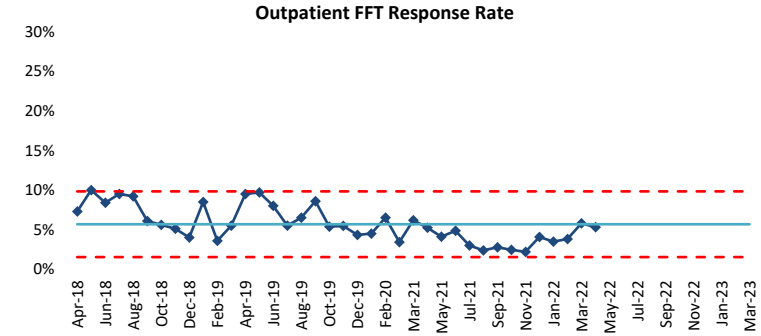
Outpatient FFT % Likely to Recommend



Inpatient FFT Response Rate



Outpatient FFT Response Rate



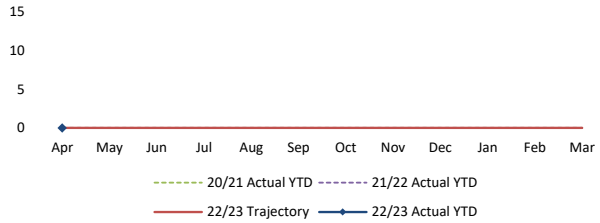
Quality of Care

Safe - Infection Control

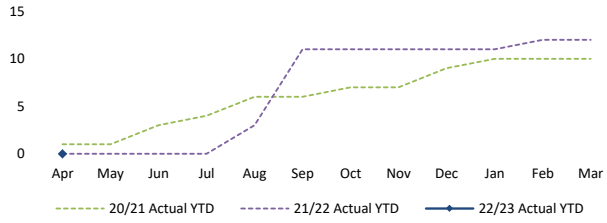
The Walton Centre NHS Foundation Trust

Excellence in Neuroscience

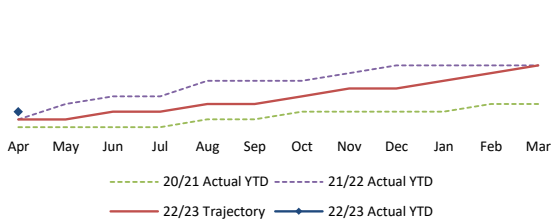
MRSA Bacteraemia



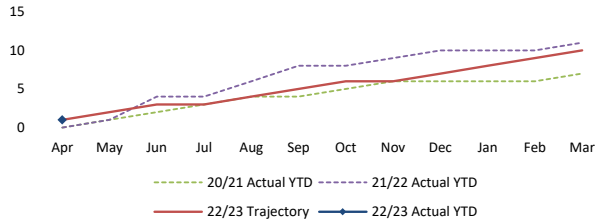
CPE



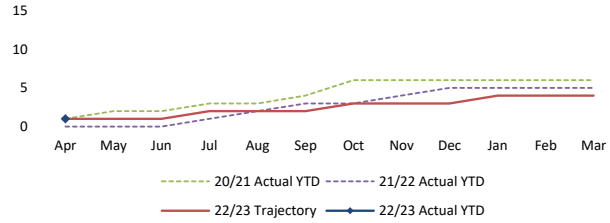
C.Diff



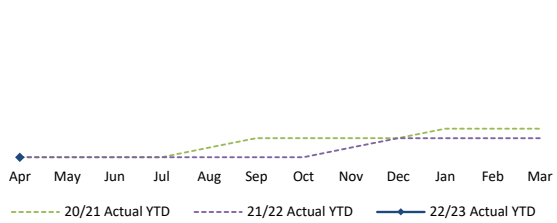
E.Coli



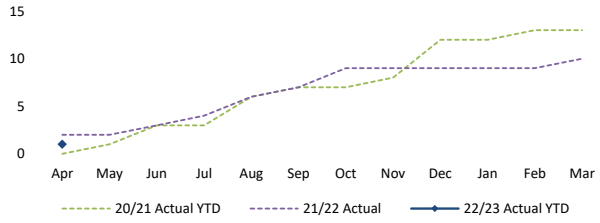
Klebsiella Bacteraemia



Pseudomonas Bacteraemia



MSSA



Total Healthcare Acquired Infections 2022/23

	MRSA B	CPE	C.Diff	E.Coli	KB	PB	MSSA	Total
Cairns								**0**
Caton								**0**
Chavasse								**0**
CRU			1		1			**2**
Dott				1				**1**
Horsley			1				1	**2**
Lipton								**0**
Sherrington								**0**
Total	**0**	**0**	**2**	**1**	**1**	**0**	**1**	**5**

April Breakdown by Ward

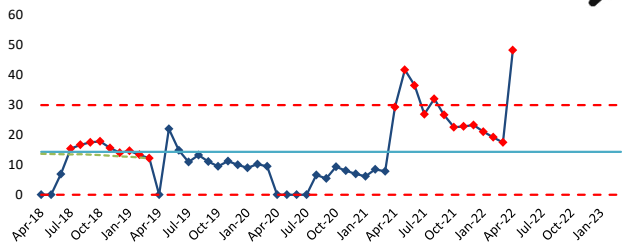
1x E.Coli - Dott
1x MSSA - Horsley
1x Klebsiella - CRU
2x C.Diff - Horsley, CRU

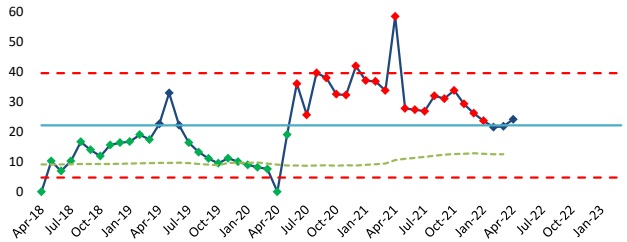
Quality of Care

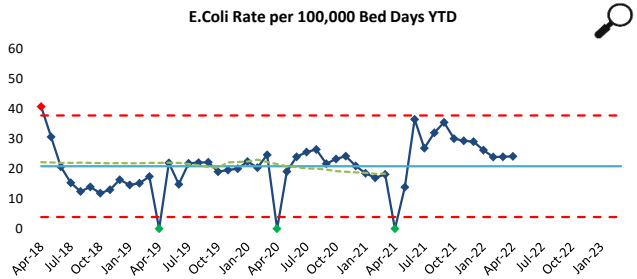
Safe - Infection Control

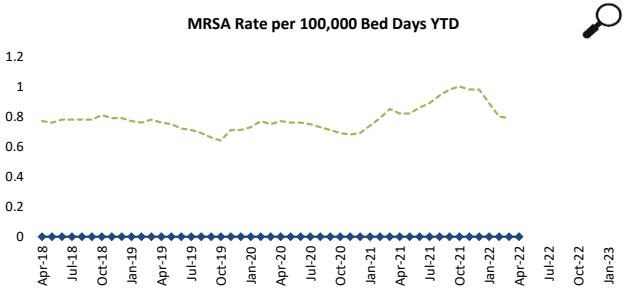
The Walton Centre NHS Foundation Trust

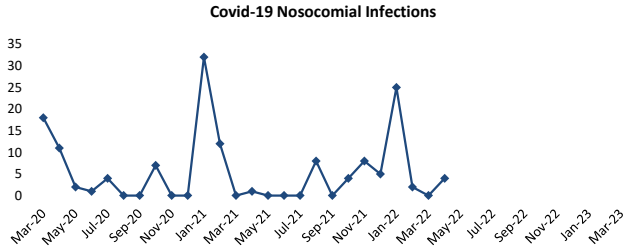
Excellence in Neuroscience

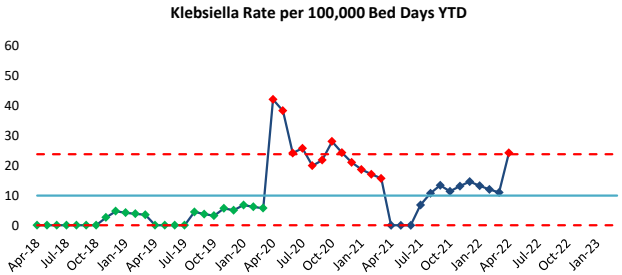












April 2022 saw an increase in the C.Diff rate per 100,000 beds at 48.34 from 2 confirmed cases in month.

There was 1 MSSA, 1 E.Coli and 1 Klebsiella in month . All at a rate of 24.17 per 100,000 bed days.

Reviews of each infection have taken place, we need to focus on clean trace for assurance re standards of cleaning across areas. Staff practices on CRU in relation to not taking equipment into individual rooms without it being cleaned, Hand Hygiene practices and catheter care. We need continued focus on IPC competencies ensuring they are all completed and up to date.

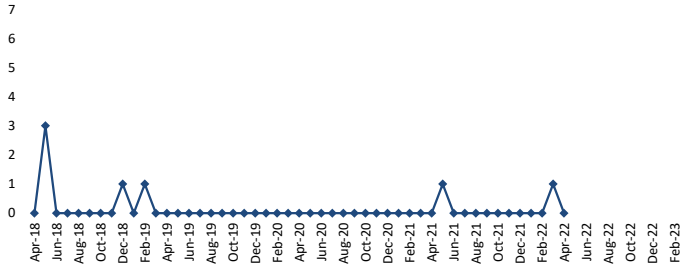
Quality of Care

Safe - Harm Free Care

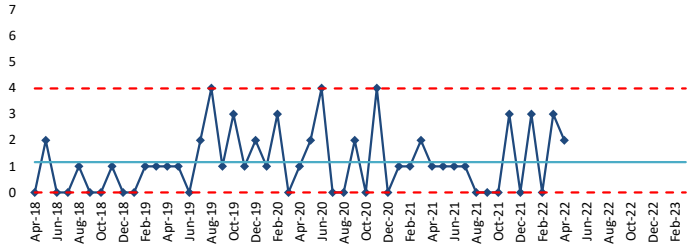
The Walton Centre NHS Foundation Trust

Excellence in Neuroscience

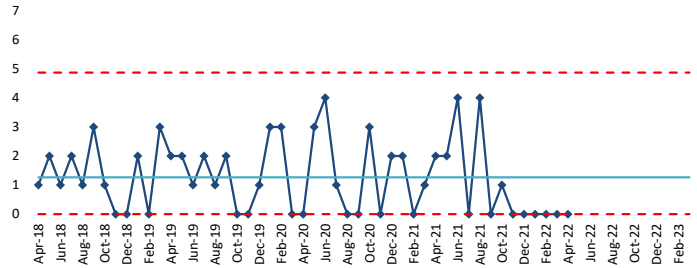
Total Moderate or Above Harm Inpatient Falls



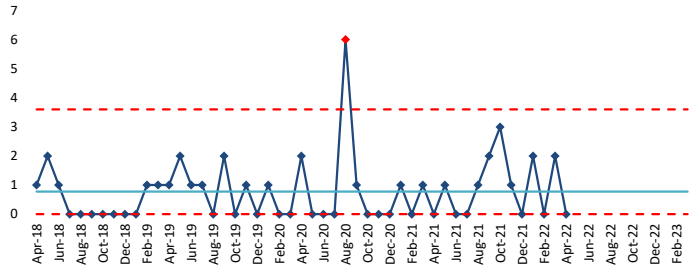
Total Hospital Acquired Pressure Ulcers (Category 2, 3, 4, Unstageable & Mucosal)



CAUTI Incidences



VTE Incidences



Falls
There were zero falls which resulted in moderate or above harm in month.

Pressure Ulcers
There were two Hospital Acquired Pressure Ulcers in month

CAUTI
There were zero CAUTI incidence in month

VTE
There were zero VTE incidences in month

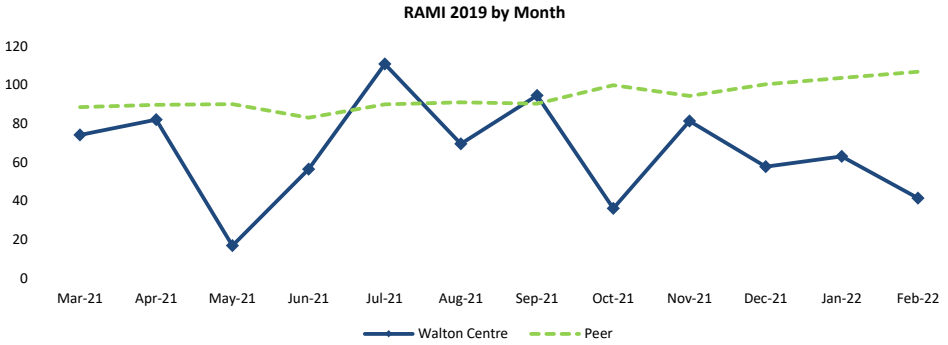
All harm measures are within normal variation.

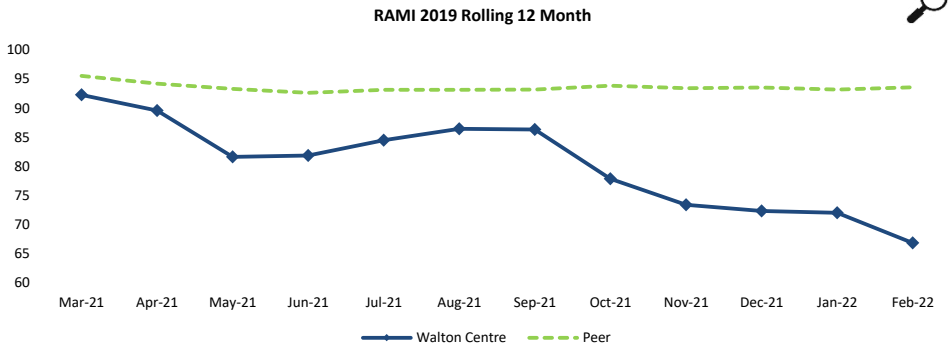
Quality of Care

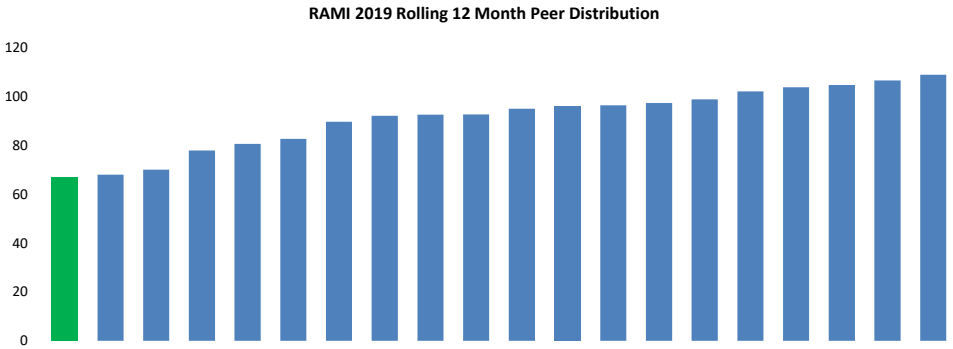
Safe - Mortality

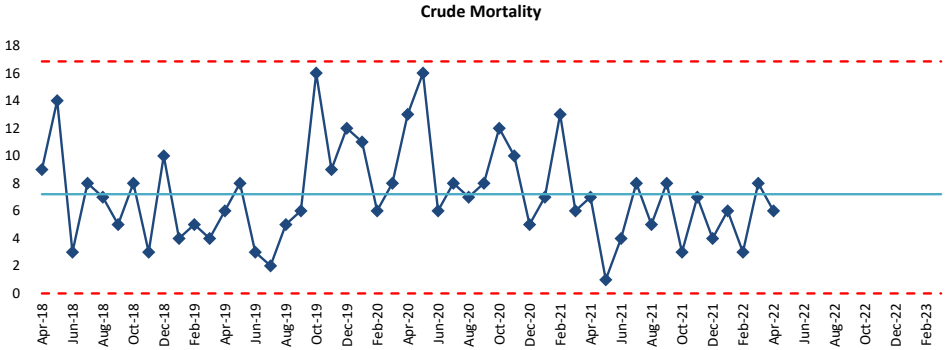
The Walton Centre NHS Foundation Trust

Excellence in Neuroscience









As at February 2022 the rolling 12 month RAMI19 figure is 66.78. During the period there were a total of 58 observed deaths against 87 expected deaths. Compared to peers The Walton Centre has performed significantly better during the period.

RAMI19 excludes deaths following a positive covid-19 result. During the rolling 12 month period there have been 11 deaths following a positive covid-19 result. In the most recent two months there has been zero.

Crude mortality is within normal variation

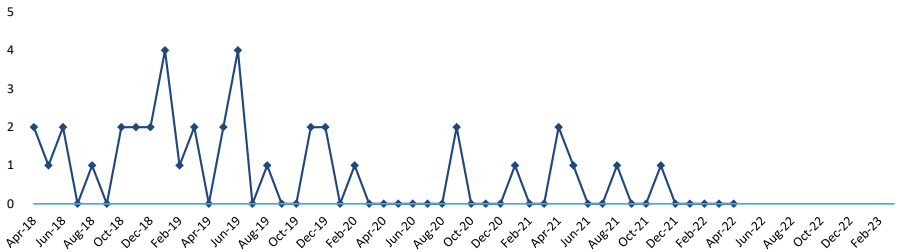
Quality of Care

Safe - Governance

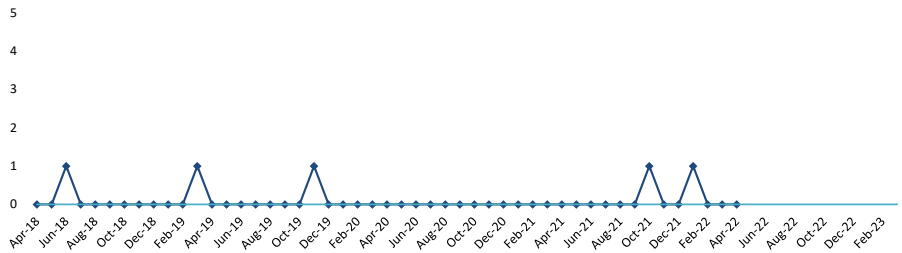
The Walton Centre NHS Foundation Trust

Excellence in Neuroscience

Total SUIs Reported



Total Never Events Reported



WELL LED

Finance

Trust I&E	In month			Full Year
	Plan £'000	Actual £'000	Variance £'000	Draft Plan £'000
Patient Care Income	10,729	10,107	(622)	128,625
Exclusions	2,430	2,163	(267)	29,160
Private Patients	3	8	5	38
Other Operating Income	643	395	(248)	7,728
Total Operating Income	**13,805**	**12,673**	**(1,132)**	**165,551**
Pay	(7,138)	(6,825)	313	(84,722)
Non-Pay	(3,383)	(2,810)	573	(47,202)
Exclusions	(2,524)	(2,202)	322	(23,988)
Total Operating Expenditure	**(13,045)**	**(11,837)**	**1,208**	**(155,912)**
EBITDA	**760**	**836**	**76**	**9,639**
Depreciation	(525)	(581)	(56)	(6,300)
Profit / Loss On Disp Of Asset	0	(15)	(15)	0
Interest Receivable	0	19	19	0
Financing Costs	(49)	(65)	(16)	(583)
Dividends on PDC	(137)	(163)	(26)	(1,639)
I & E Surplus / (Deficit)	**49**	**31**	**(18)**	**1,117**
I&E impact capital donations and profit/(loss) on asset disposals	**22**	**37**	**15**	**264**
I & E Surplus / (Deficit)	**71**	**68**	**(3)**	**1,381**

The financial regime remains based on block funding for the full financial year and anticipated spend for the same period (based on average spend in H2 of 2021/22 x2). **The current plan for 2022/23 is a £1.381m surplus position** (submitted to Integrated Care System (ICS) and NHS England and Improvement (NHSE/I) in April as part of the 2022/23 planning process).

The current plan includes:

- Elective Recovery Fund (ERF) income and costs for the delivery of activity above the national trajectory targets.
- 'Block' system funding received for Top-up, COVID related costs and growth.
- Recurrent efficiency requirement of at least 3.0% of operating expenses.

It is a requirement that the ICS delivers a balanced financial plan for the financial year. At the present time the ICS financial plan for 22/23 is a deficit position which is not being recognised by NHSE/I. This means that further work is required by all organisations to help improve the financial position and may result in a change to the current 22/23 plan. A further planning submission in June to both the ICS and NHSE/I.

In month 1, the Trust reported a £68k surplus position. This is a £3k adverse variance against the planned in month position of a £71k surplus. The performance in month is primarily driven by an under-performance against elective recovery funding of £339k, under-performance against elective baselines of £281k and an under-performance against employee benefits income £250k due to the delayed transfer of Healthcare Procurement Liverpool staffing (offset in reduced expenditure). This has been offset by savings within non pay due to an underspend against plan on clinical supplies due to a delay in the spinal transfer from Liverpool University Teaching hospital and lower than planned levels of activity.

STATEMENT OF FINANCIAL POSITION - 2022/23	April-22 Plan	April-22 Actual	Variance
	£'000	£'000	£'000
Intangible Assets	732	1,004	272
Tangible Assets	94,737	94,649	(88)
Receivables	428	434	6
TOTAL NON CURRENT ASSETS	**95,897**	**96,087**	**190**
Inventories	1,841	1,690	(151)
Receivables	6,315	4,247	(2,068)
Cash at bank and in hand	37,583	41,829	4,246
TOTAL CURRENT ASSETS	**45,739**	**47,766**	**2,027**
Payables	(29,014)	(31,444)	(2,430)
Borrowings	(1,677)	(1,683)	(6)
Provisions	(55)	(66)	(11)
TOTAL CURRENT LIABILITIES	**(30,746)**	**(33,193)**	**(2,447)**
	0	**0**	**0**
TOTAL ASSETS LESS CURRENT LIABILITIES	**110,890**	**110,660**	**(230)**
Borrowings	(22,281)	(22,273)	8
Provisions	(707)	(692)	15
TOTAL ASSETS EMPLOYED	**87,902**	**87,695**	**(207)**
Public Dividend Capital	34,839	34,617	(222)
Revaluation Reserve	7,377	7,377	0
Income and Expenditure Reserve	45,686	45,701	15
TOTAL TAXPAYERS EQUITY AND RESERVES	**87,902**	**87,695**	**(207)**

STATEMENT OF CASH FLOW - 2022/23	April-22 Plan	April-22 Actual	Variance
	£'000	£'000	£'000
Cash flows from operating activities			
Operating surplus/(deficit)	**235**	**255**	**20**
Non-cash income and expense:	525	596	71
Working Capital	0	2,005	2,005
Net cash generated from/(used in) operations	**760**	**2,856**	**2,096**
Cash flows from investing activities	(2,467)	(1,739)	728
Cash flows from financing activities	217	(11)	(228)
Increase/(decrease) in cash and cash equivalents	**(1,490)**	**1,106**	**2,596**
OPENING CASH	**39,072**	**40,723**	**1,651**
CLOSING CASH	**37,582**	**41,829**	**4,247**

Capital

In month variance - £315k below plan.

Annual capital funding is now set at an ICS level (rather than using a nationally determined formula). For 2022/23 allocated capital funding is £4.4m.

The plan reflects the final submission to Cheshire and Merseyside HCP as part of the planning process.

The Trust has received an allocation of external funding in relation to Digital Aspirant for IM&T innovation of £2.7m.

CAPITAL - Subject to prioritisation

	In month			Forecast
	Plan £'000	Actual £'000	Var £'000	Plan £'000
Division				
Heating & Pipework	100	0	100	1,200
Estates	69	0	69	836
IM&T	0	0	0	0
Neurology	0	0	0	0
Neurosurgery	0	0	0	2,354
Corporate	0	0	0	0
TOTAL (excl. external funding)	**169**	**0**	**169**	**4,390**
Donated Assets	0	0	0	0
Digital Aspirant	222	76	146	2,675
TOTAL (incl. external funding)	**222**	**76**	**146**	**2,675**
TOTAL	**391**	**76**	**315**	**7,065**

Capital spend in month is £76k.

- **Digital Aspirant (PDC funded):** £76k.

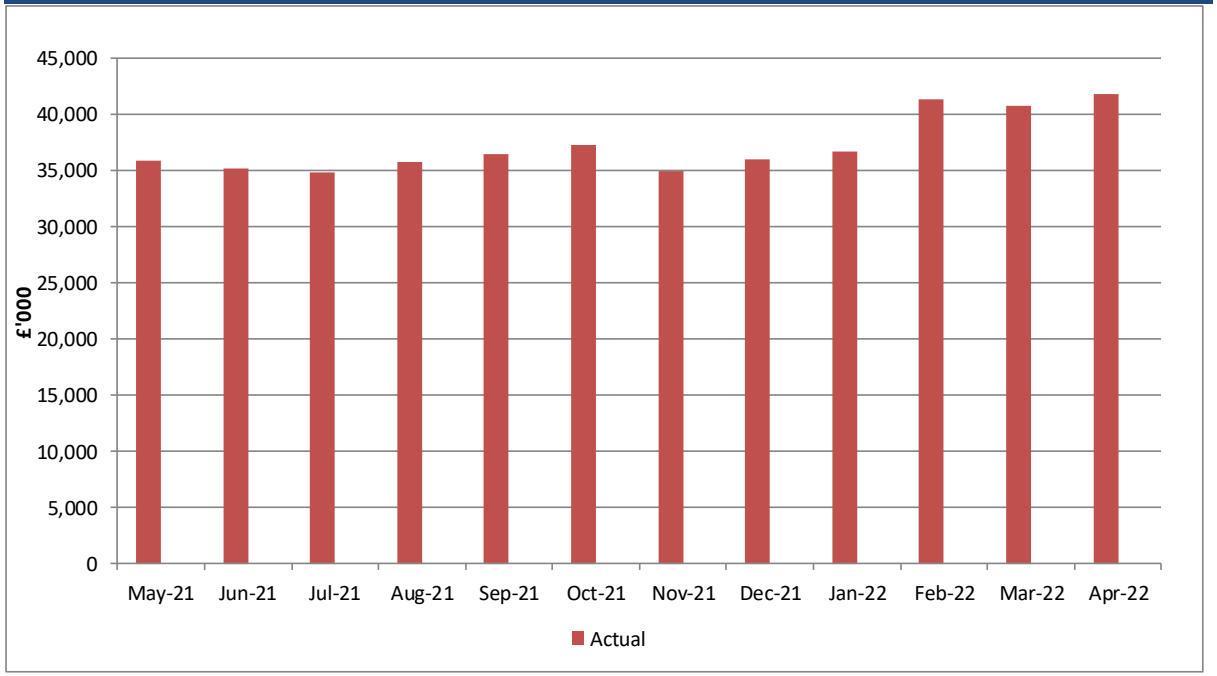
Work is currently being undertaken with clinical and operational staff to prioritise the capital spend for 22/23 to ensure that it is delivered in line with agreed funding levels.

As of the end of April:

Actual Cash Balance: £41.8m.

Number of days operating expenses = 104 days.

Cashflow (Rolling 12 months)



The Trust cash balance at the end of April was £41.8m, £4.2m ahead of the trusts plan of £37.6m.

This increase compared plan, is due to:

- Higher than planned opening cash balance due to the timing of capital PDC at the end of 2021/22 with the payment of invoices in 2022/23.
- Lower than planned capital payments.
- An increase in Trade Creditors and decrease in trade receivables against plan.

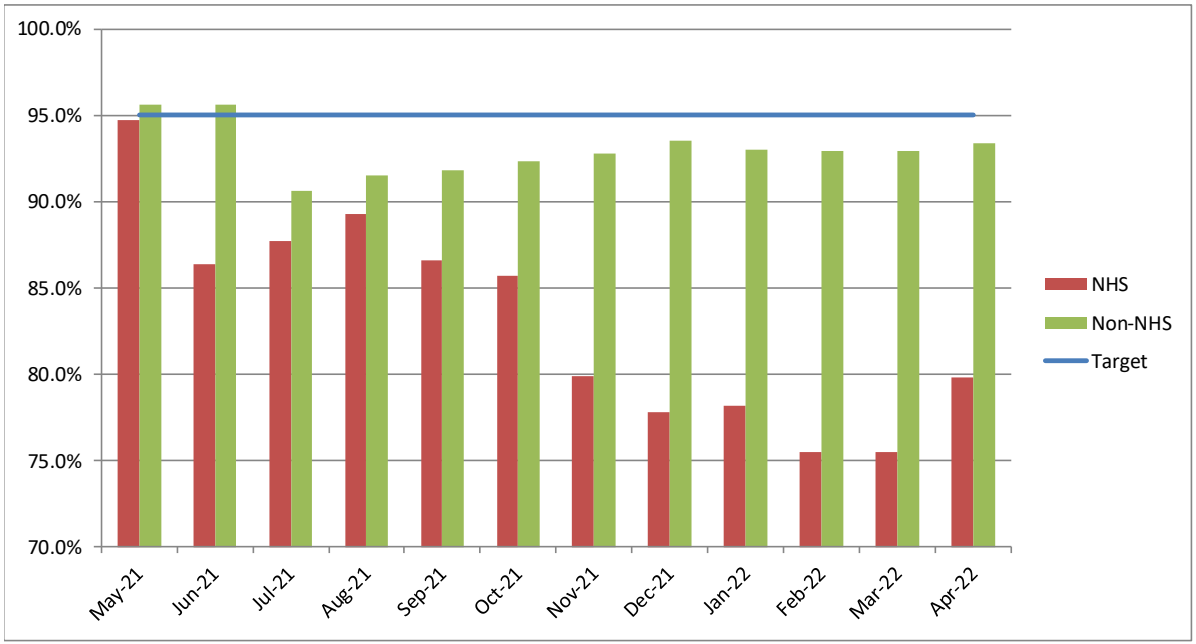
Better Payments Practice Code (BPPC):

There is an increased focus by NHSE/I performance against the better payments practice code standard of settling at least 95% of invoices within 30 days.

The Regional NHSEI team have contacted the CFO about BPPC as the performance has been below the national 95% target for a number of months. They will be closely monitoring the Trusts performance over coming months.

The Deputy Chief Finance Officer is in the process of developing an action plan to improve BPPC performance.

Cumulative BPPC by value of invoices



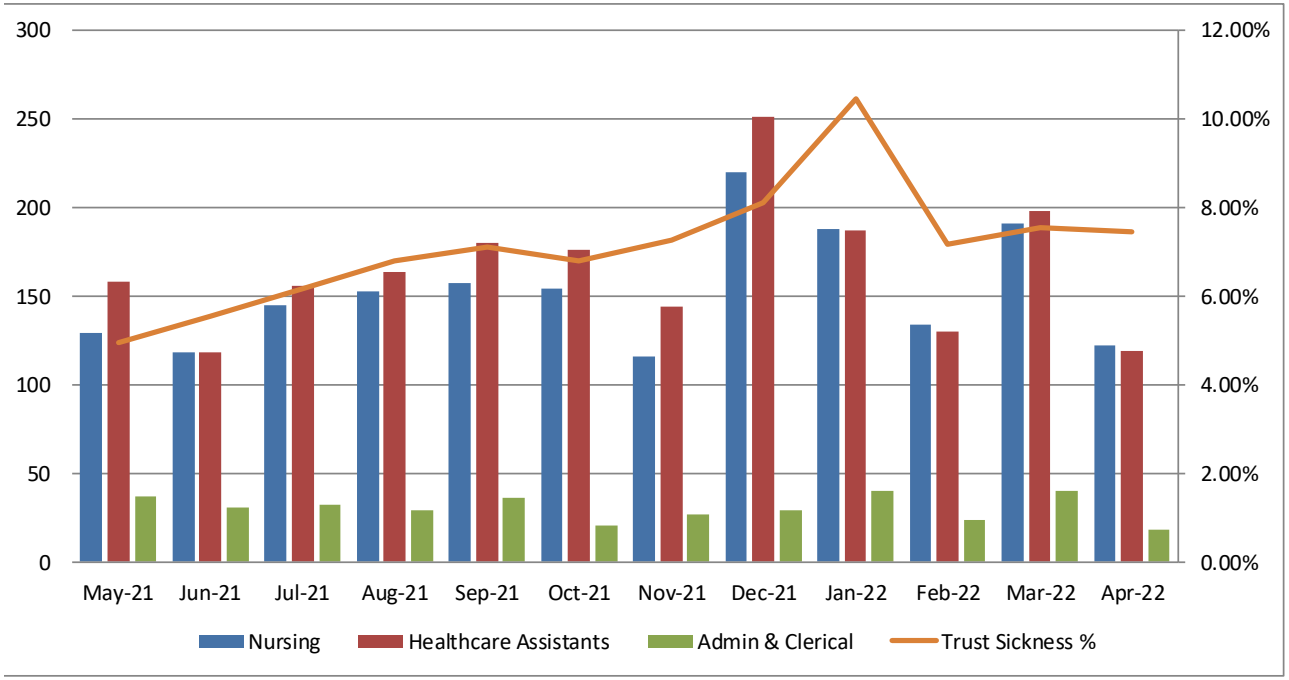
The Trust BPPC percentage (by value) at the end of April against the target of 95.0% was:

- Non-NHS 93.4%.
- NHS 79.8%.
- Total 91.6%.

This has seen Non-NHS payments improve by 0.5% and NHS payments improve by 4.3%, an overall improvement of 5.2% since the end of March.

The Trust BPPC percentage (by number of invoices paid) at the end of April is 90.4%.

The low % of NHS invoices paid is due to queries being resolved which have already passed the 30-day payment period. This is as the Financial Services team focus on resolving aged payables outstanding on the system.

Bank Expenditure: In month Actual: £263k.	**Monthly Bank Expenditure by Category and Trust Sickness (Rolling 12 months)**  	Bank expenditure incurred in April was £263k, a decrease of £170k when compared to March. Work remains ongoing to reduce the level of bank spend utilising the e-rostering system. The trusts overall sickness rate decreased from 7.54% to 7.45% in April.

Key Risks and Actions in 2022/23

- ERF Income:
    - Level of income calculated- whether this will materialise at these values
    - Achievement of activity targets to receive ERF-there is a risk that the Trust might not be able to deliver the required level of activity meaning that ERF funding allocated will be clawed back by commissioners making it difficult to reach a break-even position.
- Plan delivery – assumptions based on workforce availability and a level of productivity to deliver in 22/23, if this is not possible, the trust will struggle to achieve the activity levels required.
- Delivery of CIP-The 22/23 efficiency requirement of the Trust has currently been set at £4,947k, with £3,500k required to be delivered recurrently. Further work is being undertaken to identify schemes to cover this value, and monthly updates will be provided on the progress of CIP identification and delivery
- Transfer of new services to WCFT – The costing and associated income of services such as the Spinal Transfer has been based upon the latest information available, but this could be different to how it materialises.
- Utility costs – climbing price of energy means that although a 10% increase has already been factored in, the worldwide environment could push prices higher still.
- Inflation – since planning assumptions published, inflation has increased well above the levels assumed. This is being reviewed at a regional and national level.
- Block income and exclusions – As these are funded through a combination of block and cost and volume, it means that increased costs will not always be matched by income.
- Still awaiting the outcome of funding of some NICE approved devices-uncertainty whether funding will be available for these.
- ICS partners performance – if other Trusts fail to hit their financial target, this may put pressure on those that can deliver to improve positions to help contribute towards the total system position.
- Capital – reduced level of capital allocation in 22/23 which means trust will have to ration to key priorities.
- Outpatient Follow Up targets – if reductions cannot be made in line with funding, this is a pressure as costs will not be covered above 85% delivery.

Board of Directors Key Issues Report

The Walton Centre NHS Foundation Trust

Report Date: 26/5/2022		**Report of:** Business Performance Committee
Date of last meeting: 24/5/2022		**Membership Numbers:** Quorate
1	**Agenda**	The Committee considered an agenda which included the following: • Integrated Performance Report April 2022 • Capital Programme 2022-23 • Estates & Facilities Annual Report Follow-Up • People Pulse Survey Report • Digital Aspirant NHSX Monthly Update • Resilience Planning Group – Terms of Reference • Digital Aspirant Funding x 3 staffing resource business cases • Consent Agenda – Feedback from incident at LWH • Sub-committee Chair's Reports for 5 sub-committee meetings
2	**Alert**	None
3	**Assurance**	Integrated Performance Report • Activity performance for cancer, diagnostics and the trajectory for reducing long waits all met plan in April. • Activity restoration met target for day cases but was behind target for elective and new outpatients, largely caused by staff sickness. It is believed that most regional trusts struggled similarly. The Trust did not meet its Elective Recovery Fund financial target for M1 due to the weighting in the ERF calculation given to elective work which the Trust did not achieve. This was primarily due to Covid related staff sickness in theatres and the Trust has the opportunity to recover this by the end of Q1 and still achieve the ERF. • Sickness remained high at over 7% in April, although was starting to fall during May. • Staff appraisal recorded completion rate remains well below the minimum target; progress from the current leadership focus on this will be reviewed next month. • Nursing turnover has stabilised at around 14% (broadly the long-term average) but corporate / administrative turnover has continued to rise since last summer, now 18%. • I&E was in line with plan. Loss of income from ERF and under performance due to lower activity was mitigated through reduced costs from activity and planned phasing of costs. Income and expenditure were also both impacted by the delay of transferring some of the Health Procurement Liverpool staff and the transfer of the spinal activity from LUHFT.

		• On-time payment to creditors remains below the targets of the Better Payments Practice Code, but this has started to improve and there is an action plan in place.		
4.	**Advise**	• The content of April's quarterly People Pulse Survey was reviewed in depth and received enthusiastically. There were 236 participants which was still low, but more than double the previous highest response and enough to provide meaningful insights, together with some benchmarking comparisons, and some valuable narrative comments on feelings and feedback to leadership. The insights and issues highlighted will be explored further in forthcoming staff engagement sessions and taken into the People action plan. This promises to become a valuable 'low maintenance' quarterly feedback tool from which leading indicators can be derived and action taken much quicker than from the annual full People Survey. • The capital budget allocated by the ICS is currently £4.4m, versus an internal demand of £6.4m (which has already been reduced by challenge and rephasing). A bid has been made for a second tranche of budget allocation, the outcome of which is expected soon. • A review of how the Trust's estate compares against national assessment methodologies and benchmarks (integrating insights from the Premises Assurance Model, 6-Facet Survey, Estates Return Information Collection (ERIC) and Model Hospital) has been requested for a meeting in the autumn. • Three business cases to continue to resource the Digital Aspirant project implementation were approved. • Some learning from the incident at Liverpool Women's Hospital in November 2021 relating to improving resilience was noted.		
5.	**Risks Identified**	• None		
6.	**Report Compiled**	David Topliffe, Non-Executive Director	Minutes available from:	Corporate Secretary

Board of Directors' Key Issues Report

The Walton Centre NHS Foundation Trust

Report Date: 09/06/22		**Report of:** **Quality Committee**
Date of last meeting: 19/05/22		**Membership Numbers:15** **Quorate**
1.	**Agenda**	The Committee considered an agenda which included the following: • Patient Story • Quality or Risks for escalation to Quality Committee • Integrated Performance Report/Divisional KPI Reports • Governance, Risk and Patient Experience Annual Report • Mortality & Morbidity Q4 report • Safeguarding Annual Report • Quality Accounts – Full Final Draft • PLACE - Lite Report & Action Plan • Infection, Prevention & Control Q4 & Annual Report • External Visits Regarding Quality • CQC – Bi-Monthly Report • Quality Committee Cycle of Business • Sub-Committee Key Issues Reports to Quality Committee
2.	**Alert**	**Quality or Risks for Escalation to Quality** • There is a national shortage of Omnipaque Contrast and supplies are not expected until June. This is the only licensed drug and there is no alternative. The Divisional Team is conducting a risk analysis. Currently there is approximately 3 weeks supply in stock. Patients will not be advised until risk analysis has been completed. **Integrated Performance Report – Bed Repurposing** • It was noted that bed repurposing is going well with little or no disruption or disturbance to patients. However, patient capacity on Lipton Ward is currently 9 patients as opposed to 10 patients as work is on-going to make an area more functional for patients. The issue has been escalated to the Rehab Network. Should demand for the 10th bed be required, this can be accommodated Following the QC meeting it was confirmed that the ward now has returned to the full ten-bed capacity **CQC Insight Report** • Key message in the report indicated Safe performance as declining. This was attributed to two Never Events and outstanding CAS alerts (Central Alerting System) for which updates were provided to CQC at the last engagement meeting in April. Safe performance status is expected to improve in the next quarter

	Assurance	**Risk, Governance & Patient Experience Annual Report** • MiAA awarded highest assurance in relation to the Trust complaints process and 100% of Trust KPI for acknowledging and responding to complaints achieved in 2021/22 • Specialised Commissioners deemed the Botox incident to be a Never Event • Substantial progress has been made to reduce the number of outstanding incidents with all serious incidents and historical incidents being closed • Individual annual reports for Risk & Governance and for Patient Experience will be submitted for 2022-23 **Mortality & Morbidity Q4 Report** • The report noted a reduction in the number of deaths in the past 12 months • Mortality reporting progressing well with the new process. Delays are currently with the Coroner are from Oct due to Covid-19. However, contact with patients affected by such delays, is maintained by Patient Experience Team • Mortality Compliance stands at 90% with 7 outstanding for this quarter • Positive feedback has been received from families and staff via the Medical Examiner **Safeguarding Annual Report** • Partial Assurance was noted due to changes to the Inter-Collegiate document impacting negatively on Safeguarding Training KPI compliance. Increased training is now required. A training action plan has been implemented. The CCG are aware and are satisfied with work completed to date. • Liberty Protection Safeguards is expected to be implemented in April 2023 with consultation closing in July 2022 • Significant work has been undertaken with regards to Learning Disabilities and Autism • The Safeguarding Team has been asked to share learning arising from complex cases with wider external stakeholders. **Infection, Prevention & Control Q4 and Annual Report** • A 20% reduction in the number of MSSA incidents in comparison to the previous year. WCFT is no longer an outlier for MSSA & CDT within the region • There have been no incidents of MRSA since November 2017 • Flu Campaign for 2021-22 only reached 59% against 80% achieved in the previous year . Plans for a WCFT campaign for this year are underway • The IPC Strategy is under review following circulation for comments • Hand Hygiene remains a basic focus for all who work in the Trust		
	Advise	**Quality Accounts** • The final Quality Accounts were ratified by the Quality Committee with the recommendation for final approval by Trust Board • Updates for outstanding actions will be delivered quarterly at Quality Committee		
2.	Risks Identified	• See risk above in alert section (first bullet point)		
3.	Report Compiled by	Ray Walker	Minutes available from:	Corporate Secretary

The Walton Centre NHS Foundation Trust

Report to Trust Board
9th June 2022

Report Title	Nurse Staffing Bi-Annual Acuity Review
Executive Lead	Lisa Salter, Chief Nurse
Author (s)	Nicola Martin, Deputy Chief Nurse
Action Required	To note

Level of Assurance Provided

☐ **Acceptable assurance** Systems of controls are suitably designed, with evidence of them being consistently applied and effective in practice	✓ **Partial assurance** Systems of controls are still maturing – evidence shows that further action is required to improve their effectiveness	☐ **Low assurance** Evidence indicates poor effectiveness of system of controls

Key Messages

- Assurance provided that safe staffing is in place across The Walton Centre
- Areas of professional judgement is higher than established so a further acuity and dependency review will be undertaken Nov 2022

Next Steps

- Launch of 'Safe Care' via e rostering system
- Acuity and Dependency audit November 2022 using safe care

Related Trust Strategic Ambitions	**Impact**		
Leadership	Workforce	Quality	Choose an item.

Strategic Risks		
005 Recruitment and Retention of Staff	004 Patient Care and Experience	Choose an item.

Equality Impact Assessment Completed		
Strategy ☐	Policy ☐	Service Change ☐

Report Development

Committee/ Group Name	**Date**	**Lead Officer (name and title)**	**Brief Summary of issues raised and actions agreed**
n/a			

Nurse Staffing Bi-Annual Acuity Review

Executive Summary

1. The purpose of this paper is to provide assurance regarding nurse staffing and other clinical staff groups including AHP staffing in line with good practice at The Walton Centre. All NHS providers are required to undertake a minimum annual review of nursing staffing levels (NQB, National Quality Board *Safe, sustainable, and productive staffing* an improvement resource for adult inpatient wards in acute hospitals) (Quote NQB doc). This review is undertaken 6-monthly as per NICE guidance, with the last paper being presented in Sept 2021. The review is undertaken to ensure that all stakeholders including patients, families, staff, and the Trust Board recognise and understand the 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 Trust Board are requested to receive a further report in 6 months, or sooner should staffing alter.

Background and Analysis

2. In January 2018, the National Quality Board (NQB)[1] released updated guidance in respect of adult in-patient areas, defined as wards that provide overnight care for adult patients in acute hospitals. For this review, it includes the following areas.

3. Wards: Cairns, Dott, Caton, Chavasse, CRU, Lipton, ITU, Theatres and OPD. Whilst Theatres and OPD do not provide overnight care, staffing has been reviewed.

[1] National Quality Board *Safe, sustainable, and productive staffing* an improvement resource for adult inpatient wards in acute hospitals

Safe, Effective, Caring, Responsive and Well- Led Care		
Measure and Improve -patient outcomes, people productivity and financial sustainability- -report investigate and act on incidents (including red flags) - -patient, carer and staff feedback-		
-implement Care Hours per Patient Day (CHPPD) - develop local quality dashboard for safe sustainable staffing		
Expectation 1	**Expectation 2**	**Expectation 3**
Right Staff 1.1 evidence based workforce planning 1.2 professional judgement 1.3 compare staffing with peers	**Right Skills** 2.1 mandatory training, development and education 2.2 working as a multi-professional team 2.3 recruitment and retention	**Right Place and Time** 3.1 productive working and eliminating waste 3.2 efficient deployment and flexibility 3.3 efficient employment and minimising agency

Table 1; NQB's expectations for safe, sustainable, and productive staffing

Expectation 1 - Right staff

4. Here at The Walton Centre, the Safer Nursing Care Tool used is the Shelford model. This was developed to help NHS hospital staff measure patient acuity to inform evidence-based decision making on staffing and workforce. This acuity review is undertaken twice a year in line with NQB recommendations. From June 2022 the Trust is moving to Safe Care which reviews acuity and dependency daily.

5. Table 2 shows the outcomes of the acuity review taken over a 21-day period for the month of April 2022. It is important to note that this tool does have an element of dependency in but not as comprehensive as the actual dependency tool. Other organisations use Professor Keith Hurst's Dependency tool (Prof Hurst is one of the designers of the Shelford model) alongside the Shelford model so a detailed review of both dependency and acuity is undertaken but this is unfortunately no longer licensed.

6. It is important to note that wards have not been functioning at their speciality level and colour coded covid pathways have remained in place to support the safe management and risks of covid. From May 2022 wards have since returned to their speciality.

7. Occupancy has remained low particularly of a weekend therefore the acuity review demonstrates that all areas are currently safely staffed but a further review in 6 month's time is required, as per national guidance.

Ward	Funded establishment (wte)	Acuity tool outcome	Professional judgement tool	Incident/moderate harm.

		(wte)		
CRU	56.21	39.1	56.21	Fall fracture- during therapies, not staffing related
Lipton	29.37	15.5	29.37	Never event- individual error not staffing related
Cairns	40.57	34.7	40.57	Nil
Caton	40.57	29.5	40.57	Nil
Chavasse	56.95	39.1	56.95	Nil
Dott	39.99	32.2	39.99	Nil

Table 2: Outcome of acuity review April 2022

8. Historically The Walton Centre had a pool of HCAs for 1-1 care, but this was disbanded, the ward areas were given the additional HCAs which equates to the acuity in their areas. A piece of work is to be undertaken with finance and HR to determine this. A review of weekend staffing levels may also be required if occupancy levels do not increase once pre covid surgical procedure levels are maintained.

Process for determining staffing levels

a) Professional judgement

The judgement of senior experienced nurses should also be a critical factor in determining staffing levels. Judgement takes into consideration.

- Cohort nursing requirement
- Ward leadership
- Ward layout and environment
- Additional specific training requirements
- Support of carers/patients
- Escort duties
- Multi-professional working
- Shift patterns

9. Each division is working to ensure safe staffing for every area on a 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.

b) Registered Nurse to Patient ratio

10. The Registered Nurse (RN) to patient ratio is based on the number of RNs on duty to care for patients during a shift. NICE and RCN guidelines recommend no more than 8

patients per RN on a day shift (early or late). This is based on NICE evidence highlighting that there is increased risk of harm to patients when RNs care for more than 8 patients at any one time. The ward manager should have supervisory capacity. All ward managers at The Walton Centre are supernumerary but do cover sickness and staffing gaps as and when required. There is no specific guidance regarding night duty, albeit the RCN guidance on safe nurse staffing levels in the UK 2021 states no more than 10 patients to 1 RN.

11. 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.

12. The Trust continues to have a daily safety huddle chaired by the Chief Nurse and staffing is discussed for the organisation at this meeting.

Table 3; Compliance against key recommendations

Recommendation	Assessment	Compliant	Variation
RN to Patient ratios not exceeding 1:8 day shifts	All adult in-patient areas achieve a maximum ratio of 1 RN to 8 patients on day shifts	√	Some areas have benefitted from higher RN to patient ratios due to ward closure and reduction in bed occupancy (please see occupancy levels below)
Evidenced based Tool	The Organisation has Safer Nursing Care Tool which analyses acuity and dependency and review was undertaken	√	Whilst this has been undertaken, it is noted that there is a lack of validity and

	for 21 days from April 2022		reliability due to the current ward case-mix changes during covid-19 pandemic
Headroom/uplift	Headroom/uplift is calculated at 21% - compliant for Rns and 19% HCA	√	In line with guidance
Skill Mix	All areas to be re-reviewed in Winter 2022 given all wards moved back to speciality	√	A ward closed due to pipework resulting in redeployment of staff to various wards
Professional judgement	All areas have been reviewed in 2022 and are also reviewed monthly by the Divisional Nurse Directors and the Informatics team	√	All areas current staffing levels deemed safe

c) Headroom / Uplift

13. Headroom relates to the percentage of non-effective working days that are included in each establishment (for annual leave, training, sickness etc). Uplift is the required increased staffing to cover the non-effective days to ensure the shifts are covered and patient care delivery is safe.

14. The NQB provides indicative figures based on annual leave, sickness, study leave, parenting leave and 'other'. The uplift of establishments at The Walton Centre 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 of 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.

d) Skill Mix

15. This is the ratio of RNs to unregistered staff, such as healthcare assistants (HCA). Traditionally, the nationally recommended benchmark has been 60% RNs, whilst the Royal College of Nursing (RCN) has advocated a benchmark of 65%/35% split. More recent NICE guidance has focussed more specifically on the RN to patient ratio, as skill mix can be skewed by higher (appropriately) numbers of unregistered staff whilst the ratio of RN to patients can still be appropriate and compliant.

16. The current RN/HCA skill mix at The Walton Centre is:

There is an issue with current utilised skill mix vs funded skill mix.

Wards	**Number of beds**	**Establishment Early**	**Late**	**Night**
Cairns	26	Ward manager supernumerary 4 RNs 3 HCAs	4 RNs 3 HCAs	3 RNs and 3 HCAs
Caton	25	Ward manager supernumerary 4 RNs 3 HCAs	4 RNs 3 HCAs	3 RNs and 3 HCAs
Dott	27	Ward manager supernumerary 4 RNs 3 HCAs	4 RNs 3 HCAs	3 RNs and 3 HCAs
Chavasse (Neurology)	29	Ward manager supernumerary 6 RNs 6 HCAs	5 RNs 6 HCAs	4 RNs and 5 HCAs
CRU (Rehab)	30	Ward manager supernumerary 5 RNs 6 HCAs	4 RNs 6 HCAs	4 RNs 6 HCAs
Lipton (Acute Rehab)	10	Ward manager supernumerary 3 Rns and 3 HCAs	3RNs 3HCAs	2RNs 2HCAs

Table 4: Current skill mix establishment

17. At The Walton Centre there are more HCAs on duty than RNs due to the nature of the patient's conditions. HCAs will support the enhanced needs of the patient particularly when they require enhanced support or rehabilitation.

e) Safety outcome indicators

18. NICE originally advocated specific indicators that could be incorporated to determine safe staffing levels. These indicators were noted to be specifically affected by the presence (and hence absence) of registered nursing staff. These indicators include.

- Falls
- Medication errors
- Infection rates
- Pressure ulcers
- Omissions in care
- Missed or delayed observations
- Unplanned admissions to ITU

This monitoring can be found in Appendix One.

Walton Accreditation Tool

19. The Walton CARES (Communicate, Assess, Respect, Experience and Safety) Review assesses performance based on the Trust core standards. The framework is designed around 15 standards with each one subdivided into four categories including, patient experience, and observations, documentation, and staff experience. Compliance against these standards is measured in various ways to gather a full picture of the ward and care delivered.

20. Post Covid the Trust has launched Tendable which is an electronic audit solution which allows staff to look closer at themes and trends and will also allow benchmarking against other trusts within Cheshire and Mersey who have Tendable. Whilst launching this tool the Walton CARES was reviewed and stretch targets were added and specific elements such as falls, and safeguarding sections included. This now also focuses on much more detail regarding staff knowledge, understanding and seeking assurance in more detail.

21. Post covid, the renewed Walton CARES audit has been undertaken for Caton ward and result has shown a bronze result which is a reduction from Silver. Themes and trends show documentation is poor in areas and support is required to improve documentation with IT with some issues, staff require further education in Safeguarding, risk and governance, end of life, and COSHH files are out of date. A detailed action plan is now in place for this area and was presented and updated following review with the leadership team and Deputy Chief Nurse.

22. The overall outcome of the review will determine the frequency of forthcoming reviews as per below:

Bronze	Review again in 3 months
Silver	Review again in 9 months
Gold	Review again in 12 months
Platinum (achieved Gold rating for 3 consecutive reviews)	Review again in 12 months

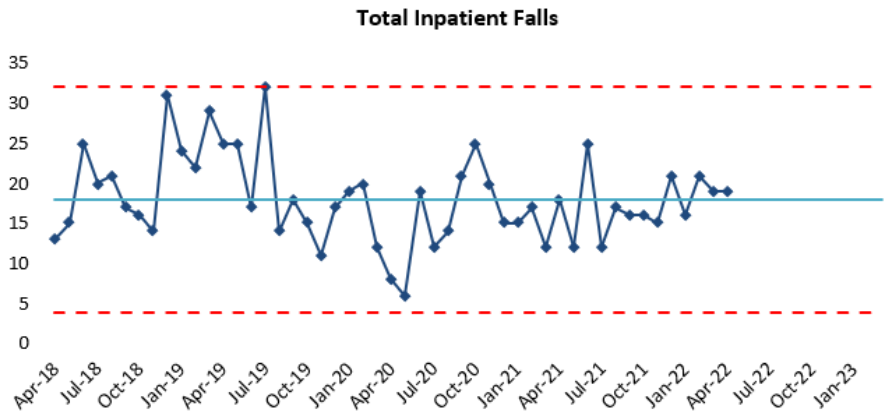
23. The plan is to ensure all clinical areas across the Trust have a CARES review undertaken by year end, with 3 further ward areas planned to be completed in June 2022.

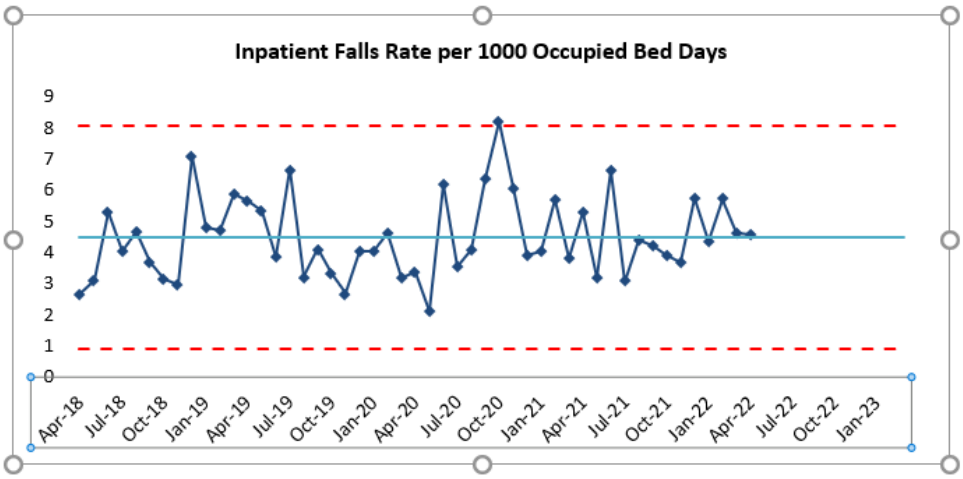
Harm data per 1000 bed days

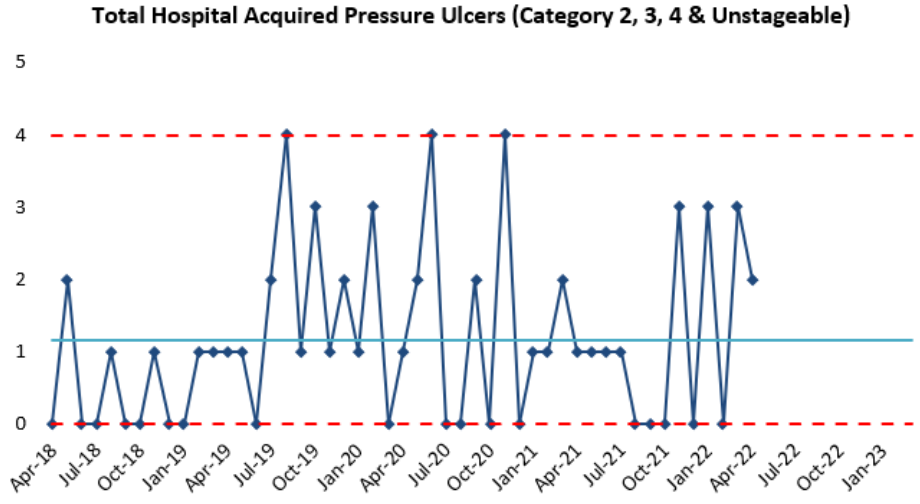
24. The overall Trust falls and pressure ulcers remain within normal variation and outcomes per 1000 beds days were favourable compared to national data at last reporting pre covid-19. This data can be found overleaf.

25. IPC data for the Trust can be found overleaf.

    For individual ward data please see appendix One.


Total Inpatient Falls
35
30
25
20
15
10
5
0
Apr-18
Jul-18
Oct-18
Jan-19
Apr-19
Jul-19
Oct-19
Jan-20
Apr-20
Jul-20
Oct-20
Jan-21
Apr-21
Jul-21
Oct-21
Jan-22
Apr-22
Jul-22
Oct-22
Jan-23


Inpatient Falls Rate per 1000 Occupied Bed Days
9
8
7
6
5
4
3
2
1
0
Apr-18
Jul-18
Oct-18
Jan-19
Apr-19
Jul-19
Oct-19
Jan-20
Apr-20
Jul-20
Oct-20
Jan-21
Apr-21
Jul-21
Oct-21
Jan-22
Apr-22
Jul-22
Oct-22
Jan-23


Total Hospital Acquired Pressure Ulcers (Category 2, 3, 4 & Unstageable)
5
4
3
2
1
0
Apr-18
Jul-18
Oct-18
Jan-19
Apr-19
Jul-19
Oct-19
Jan-20
Apr-20
Jul-20
Oct-20
Jan-21
Apr-21
Jul-21
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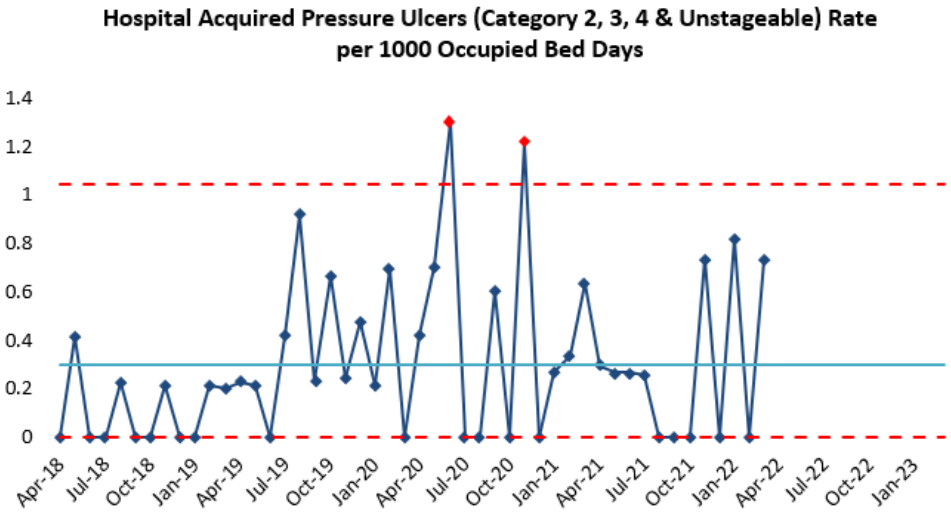
Jul-22
Oct-22
Jan-23


Hospital Acquired Pressure Ulcers (Category 2, 3, 4 & Unstageable) Rate per 1000 Occupied Bed Days
1.4
1.2
1
0.8
0.6
0.4
0.2
0
Apr-18
Jul-18
Oct-18
Jan-19
Apr-19
Jul-19
Oct-19
Jan-20
Apr-20
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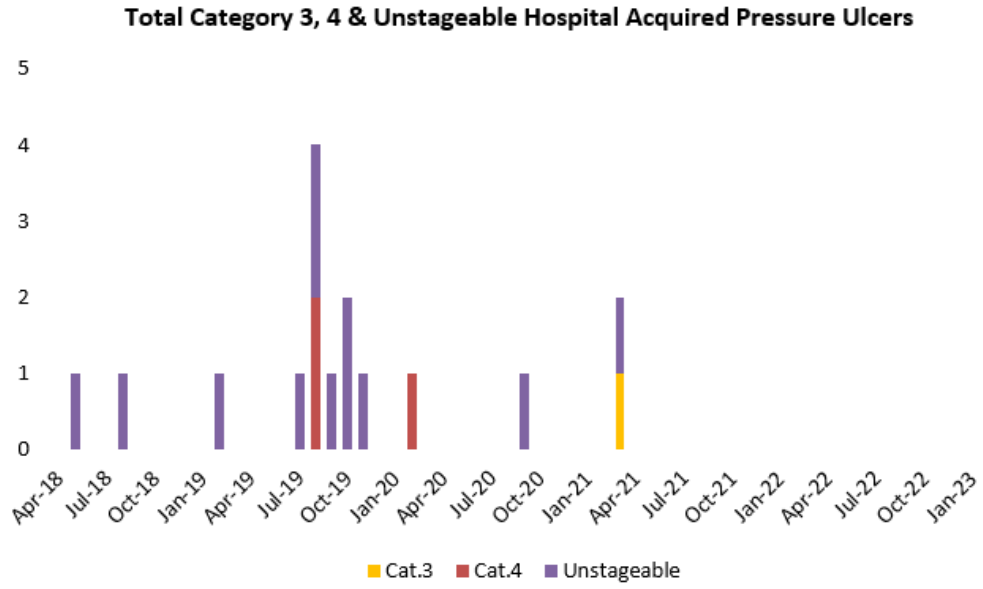
Jul-21
Oct-21
Jan-22
Apr-22
Jul-22
Oct-22
Jan-23


Total Category 3, 4 & Unstageable Hospital Acquired Pressure Ulcers
5
4
3
2
1
0
Apr-18
Jul-18
Oct-18
Jan-19
Apr-19
Jul-19
Oct-19
Jan-20
Apr-20
Jul-20
Oct-20
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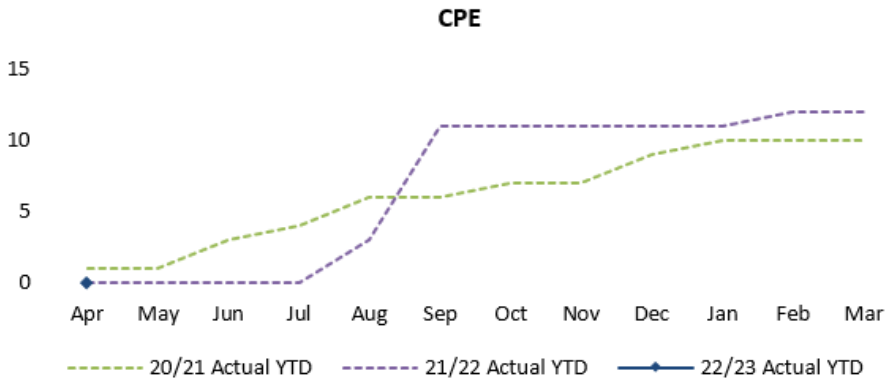
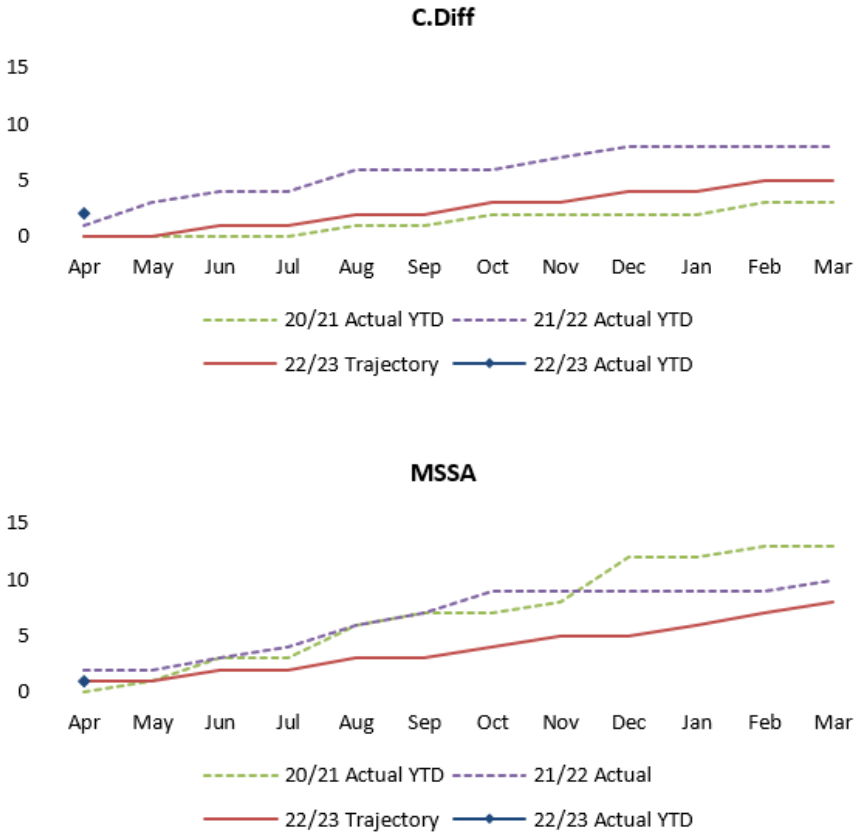
Oct-21
Jan-22
Apr-22
Jul-22
Oct-22
Jan-23
Cat.3
Cat.4
Unstageable


CPE
15
10
5
0
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
20/21 Actual YTD
21/22 Actual YTD
22/23 Actual YTD



Red Flags

26. In accordance with NICE (2018) guidance for Safe Staffing, clinical establishments should be reviewed alongside Nursing and Midwifery red flags. Red flag events are classified as:

    - An unplanned omission in providing medications
    - A delay in providing pain relief
    - An incidence where vital signs have not been assessed or recorded
    - Missed intentional rounding (3Cs)
    - A shortfall in 25% of the required Registered Nursing or Midwifery hours for a shift
    - Less than two Registered Nurses or Midwives available on a shift.

27. Red flags for inpatient services are reported by clinical staff via the datix system.

Red Flags Dec 2021- May 2022 Red Flags	Totals
	TWC
An unplanned omission in providing medications	0
A delay in providing pain relief	0
An incidence where vital signs have not been assessed or recorded	0
Missed 3Cs	0
A shortfall in 25% of the required Registered Nursing or Midwifery hours for a shift	0
Less than two Registered Nurses or Midwives available on a shift.	0

f) Staffing data & Training and Education

- Appraisal, retention, vacancy, sickness, maternity leave
- Mandatory training, clinical training

	Stat					Mand					PDR				
	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22
Corporate	92%	91%	90%	90%	89%	88%	86%	86%	87%	86%	68%	72%	75%	68%	66%
Neurology	92%	91%	91%	90%	91%	90%	91%	90%	91%	92%	76%	78%	79%	79%	77%
Surgery	86%	85%	87%	87%	86%	80%	80%	81%	82%	83%	75%	75%	72%	72%	66%

Table 5: Percentage of staff completed training and PDR

- **Triangulation of Quality metrics and staff and patient reported outcomes**

28. Evidence contained demonstrates that there has been an overall deterioration across infection prevention and control. Clearly it is a challenge to isolate this to a specific cause and the covid-19 pandemic obviously remains an over-riding factor. The Trust

has reported one never event and one major harm during this period and both areas were fully staffed at the time of the incident.

29. The Trust continues to see a reduction in skin damage following work completed by the Tissue viability nurse.
30. Falls remain a concern but the lead for falls has now been given to a Divisional Nurse Director who has recommenced the fall champions programme, reviewed all falls prevention equipment. A study day has been planned for 10th June 2022 with a detailed agenda to enhance education. Patient family centred care has been relaunched with 6 key working groups leading on each step of the patient experience journey.

31. A matron is now leading on nutrition and hydration and has carried out extensive work resulting in a reduction in incidents and is working with the clinical team regarding mealtime coordinator roles.

Staffing incidents

32. The Walton Centre has seen an increase in staffing incidents for 2021/22 in comparison to 2020/21, a full review of all the 44 incidents has taken place. No concerns were noted following the review. The incidents included all areas from across the whole Trust including Theatres, ITU, all wards, ISS Staffing and medic staffing. These 44 incidents have occurred during covid when the Trust has seen a significant increase in sickness and covid sickness with staff having to work from home. Of the 44 incidents, 9 are for the year 2022, this is a reduction which also mirrors reduction in covid and high sickness levels. There are 2 themes highlighted from this review which are staffing levels in relation to staff required for patients requiring 1-1 and the expectation of full staffing numbers despite lower occupancy levels and empty beds.

	2020/21	2021/22	Total
Cairns Ward	0	5	5
Caton Ward	0	5	5
Chavasse Ward	0	5	5
CRU	0	13	13
Dott Ward	2	2	4
Horsley - ITU	0	5	5
Lipton Ward	1	3	4
Sherrington Ward	1	5	6
Theatre	1	1	2
Total	5	44	49

Table 6: No of incidents relating to staffing

g) Comparison with peers

33. Peer comparisons can act as a platform for further enquiry, although caution should be exercised. The model hospital dashboard can also be used as a reference point.

Usually, the report would cover benchmark data with other trusts to provide assurance however no 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 senior nursing team plan to benchmark with Queens Square London, and this will be provided in the next update to Board.

Expectation 2 – Right Skills

34. The NQB states that clinical leaders should be supported at a local level to deliver high quality, efficient services with a staffing resource that reflects a multi professional team approach. Specifically, the following is recommended.

    - Skill mix – this should be reviewed ensuring compliance with professional judgment and evidence reviews and may consider presence of additional roles
    - Training – all members of the clinical team must be appropriately trained to be effective in their role
    - Leadership – it is important to ring-fence time in the roster for managerial work and for the supervision of staff. The NQB (2018) references the Mid-Staffordshire inquiry report as follows.

35. *"Ward nurse managers should operate in a supervisory capacity, and not be office bound or expected to double up, except in emergencies as part of the nursing provision on the ward. They should know about the care plans relating to every patient on his or her ward. They should make themselves visible to patients and staff alike, and be available to discuss concerns with all, including relatives. Critically, they should work alongside staff as a role model and mentor, developing clinical competencies and leadership skills with the team."*

36. As noted earlier in the report, all Ward Managers at The Walton Centre are supernumerary and this is planned in every month.

37. Recruitment and retention – strategies are in place

International Nurse Recruitment

38. 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 a fixed term post for a band 6 pastoral care nurse to support the international nurses in 2021.

39. All 40 nurses were recruited, and a business case was approved for a further 50 international nurses. Following a review of sickness levels, vacancies, nurses in the pipeline and bed repurposing, The Walton Centre have collaborated with LUHFT and have now assigned 20 of the registered nurses to LUHFT to support with their recruitment.

Expectation 3 – Right place, right time

40. The NQB recommends that in addition to the delivery of high-quality care, Boards should ensure improvements in productivity. This will include effective management and rostering of staff, with clear escalation policies if concerns arise.

41. Recommendations to support this include.

- Productive working (LEAN, Productive ward)
- E-rostering
- Flexible working
- Staff deployment
- Minimising agency staffing
- Measure and improve – a local quality dashboard for safe and sustainable staffing that includes ward-level data should be in place

Right place, right time

42. The Walton Centre has now launched a SMART E-Rostering system to support the inpatient nursing workforce. E-Rostering enables organisations to provide further assurance on their effective use of resources by targeting key performance indicators (KPIs) for roster publications, annual leave, sickness levels, study requests, changes to rosters after sign off and if rosters are signed off on time. E-Rostering KPI reports have been compiled and cascaded across the areas that are currently utilising e roster.

43. Safe care full launch is planned for 13th June 2022 and all wards are now live on e roster. ITU has gone live in May and theatres, specialist nurses are in the planning phase. Safe care will provide daily data regarding acuity and dependency on each area to support decision making when risk assessing whether to move nurses across areas to support safe staffing.

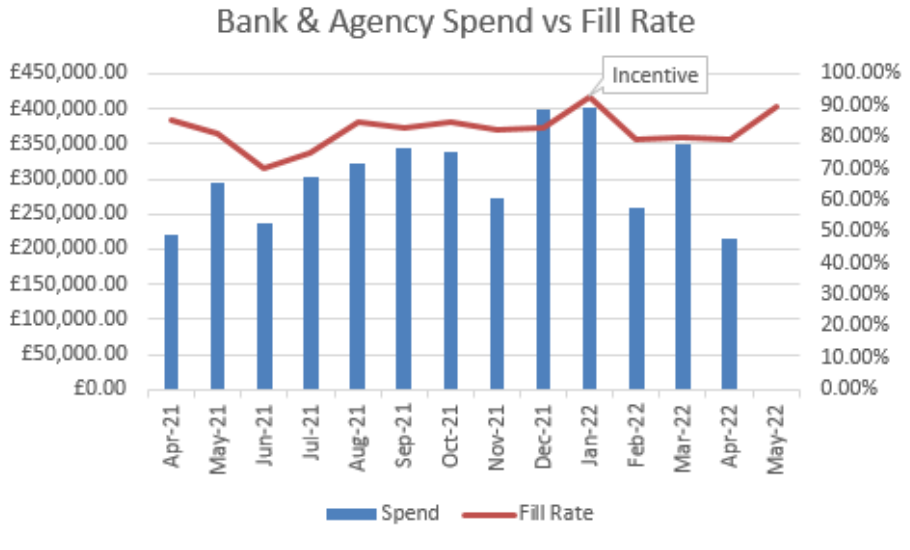
Temporary staffing

44. The Deputy Chief Nurse has worked closely with the matrons to ensure staffing levels are appropriate and safe and additional shifts, bank usage is required. Several actions have been put into place to ensure this which include: -

- Removal of 8 weeks retrospective adding of NHSP shifts. Only matrons or above can add any retrospective shifts
- Introduced an escalation process for adding shifts over and above establishments and again only matron or above can add shifts

- Review of 1-1 care undertaken every day and education provided in real time re special observation policy
- Audit of special observation policy
- Education for special observations
- Removal of NHSP book and put a process in place so each ward/department has their own signing in sheets
- Reduced the number of staff approving NHSP so ward/department managers approve their own areas shifts only
- Removed SMART team from staffing process so they can focus on quality care and supporting of poorly patients
- Removal of staffing from bronze bleep so ward managers manage their own staffing. The matron is contacted for escalation only so matrons can focus on quality agenda
- Introduced a health roster sign off process to ensure effective use of health roster before it is shared with staff. Some wards have reduced hours owed to the Trust from 800- Zero.
- Agreed KPIs with Health roster lead to monitor performance with health roster and outcomes

45. All the above has resulted in April being the first month in 24 months to have the lowest bank and agency spend and an increased bank fill rate (chart below).



Graphs can be found in Appendix Two for our RN and HCA hours required for September 2021.

Vacancies

The table below displays the current Registered Nurse vacancies

Row Labels	Budget WTE	Actual WTE	Vacancy	Percentage
Neurology & Long Term Care	**71.50**	**59.28**	**12.22**	**17.09%**
Chavasse Ward	26.66	22.61	4.05	15.19%
Complex Rehab Unit	24.53	16.47	8.06	32.86%
Lipton Ward	15.83	17.20	-1.37	-8.65%
Outpatients Department	4.48	3.00	1.48	33.04%
Surgery & Critical Care	**221.17**	**202.35**	**18.82**	**8.51%**
Cairns Ward	21.89	21.55	0.34	1.55%
Caton Ward	21.42	23.43	-2.01	-9.38%
Dott Ward	20.52	19.59	0.93	4.53%
Horsley Ward	86.79	93.12	-6.33	-7.29%
Sherrington Ward	21.22	0.00	21.22	100.00%
Theatres	49.33	44.66	4.67	9.47%
Grand Total	**292.67**	**261.63**	**31.04**	**10.61%**

Table 7: Current RN vacancies not including staff in pipeline

46. The trust has recruited to all HCA vacancies except one post. The table shows The Walton Centre as having 31 vacancies, 4 RN posts that are filled with Nurse associates currently. So actual current vacancies are approximately 27.04 WTE and we have 30 IR nurses and 10 students newly qualified in the pipeline to arrive between July and December 2022.

Sickness

47. Staff sickness plays a huge role in shortfalls on most wards and results in temporary shifts being requested or staff redeployment occurring to maintain safety. Sickness is managed by the Ward Manager, with Divisional Nurse Director support, Human Resources monitoring and when required, input from Occupational Health. Sickness is managed actively, fairly, and consistently balancing the needs of staff with the efficient running of a safe, clean and individual service. The target for sickness is 5%.

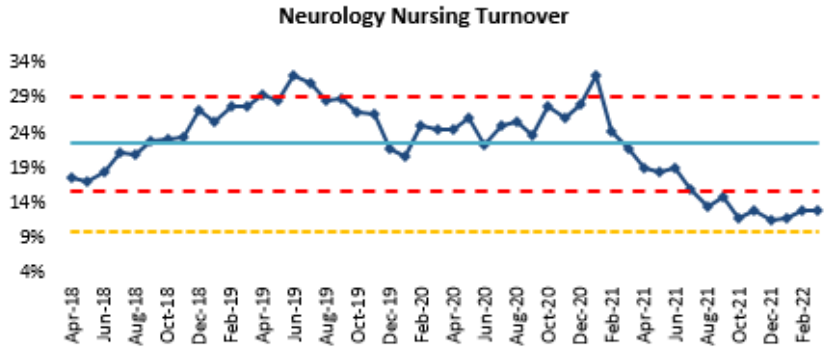
	2021 / 12	2022 / 01	2022 / 02	2022 / 03	2022 / 04
	Absence FTE %	Absence FTE %	Absence FTE %	Absence FTE %	Absence FTE %
160 Cairns Ward (1602100)	18.76%	18.16%	13.51%	13.59%	10.49%
160 Caton Ward (1602130)	15.04%	19.19%	9.38%	8.08%	9.19%
160 Chavasse Ward (1602135)	10.00%	14.89%	13.86%	16.79%	14.96%
160 Complex Rehabilitation Unit (1602080)	14.53%	25.60%	16.58%	15.75%	15.57%
160 Dott Ward (1602110)	6.61%	8.26%	6.69%	9.88%	11.78%
160 Horsley Ward (1602000)	15.25%	17.49%	10.47%	10.47%	10.05%
160 Jefferson Ward (1602090)	0.38%	8.40%	7.09%	8.63%	0.42%
160 Lipton Ward (1602115)	13.56%	30.01%	17.14%	16.42%	12.29%
160 Sherrington Ward (1602120)	0.00%	0.00%	0.00%	0.00%	0.00%
Grand Total	13.13%	18.15%	11.97%	12.46%	11.38%

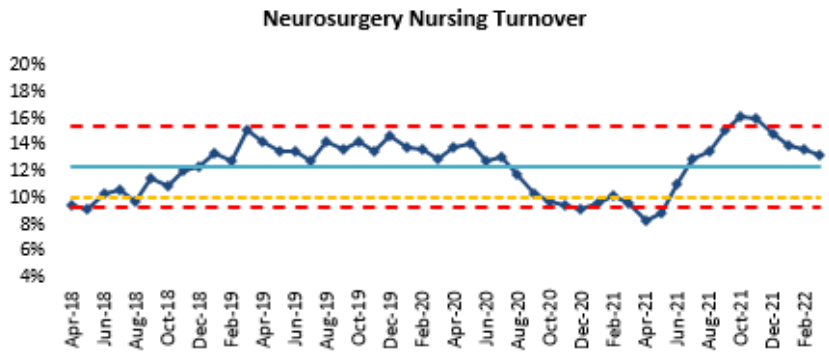
Table 8: Sickness

Retention

48. NHS Improvement (2019) advise that the retention of staff is a key issue for the NHS and it is critical that organisations focus on securing skilled and sustainable workforce for the future. In addressing the challenges of workforce supply, organisations must focus not only on recruitment but also should ensure new and existing staff are supported and encouraged to remain in the NHS. All staff are encouraged to undertake exit interviews to aid managers in identifying themes and learning related to why staff are leaving. Current themes from exit interviews are staff leaving for promotion, The Trust has lost several nurses to the community setting also. People Group meetings are now set up and this is one aspect of work the group will be focusing on. The Trust has seen nurses leave and recently contacted the senior nursing team to identify when an advert is going to be released as they wish to return.

49. The Trust is also seeing several nurses who have taken a drop in band come to work at The Walton Centre from other organisations. To improve this position both divisions must pro-actively seek our staff's opinions and ensure exit interviews are being carried out. The senior nursing team are looking at commencing HCA and RN forums to support this.

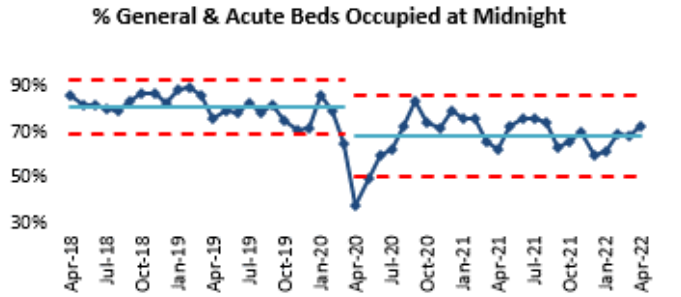


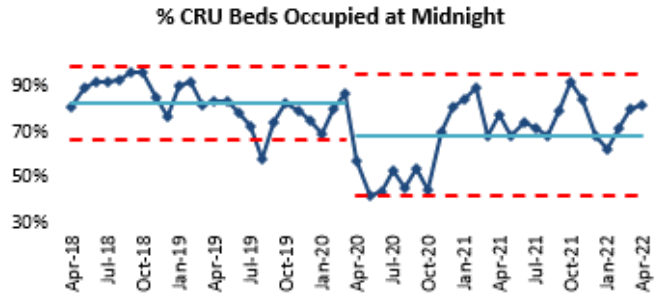


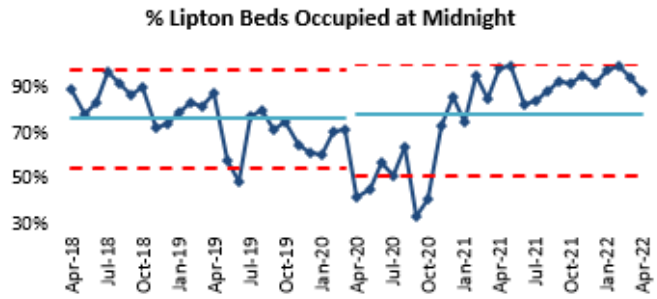
50. The Trust has recruited a practice education facilitator primarily to support and co-ordinate pre-registration students however they can further support the transition from student nurse to registered nurse and ensure staff are prepared and well equipped. The senior nursing team has requested to be made aware of any nurses planning to leave so a conversation can be held to determine if any actions can be taken to retain the nurse.

Occupancy

51. The below graphs show the occupancy levels for all inpatient areas, ITU and the rehabilitation wards.







Theatres

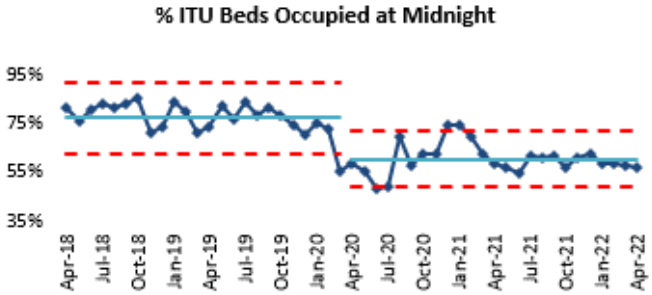
52. The theatre department has now completed its COVID Recovery plan and is now running at pre-COVID capacity. Staffing is stable with a number of staff returning from

long term sickness, new staff starting or due to start in the near future, the addition of long-term agency staff has further aided our staffing levels (X2 Agency has been agreed until the end of August); However, it should be noted that our ability to recruit into Band 5 positions remains an issue. Alternative routes into theatre are currently being explored with hopefully the addition of an ODP apprenticeship programme being implemented by the end of the year.

53. The demand on theatres to tackle the high waiting lists and incorporate the thrombectomy on call service has resulted in a number of changes to rotas and ways of working to try and further increase our theatre output. We utilise 3 session days for the Skull based service and are looking at expanding this to the spinal service in the near future, we continue to run Waiting List initiative (WLI) at the weekend.

ITU

54. ITU have recruited into all their vacancies and have staff in the pipeline to commence employment. ITU is experiencing sickness (short and long term), maternity leave so shifts are still out to NHSP and Occupancy levels remain low.



Radiology

55. Against a continuing backdrop of a national shortage of Consultant Radiologists and Radiographers, WCFT currently have no Consultant Radiologist vacancies, but have a requirement for additional reporting PA's, which are currently being supported by WLI. The ability for staff to report from home continues to increase reporting volumes, but the requirement for other imaging services has reduced the reporting PAs available. The impact of this has been identified during job planning.

56. The Radiographer staffing group remains relatively stable but remains under pressure due to members of the team on Maternity leave and long term absence. 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 2024.

57. 5.2 WTE Intervention Scrub Practitioners (ISP) have been recruited to support the 24/7 Thrombectomy service. A Lead ISP will be advertised to provide professional leadership to the team, and the team links with the Neurology Divisional Nurse.

58. The department continues to place a high level of importance on the investment of training, together with in house professional development. A further two radiographers are undertaking post graduate courses in CT and MRI advanced Imaging. The Deputy Radiology Manager is undertaking a master's program in Management, as part of the Trust apprenticeship scheme. Radiology Digital Systems Manager is undertaking a post graduate module in project management to support developments in the Radiological information system and Picture archiving and communication system. Dr S Mills is leading on BSNR 2022 National conference, which will be held in Liverpool with presentations from WCFT Neuroradiologists and Neuroradiographers.

59. In addition, the Department has Advanced Practice Radiographers in Fluoroscopy and Doppler imaging, to support different ways of working.

60. There has also been an appointment to 1 x Apprenticeship trainee Assistant Practitioner, to support the qualified Band 4 Assistant Practitioner, who is now undertaking training in fluoroscopy, with the aim to train the two AP's to undertake screening in theatre.

Therapies

61. The Walton Centre Therapies service consists of 5 AHP disciplines who hold valid HCPC registration: Occupational Therapy, Physiotherapy, Speech & Language therapy, Dietetics and Orthoptists. Together these teams provide specialist therapy intervention to acute wards, ITU, rehabilitation units CRU & Lipton Hyper acute, community rehab, outpatients, Pain management, Trauma and Spinal services.

62. Over the last 12 months, Therapies have continued the delivery of high quality evidenced based care across all areas. All in-patient and outpatient teams have benefitted from a review of skill mix and service restructure at every opportunity (vacancies) to support staff retention and succession planning. In the main, staffing has been stable but not without the challenges of unusually high levels of sickness absence due to covid 19. Therapies business continuity plans have been implemented as necessary to maintain a safe level of care. With staff have prioritizing caseloads and deploying staff to other areas when required. Throughout this time, the acuity of patients has been high and complex requiring high intensity of intervention and discharge planning. The outpatient therapy team have enjoyed a stable period for staffing, and this has allowed the team to work creatively in restarting outpatient clinics and in providing WLI clinics to help reduce waiting times.

63. Being a predominantly female workforce, this has meant higher than usual service gaps across all areas in 2021/22 due to maternity leave. The seven-day respiratory physiotherapy team have had extra challenges when both team lead's maternity leaves coincided. Junior staff stepped up to the task and ensured the most vulnerable patients

continued to receive high levels of physiotherapy care. Against a national shortage of AHPs, the therapies service has been fortunate in successfully attracting a high calibre of candidates to back fill temporary and permanent positions across most areas.

64. Despite a rollercoaster of moral due to uncertainty and inconsistent staffing levels, Walton therapy staff have worked tirelessly and creatively to ensure high levels of safe and effective patient care but also staff personal health and wellbeing, which is commendable. Therapies has contributed to the C &M workforce plan by supporting additional undergraduate clinical placements and two new apprenticeships roles within the service and have developed a staff health and wellbeing group and a CPD group to support our longer-term recovery plans and staff retention.

Conclusion

65. The attached review demonstrates a) current compliance against NQB b) current triangulation of a spectrum of outcomes that are evidenced to be directly linked to presence and absence of, registered nurse and health care assistant staffing levels.

Recommendation

66. Trust Board is asked to:

- Receive assurance that staffing across all areas is considered safe
- Receive the next 6-monthly staffing report in Nov 2022, unless further changes require reporting.

Author: Nicola Martin, Deputy Chief Nurse
Date: 30th May 2022

Appendix 1

There has been a ward closed during 2021/22 and 2022/23 at different times.

Total Inpatient Falls

	18/19	19/20	20/21	21/22	22/23	Total
Cairns	37	24	36	38	2	**137**
Caton	34	24	29	20	3	**110**
Chavasse	45	36	39	42	7	**169**
CRU	45	32	25	43	1	**146**
Dott	29	31	42	17	4	**123**
Horsley	2	4	3	3	1	**13**
Lipton	11	2	8	8	1	**30**
Sherrington	42	64	8	40	0	**154**
Total	**245**	**217**	**190**	**211**	**19**	**882**

Total Moderate & Above Harm Inpatient Falls

	18/19	19/20	20/21	21/22	22/23	Total
Cairns	3	0	0	1	0	**4**
Caton	0	0	0	0	0	**0**
Chavasse	0	0	0	0	0	**0**
CRU	0	0	0	1	0	**1**
Dott	1	0	0	0	0	**1**
Horsley	0	0	0	0	0	**0**
Lipton	0	0	0	0	0	**0**
Sherrington	1	0	0	0	0	**1**
Total	**5**	**0**	**0**	**2**	**0**	**7**

Total Hospital Acquired Pressure Ulcers (Category 2, 3, 4 & Unstageable) 2022/23

	Category 2	Category 3	Category 4	Unstageable	Total	Total Device Related
Cairns					**0**	
Caton					**0**	
Chavasse	1				**1**	
CRU					**0**	
Dott					**0**	
Horsley					**0**	
Lipton					**0**	
Sherrington					**0**	
Theatre	1				**1**	

Total Healthcare Acquired Infections

2022/23

	MRSA B	CPE	C.Diff	E.Coli	KB	PB	MSSA	Total
Cairns								**0**
Caton								**0**
Chavasse								**0**
CRU			1		1			**2**
Dott				1				**1**
Horsley			1				1	**2**
Lipton								**0**
Sherrington								**0**
Total	**0**	**0**	**2**	**1**	**1**	**0**	**1**	**5**

The Walton Centre NHS Foundation Trust

Report to Trust Board

9 June 2022

Report Title	Infection Prevention & Control Annual Report (including Quarter 4)
Executive Lead	Lisa Salter, Chief Nurse
Author (s)	Helen Oulton, Lead Nurse Infection Prevention/Tissue Viability
Action Required	To note

Level of Assurance Provided

☐ **Acceptable assurance** Systems of controls are suitably designed, with evidence of them being consistently applied and effective in practice	✓ **Partial assurance** Systems of controls are still maturing – evidence shows that further action is required to improve their effectiveness	☐ **Low assurance** Evidence indicates poor effectiveness of system of controls

Key Messages

- Although HCAI reduction targets were exceeded, the Trust reduced MSSA bloodstream infections by 20% and no MRSA bacteraemias occurred
- The ongoing COVID-19 Pandemic has impacted considerably on both patients and staff. Despite this there has been ongoing collaboration with clinical and non-clinical teams to improve both quality and patient safety
- Staffing withing the IPC Team has been challenging and this has led to some objectives in the HCAI Reduction Plan not fully achieved

Next Steps

- Action plan for 2022/23 will be progressed

Related Trust Strategic Ambitions	**Impact**		
Quality of Care	Quality	Finance	Legal

Strategic Risks

001 Impact of Covid 19 on delivery of strategic objectives	016 Infection Prevention and Control	004 Patient Care and Experience

Equality Impact Assessment Completed

Strategy ☐	Policy ☐	Service Change ☐

Report Development

Committee/ Group Name	Date	Lead Officer (name and title)	Brief Summary of issues raised and actions agreed
Quality Committee	17th May 2022	Lisa Salter Chief Nurse	Noted

Infection Prevention and Control Annual Report (Quarter four report incorporated)

Executive Summary

1. **Mandatory reporting Health Care Associated Infections:**

   - No patients acquired an MRSA bloodstream infection during 2021-2022. The last MRSA bloodstream infection was in November 2017.
   - Ten hospital acquired MSSA bloodstream infections. Although the Trust did not meet its internal reduction threshold and was an outlier for hospital acquired cases, there was a decrease of three cases compared to 2020-2021 which equates to a 20% reduction.
   - Eight hospital acquired CDI therefore exceeding the target of five cases.
   - Eleven hospital acquired E. coli bloodstream infection by year-end against a reduction threshold of 10.
   - Five hospital acquired a Klebsiella bloodstream infection during 2021 - 2022 against a target of 2.
   - Two hospital acquired Pseudomonas bloodstream infection against a target of zero.
   - Twenty-three catheter-associated infections (CAUTI's) compared to 17 in 20202021. Out of the 23 cases, E. coli was cultured in seven cases with gram negative bacterium responsible for 17 of 23 CAUTIs.
   - Twelve patients who acquired CPE during their inpatient stay compared to 10 in 2021-2022.

2. Further detail is provided in the report in Appendix 1.

3. Throughout the reporting period the Trust has continued responding to the ongoing global COVID19 pandemic. In total there were 98 positive cases compared to 156 in 2020/2021 (see Appendix 6) with the largest number of cases occurring in January 2022 which caused considerable pressure on staffing and patient flow.

Background

4. The Director of Infection Prevention and Control (DIPC) Annual Report reports on infection prevention and control activities within The Walton Centre NHS Foundation Trust for the period April 2021 to March 2022. The publication of the IPC Annual Report is a requirement to demonstrate good governance, adherence to Trust values and public accountability.

5. 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 the ongoing global Pandemic.

6. In addition, the Trust continues to work collaboratively with a number of outside agencies as part of its IPC and governance arrangements, including:
    4. NHS England/Improvement.
    5. Liverpool CCG.
    6. Sefton CCG.
    7. UK Health Security Agency (UKHAS) (formerly Public Health England).
    8. Acute and community provider organisations.

COVID-19 Pandemic

7. Throughout the reporting period the Trust has continued responding to the ongoing global COVID19 pandemic. In total there were 98 positive cases compared to 156 in 2020/2021 (see Appendix 6) with the largest number of cases occurring in January 2022 which caused considerable pressure on staffing and patient flow.

8. The following was undertaken/implemented by the IPCT to mitigate COVID-19 risks to patients and staff:
    - Provided support to the COVID line/Team.
    - Advice and support to clinical and non-clinical staff and patients.
    - Increased support visits in ward areas.
    - Linked with the operational teams to introduce new Patient Pathways to stream patients to appropriate areas.
    - Worked closely with Bed Management Team and Divisions to support safe placement of patients.
    - Weekly walkaround to audit Covid measures.
    - Development of COVID-19 investigation SOP.
    - COVID-19 vaccination for eligible inpatients.
    - Promotion of staff vaccination including myth busting and 1 :1 support.
    - The Trust purchased additional screening between bed spaces and other areas to support the COVID-19 risk mitigation strategy along with additional hygiene stations.
    - Collaboration with external infection prevention and control colleagues.
    - Participated in local, regional, and national teleconferences.
    - COVID-19 Board Assurance Framework reviewed and updated.
    - Support operational teams with post COVID-19 restoration.

9. Estates and Facilities

- There is a Water Safety Group that overseas safe water management and an external Authorising Engineer (Water) has been appointed, who is working with the Trust to ensure full compliance in water safety requirements.
- A Ventilation Safety Group (VSG) is now set up and work is underway to re-appoint new external Authorising Engineer (ventilation) who with work with the Trust in the same capacity as AE(W).
- The incumbent provider was reappointed to provide soft FM services following a competitive tender process with the new contract commencing on 1st April 2022.
- The National Cleaning standards were implemented across the Trust.

10. Education

- There was an increase in education and training provided by the IPCT both at ward level and structured training sessions.

11. Outbreaks and incidents

- Four COVID-19 outbreaks with thirty-five patients affected with all positive patients and contacts cohorted on Chavasse.
- Two outbreaks of CPE on Sherrington Ward.
- IPC surveillance identified an increase in clinical Pseudomonas infections during quarter three.

12. Annual Staff Seasonal `Flu campaign

- Liverpool University Hospital Foundation Trust (LUFT) delivered the 2021-22 `flu campaign. At the closure of the campaign was 56% (was 60%) which is a significant reduction to previous years >80%

13. Surgical Site Infection (SSI)

- The total percentage rate of surgical site infections for the period April 2021-March 2022 is 1.41% which is below 3% internal threshold set by the Trust (see Appendix 4)
- The Surgical Site dashboard became operational which will improve data quality.

14. HCAI Reduction Plan 2021 – 2022

Staffing within the IPCT and Tissue Viability service (vacancies and sickness absence COVID and non-COVID-19 related) impacted on the achievement of all objectives within the plan due. Therefore, some work streams will transfer to the 2022-2023 workplan

Conclusion

15. The COVID-19 pandemic remained the key challenge during 2021/2022. As the Trust moves to the restoration of service and “back to normal,” robust and proactive infection prevention will be essential, especially when considered in the context of delays in treatment, increasing patient dependence, complexity of treatments, and the continued emergence of new organisms.

16. Although 2021 – 2022 proved challenging with increased pressures evident throughout the Trust due to the ongoing COVID 19 pandemic. There has been significant staff engagement and collaboration across all disciplines.

Recommendation

To note.

Author: Helen Oulton, Lead Nurse Infection Prevention/Tissue Viability
Date: 11th May 2022

Appendix 1

Infection Prevention and Control Annual Report 2021/2022 (Including quarter four)

Introduction

1. 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.

2. 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, 2021, to March 31, 2022, the position of infection prevention and control within The Walton Centre, and progress against performance targets.

3. 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 the ongoing global Pandemic.

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

The Code is considered 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

2.0 Infection Prevention and Control Arrangements

Infection Prevention and Control Team

Mrs. L Salter	Chief Nurse /Director of Infection Prevention and Control (DIPC)
DR S Larkin	Consultant Microbiologist**/**Deputy Director of Infection Prevention and Control
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 (until July 2021)
Mrs. A Samad	Associate Nurse Specialist Infection Prevention and Control (from September 2021)
Mrs. S Sajan	Associate Nurse Specialist Infection Prevention and Control (from September 2021)
Mrs. J Smith	Administrative support
Mrs. C Crompton	Clinical audit support (until October 2021)
Mr. K McShane	0.2 WTE IPC analyst (from October 2021)

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 was the named microbiology consultants for the Walton Centre during 2021/22.

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.

2.1 The Infection Prevention and Control Committee (IPCC)

The Committee is chaired by the Chief Nurse/ DIPC and meets monthly with a minimum of nine meetings a year. Membership involves representation from across all clinical areas within the Trust, Non-Executive Director. UKHAS and Specialist Commissioning receive the minutes and are invited to attend.

During this reporting period the Infection Prevention and Control Committee met as set out in its terms of reference.

3. Performance against HCAI Objective 2021-2022

3.1 Table 1. HCAI reduction thresholds 2021-2022 and performance against 2020-2021

**National reduction objectives not yet received therefore 2022-2023 objective are subject to change.
*National reduction objectives received late summer 2022

Key to Table 1.

Objective achieved 2021-2022	Exceeded trajectory 2021-2022 but reduction in cases compared to 2020-2021	Exceeded trajectory/increased cases 2021-2022
⟺	↓	↑

Organism	Objective 2021-2022	31st March 2022	Objective 2022-2023**	Performance 2021-2022 V 2020-2
MRSA	0	0	0	⟺
Clostridium difficile	5	8	5	↑
MSSA BSI	8	10	8	↓
E. coli BSI	10 external 7 internal	11	7	↑
Klebsiella BSI	2*	5	2	↑
Pseudomonas BSI	0	2	2	↑
CPE	No threshold set	12	No threshold set	↑

3.2 Meticillin Resistant Staphylococcus Aureus (MRSA)

Nationally there is a zero-tolerance for MRSA bloodstream infections for all Trusts. There were no patients who acquired an MRSA bloodstream infection during 2021-2022. The last MRSA bloodstream infection was in November 2017. We continue to strive for zero avoidable infections.

3.3 MRSA Screening

MRSA screening of patients within 6 hours of admission was on average 94.92% for the period 2021-2022.

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.

3.4 Clostridium Difficile

The Trust trajectory for 2021 – 2022 was no more than five cases of Clostridium difficile infection (CDI). At year end, there were eight patients who acquired CDI therefore exceeding the Trust objective of five cases.

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 factors increase the risks associated with the development of a Clostridium difficile infection. Despite this complexity, 2021-2022 is the first time in five years that the Trust has not reduced its Clostridium difficile infections and has exceeded its CDI trajectory (see Appendix 4).

To ensure oversight, the risk associated with Clostridium difficile was added to the Trust Board Assurance Framework.

A period of increased incidence (PII) relating to Clostridium difficile was declared on Critical Care. Extensive action plans were implemented to address this increase which focussed on environmental cleanliness, “Clean Trace” (ATP) testing, application of fundamental infection prevention and control (IPC) precautions.

3.5 Meticillin Sensitive Staphylococcus Aureus (MSSA) Bacteraemia

There were ten hospital acquired MSSA bacteraemia’s against an internal reduction threshold of eight cases.

Six cases occurred on Critical Care and the Critical Care Matron developed an action plan which included:

- Education & Training
- Observations of Care
- Intravenous device audit
- Review of blood culture sampling

Progress against the action plan was monitored at IPCC in addition to weekly review meetings.

3.6 Gram negative Bacteraemia

3.7 Escherichia coli (E-coli)

The Trust set an internal reduction threshold of seven cases against an external trajectory of ten. There were eleven patients who acquired an E. coli bacteraemia by year-end. This is above both the Trust internal and external annual reduction threshold of 12 (see Appendix 4).

The Trust had twenty-three catheter-associated infections (CAUTI’s) during 2021 - 2022 compared to 17 in 2020-2021. Out of the 23 cases, E. coli was cultured in seven cases with gram negative bacterium responsible for 17 of the 22 CAUTI.

3.8 Klebsiella

The Trust was set an external trajectory of no more than two cases of Klebsiella which is the first time that trajectories have been set nationally. Five patients acquired a Klebsiella bloodstream infection during 2021 - 2022 which was the same number of cases in 2020-2021.

3.9 Carbapenemase Producing Enterobacteriaceae (CPE)

There were twelve patients who acquired CPE during their inpatient stay compared to 10 in 2021-2022. Seven patients who acquired CPE did so on Sherrington ward of which further information is contained in paragraph six.

4.0 COVID-19 Pandemic

Throughout the reporting period the Trust has been responding to the global COVID19 pandemic. COVID-19 has brought significant challenges to the healthcare system and the impact on patients and staff has been significant.

There were 98 positive cases compared to 156 in 2020/2021 (see Appendix 5) with the largest number of cases occurring in January 2022 which caused considerable pressure on staffing and patient flow.

The following was undertaken/implemented by the IPCT to mitigate COVID-19 risks to patients and staff:

4. IPCT provided support to the COVID line/Team.
5. Advice and support to clinical and non-clinical staff and patients.
6. Increased support visits in ward areas.
7. Linked with the operational teams to introduce new Patient Pathways to stream patients to appropriate areas.
8. Worked closely with Bed Management Team and Divisions to support safe placement of patients.
9. Weekly walkaround to audit Covid measures.
10. Development of COVID-19 investigation SOP.
11. COVID-19 vaccination for eligible inpatients.
12. Promotion of staff vaccination including myth busting and 1 :1 support.
13. Hygiene stations purchased.
14. Additional screening between bed spaces and other areas was purchased to support the Trust COVID-19 risk mitigation strategy along with additional hygiene stations.
15. Collaboration with external infection prevention and control colleagues Participated in local, regional, and national teleconferences.
16. COVID-19 Board Assurance Framework reviewed and updated.

4. Estates and Facilities

4.1 Water Safety

- A Water Safety Group is in place and reports into the IPCC.
- The Trust appointed an external Authorising Engineer (Water), who is working with the Trust to ensure full compliance in water safety requirements.
- Water sampling is undertaken across both the Walton and Sid Watkins site. Where samples identify water borne pathogens remedial actions are undertaken and Point of Use filters are installed.

17. Estates and facilities now have a slot on Induction training to give an overview of water and its importance and staff understand the potential risks, and the requirements to minimise the risk of water borne pathogens posing a healthcare risk.

- All remedial work related to Legionella have been completed.

18. There was an increase in clinical Pseudomonas infections during quarter three (see paragraph 6.5 for further information).

4.2 Ventilation

19. A Ventilation Safety Group (VSG) was set up which is currently combined with Water Safety Group (WSG) due to attendees being similar.
20. The Trust are in the process of re-appointing a new external Authorising Engineer (ventilation) who with work with the Trust in the same capacity as AE(Water).
21. Both the Head of Estates and Estates Manager have successfully completed HTM Authorised Persons course for ventilation.
22. Capital Planning for replacement Air Handling plant for Theatres 1 to 5 has continued, and a paper has been approved by the Executive Team to proceed with design to tender process.

4.2 Soft FM Services

- The incumbent provider was reappointed to provide soft FM services following the tender process with the new contract commencing on 1st April 2022.
- The National Cleaning standards were implemented across the Trust.
- 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. This programme with be aligned with the National Cleaning Standards requirements.
- The first place PLACE-Lite was undertaken January 2022.

5. Education

23. Mandatory training.
24. PPE education which included donning and doffing.
25. ANTT competency/training.
26. The Trust participated in the national Infection Prevention week. A range of activities were undertaking including stands, Glo` Tell box to promote hand hygiene across clinical areas, “Clean Trace” training.
27. “Bug of the day” info circulated Trust wide.
28. Ward based catheter management sessions for nursing and therapy staff.
29. Bite size programme delivered.
30. Student nurse day placement with the IPC team.
31. Desktop outbreak incident training for new IPC nurses.
32. Water safety week.
33. Ward based education in link areas.

6. Outbreaks/Untoward Incidents

There were two outbreaks of CPE on Sherrington ward during August 2021.

6.1 Outbreak one

The first outbreak was identified at the beginning of August 2021 when patient one who had been tested on admission to the Trust was retested and identified as CPE positive with a Klebsiella New Delhi metallo-β-lactamase (NDM)-1 strain. Patient one was isolation with the appropriate precautions in place.

Patient two was in the same bay as patient one for three days and had also had a negative CPE test on admission. Patient two tested positive with a Klebsiella New Delhi metallo-13-lactamase (NDM)-1 strain on the second round of contact screening. All appropriate interventions undertaken which included:

- Outbreak meeting held
- Contact tracing completed by the IPC team and a 4-week enhanced screening commenced for the contacts as per Trust policy.
- Enhanced cleaning in place across the ward.

6.2. Outbreak two

Patient one was identified on 29/08/21 as CPE positive with a Verona Integron-encoded Metallo-13-lactamase (VIM) CPE. The genotype was different from the earlier cases on Sherrington and therefore not connected. All patients on the ward were screened and a further two cases identified; the patients had not been in the same bay as the first patient who became positive. Enhanced screening continued and in total there were six patients who acquired CPE on Sherrington.

There was an extensive review of the ward environment and the following themes identified:

- Patients not screened in line with the Trust policy.
- Sub-optimal environmental cleaning.
- Lack of knowledge regarding the CPE policy and changes to admission and outbreak screening.

In addition, it became evident that although considerable reassurance was being provided at ward level there was a lack of assurance that processes were robust and monitored. To address this the Lead Nurse Infection Prevention and Deputy Chief Nurse delivered an educational session for the ward managers which covered IPC processes, monitoring and roles and responsibilities which was positively received. This session will be provided again for those ward managers who could not attend. As a result of this a “clean the clutter” day was implemented and a ward walk through will be replicated across all wards to ensure that the areas reviewed on Sherrington e.g., drainage, cleaning etc, are consistently addressed.

A comprehensive action plan was developed which was reviewed weekly to ensure that actions were addressed and completed.

6.3 Outbreak 3 COVID-19 – Complex Rehabilitation Unit

The outbreak started on 5th August 2021 when two patients were found to be COVID-19 positive on routine screening. An initial outbreak meeting was held, and infection prevention interventions reviewed.

Between 5th August 2021 and 19th August 2021 there were eight patients who acquired COVID-19 (nosocomial infection) and eight staff. The outbreak was contained to one side of the unit and there were no deaths because of the outbreak and a cluster review undertaken.

The probable source of the outbreak was a staff member who had attended the workplace when symptomatic. This identified a gap in local induction procedures which was escalated to managers.

6.4 Outbreak 4 – COVID-19 Sherrington Ward

An outbreak was declared on 5th January 2022 with the last COVID-19 positive patient was 21st January 2022. In total 18 patients tested positive with two community acquired cases, 14 nosocomial and 2 indeterminate cases.

6.5 Outbreak 5 COVID-19 Lipton Ward

An outbreak was declared on 5th January 2022 with the first case 31st December 2021 and the last COVID-19 positive patient 6th January 2022. In total five patients tested positive and identified as nosocomial infections.

6.6 Outbreak 7 – COVID-19 Cairns Ward

An outbreak was declared on 9th January 2022 with the last COVID-19 positive patient was 28th January 2022. In total eight patients tested positive with one community acquired case, four nosocomial and two indeterminate cases

6.7 Pseudomonas infections

An increase in clinical Pseudomonas infections was identified during quarter three. Each patient journey was reviewed with cross-over occurring on Dott ward identified. Positive test results were obtained from locations with tap filters on which suggested external contamination. Samples from five patients and additional water samples were sent for further testing to determine what future work was potentially required. Typing demonstrated that a positive outlet on Dott ward was linked to a clinical patient sample.

All remedial work has been completed and ISS have confirmed that full training on how to clean clinical hand wash basins and sinks has been provided to all domestic staff and random quality assurance observations have been undertaken; the IPC team continue to undertake active surveillance.

7.0 Staff Flu` campaign

The 2021-22 `flu campaign was delivered by Liverpool University Hospital Foundation Trust (LUFT) LUFT vaccination hub. Despite additional mobile vaccinations provided by the IPC team uptake at closure of the campaign was 56% (regional uptake in healthcare workers was 60%) which is a significant reduction to previous years >80%.

The reasons for reticence for `flu vaccination included a substantial number of staff who would not have the flu vaccine at the same time as the COVID-19 vaccine or did not want `flu vaccine after receiving COVID-19 vaccine.

8.0 Surgical Site Infection (SSI)

The IPCT conduct SSI surveillance for all surgical procedures that are “knife to skin” (including some pain procedures). The total percentage rate of surgical site infections for the period April 2021-March 2022 is 1.41% which is below 3% internal threshold set by the Trust (see Appendix 5).

The IPC team have work closely with Theatres to review and implement the “One Together programme” to reduce SSI. The programme was registered and approved by the Audit Committee and will run for twelve months.

The SSI group has continued to meet during 2021-2022 and the SSI action plan reviewed and updated.

The Surgical Site dashboard became operational during this reporting period and will be developed further during 2022-2023.

9. HCAI Reduction Plan 2021 – 2022

As reported in 2020-2021 Annual Report the achievement of all objectives within the plan was impacted by staffing. This was due to both vacancies and sickness absence (both COVID and non-COVID-19 related) within the IPCT and Tissue Viability service and staffing was placed on the Trust risk register.

Despite these challenges, significant progress was made in the completion of core objectives with some work streams transferring to the 2022-2023 workplan (Appendix 2)

Appendix 2

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

COMPLETED		IN PROGRESS		NO PROGRESS TO REPORT		REVIEW NOT DUE/COMPLETE	

Objective 1

- **The organisation has systems in place to manage and monitor the prevention and control of infection**

Action	Target /Timescale	Lead	Q1	Q2	Q3	Q4	Progress
Review compliance with CQC standards	April 21, July 21 , Nov 21, Feb 22	Lead Nurse IPC					Updating of policies behind schedule
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					Not submitted regularly due to staffing in IPC team
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					Attendance were possible due to staffing in IPC Team

Objective 2 **34. 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 35. Integrated Performance Report 36. Surveillance 37. Hand hygiene 38. Saving lives	May 21 September 21 October 21 January 22	Informatics					BI Analyst commenced in post October 2021 HCAI dashboard under development No further work planned with Saving Lives or hand hygiene as Trust confirmed implementation of Perfect Ward November 2021
Undertake surveillance and monitor 39. Cranial infections 40. EVD infections 41. Implant infections	Monthly	IPCT/ Hydrocephalous Nurse Specialist					Surveillance continued.

42. Lower level spinal infections		Spinal Nurse Specialist					Staff absence in Hydrocephalous Team – delay in SBAR Q.4 Gaps in EVD surveillance due to IPC staffing
10 % reduction in the number of MSSA blood stream infections 43. Quality Improvement Group 44. Competencies 45. Training plan 46. Refresh ANTT programme 47. IPCT rostered sessions in link area 48. MSSA action plan to be monitored via IPCC	April 21 – March 2022	IPCT DIPC					Trajectory exceeded ITU Task and Finish Group met ANTT training plan Q4. Although trajectory exceeded 20% reduction achieved
Objective 3 **49. 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					3 month extension agreed by Chief Nurse. To complete by end of Q4 Q4. Progress made but not completed due to IPC staffing
Provide specialist support to services to develop policies, procedures and guidance within the Trust	April 21 March 2022						

Objective 4 **50. 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					COMPLETE
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					COMPLETE
Prepare core training plan and deliver formal and informal education to all grades and disciplines of staff	April 21 – March 22	IPC Team					COMPLETE
Deliver IPC Ambassador education programme	June 21 September 21 December 21 March 22	IPC Team					Not delivered in Q3 due to ward staffing Not delivered Q4 due to ward and IPC staffing
Review and refresh ANTT across the Trust	Sept 21	IPC Team					ANTT Sessions provided additional sessions to be scheduled

							Q.4. limited uptake of train the trainer sessions
Undertake blood culture competencies and audit of practice	September 2	IPC Team/PEF's					Audit outcome presented by ACCP at IPCC
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 21	Lead Nurse IPC Senior Nurse IPC					Objectives set for new IPC staff
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					Complete
Undertake TNA for immuniser training	July 21	IPC Team					Vaccination via LUFT Vaccination Hub COMPLETE

							Q3. National ELearning programme Utilised to provide additional support to increase flu uptake
Develop Elearning package	July21	Workforce Analyst					Vaccination via LUFT Vaccination Hub COMPLETE Q3 National ELearning programme Utilised to provide additional support to increase flu uptake
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 21	IPC Team					Q3. To include in 2022-23 reduction plan
Implement national CPE guidance	June 21	IPCT					COMPLETE
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					No PL:ACE inspection 2021-2022 PLACE-Lite undertaken January 2022

Review and implement new national standards for cleaning	September 21	Head of Facilities					Currently under review. Plan for implementation 01/04/2022
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	Mr Carter/ 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 September 21 December 21 March 22	IPCT/Theatre R & G Lead					
Implement SSI dashboard	June 21	Lead Nurse IPC/Informatics					Monthly data to Surgeons to commence January 2022
Introduce education plan for management of surgical wounds	March 22	TV Nurse Specialist					TVN commenced in post November 2021. Review Q4 Q.4 Education/pathways reviewed within current resource and business case planned to increase TV resource
Provide support to Theatre User Group	Monthly	Senior IPC Nurse					Attendance were possible due to IPC staffing

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	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					

Appendix 3

Infection Prevention and Control; Healthcare Associated Infection (HCAI) Reduction Plan 2022 – 2023
(Interim document and subject to change due to development of IPC Strategy)

COMPLETED		IN PROGRESS		NO PROGRESS TO REPORT		REVIEW NOT DUE/COMPLETE	

Objective 1 • **The organisation has systems in place to manage and monitor the prevention and control of infection**							
Action	**Target/Review**	**Lead**	**Q 1**	**Q 2**	**Q 3**	**Q 4**	**Progress**
Review compliance with CQC standards	April 22, July 22, Nov 22, Feb 23	Lead Nurse IPC					
Maintain COVID-19 Assurance Framework	April 22, July 22, Oct 22, Jan 23	Lead Nurse IPC					
Continue to support operational team in the delivery of services post COVID-19	April 22, July 22, Oct 22, Jan 23	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 22, July 22, November 22, February 23 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 /Review	**Lead**	**Q 1**	**Q 2**	**Q 3**	**Q 4**	**Progress**
Continue alert organism surveillance and monitor progress against trajectories	Monthly	IPC Team					
To report mandatory surveillance data in line with national requirements	15th each month	DIPC IPC Team					
Undertake surgical site surveillance	Monthly	IPC Team					
Lead investigations of 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 22 – March 23	IPC Team					
Continue to develop digital HCAI reporting in the Trust to reduce duplication and increase efficiency • Integrated Performance Report • Surveillance	Quarterly	Informatics					
Objective 3 • **10% reduction in MSSA and Gram-Negative infections by the development and implementation of Quality Improvement Programmes**							
Action	**Target /Review**	**Lead**	**Q 1**	**Q 2**	**Q 3**	**Q 4**	**Progress**
Set up MSSA and Gram-Negative QI improvement groups Develop QI delivery plans to include: ▪ Review management of continence ▪ Review, update and develop competencies	April 22 – March 2023	IPC Lead Nurse/Divisional Chief Nurses					

▪ Audit aseptic practice ▪ Implement line competences ▪ Develop line database and share data/outcomes ▪ Embed IPCT rostered sessions in link areas							
Objective 4 • **Ensure the provision of evidence based, relevant policies procedures and guidance**							
Action	**Target /Review**	**Lead**	**Q 1**	**Q 2**	**Q 3**	**Q 4**	**Progress**
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 22 March 2022	Lead Nurse IPC					
Provide specialist support to services to develop policies, procedures, and guidance within the Trust	April 22 March 2023	Lead Nurse IPC					
Objective 4 • **Monitor compliance with IPC policies through the Infection Prevention Audit Programme**							
Action	**Target /Review**	**Lead**	**Q 1**	**Q 2**	**Q 3**	**Q 4**	**Progress**
Review and plan annual audit programme	May 2022	Senior Nurse IPC					
Implement IPC audit programme and monitor outcomes/progress via Tendable	July 22, Nov 22, Feb 23, April 23	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**							
Action	**Target /Review**	**Lead**	**Q 1**	**Q 2**	**Q 3**	**Q 4**	**Progress**
Annually review content of infection prevention and control training package	May 2022	IPC Team					
Prepare core training plan and deliver formal and informal education to all grades and disciplines of staff	April 2022 – March 2023	IPC Team					
Deliver IPC Ambassador education programme		IPC Team					
Deliver ANTT training	April 2022- March 2023	IPC Team					
Introduce “Drop the Glove” initiative to reduce inappropriate glove use	January 2023	Lead Nurse IPC/Head of Facilities					
Plan annual IPC campaign programme	June 2022	Senior IPC Nurse					
Support spoke placements for student nurses, Trainee Nurse Associates and *adhoc* placements for students and ward staff	April 22– March 23	IPC Team					
Objective 6 **51. Lead the delivery of the Staff seasonal flu campaign to support staff health and well-being**							
Action	**Target /Review**	**Lead**	**Q 1**	**Q 2**	**Q 3**	**Q 4**	**Progress**
Review 21-22 campaign	June 2022	IPC Team					
Develop delivery plan for 2022-23 campaign	June 2022	IPC Team					
Undertake TNA for immuniser training	July 2022	IPC Team					

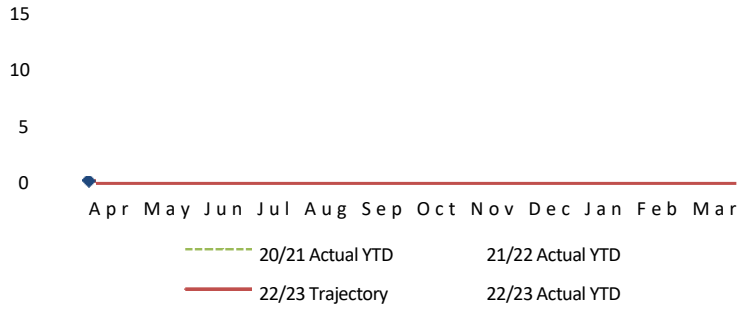
Objective 7 • **To comply with national guidance on cleanliness and provide patients, visitors and staff with a clean safe environment**							
Action	**Target /Review**	**Lead**	**Q 1**	**Q 2**	**Q 3**	**Q 4**	**Progress**
PLACE-Lite assessments will be undertaken, and action plans formulated to address any concerns	June 22	Head of Facilities					
Monitor national standards for cleaning to support implementation of star ratings system	Quarterly	Head of Facilities					
Undertake environmental audits within clinical areas in line with National Cleaning Standards Requirements	Weekly/Monthly	Facilities					
Provide expertise and specialist IPC input into Estates and Facilities meetings/works	April 22- March 23	IPCT					
Objective 8 • **Appropriate antimicrobial prescribing in in line with "Start Smart and Focus" to ensure compliance Antimicrobial Stewardship will be embedded and monitored across the Trust**							
Action	**Target /Review**	**Lead**	**Q 1**	**Q 2**	**Q 3**	**Q 4**	**Progress**
Develop Antimicrobial Strategy	January 2023	Antimicrobial Pharmacist					
Undertake antibiotic ward rounds	Daily – HITU Weekly – Wards	Consultant Microbiologist					
Antibiotic audits/prevalence studies	Monthly	Antimicrobial Pharmacist					
Antimicrobial Stewardship Group	Quarterly	Clinical Director Neurosurgery					

Objective 9 • **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**
Complete “One Together” programme	March 2023	IPCT/Theatre R & G Lead					
Continue development of SSI dashboard	March 2023	Lead Nurse IPC/Informatics					
Develop business case to increase Tissue Viability resource to support SSI reduction e.g., education plan for management of surgical wounds, development of surgical wound management pathways and outpatient management of complex wounds/infections	August 2022	Lead Nurse IPC/TV					

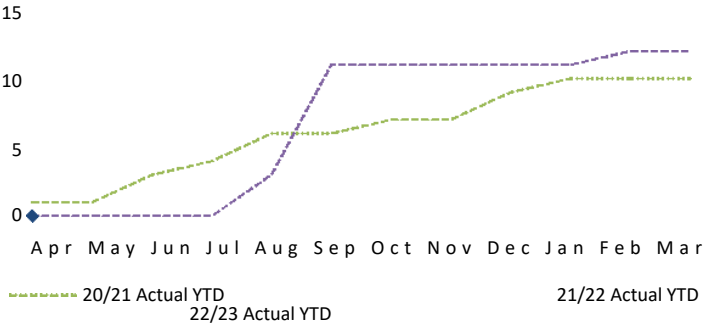
Appendix 4

HCAI Data April 2021 – March 2022

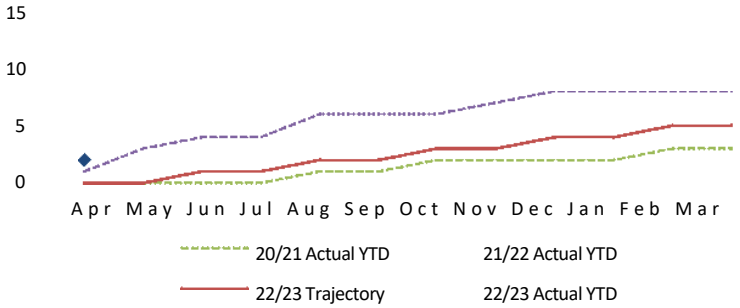
MRSA Bacteraemia



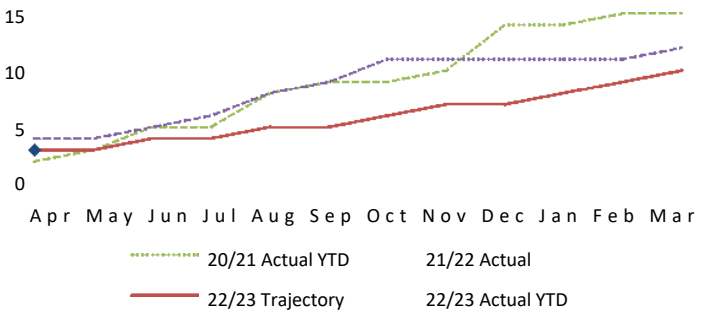
CPE

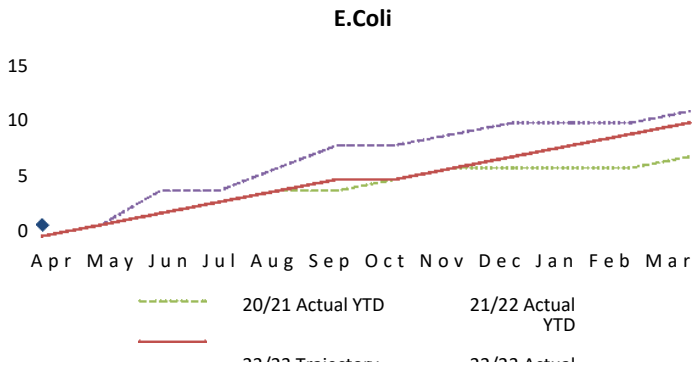


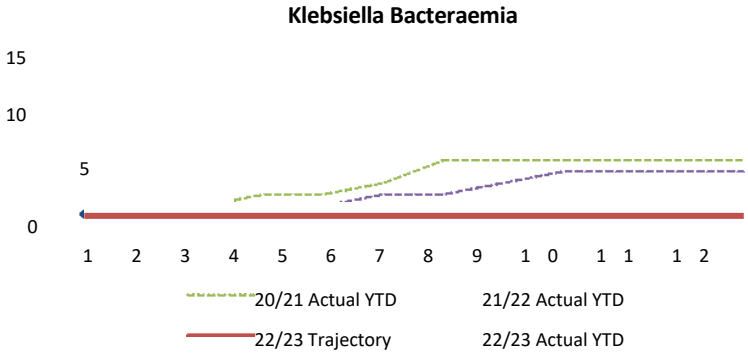
C.Diff



MSSA




E.Coli
15
10
5
0
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar
20/21 Actual YTD
21/22 Actual YTD


Klebsiella Bacteraemia
15
10
5
0
1 2 3 4 5 6 7 8 9 10 11 12
20/21 Actual YTD
21/22 Actual YTD
22/23 Trajectory
22/23 Actual YTD

Appendix Five

IPC Surgical Site Infection Surveillance

Annual Audit Report April 2021 – March 2022

Totals

Total Procedures	4469
Total Infections	63
Infection Rate	1.41%

Operation Type

Elective	2750
Urgent	756
Expedited	450
Emergency	510
Not Recorded	3

Elective (Infected)	26 (0.95%)
Urgent (Infected)	20 (2.65%)
Expedited (Infected	14 (3.11%)
Emergency (Infected)	3 (0.59%)

Infection Rate by Procedure Group

Cranial	2.55%
CSF	2.27
Implants	1.65
Spinal	1.90%
Other	0.08%

Type of Infection

Deep	43
Superficial	12
Empyema	3
Meningitis	5
Not Recorded	0

Deaths (SSI)

No deaths were recorded where the patient was also diagnosed with an SSI.

Specimens Received

Received (Yes)	59
Not Received (No)	4

Organisms Located

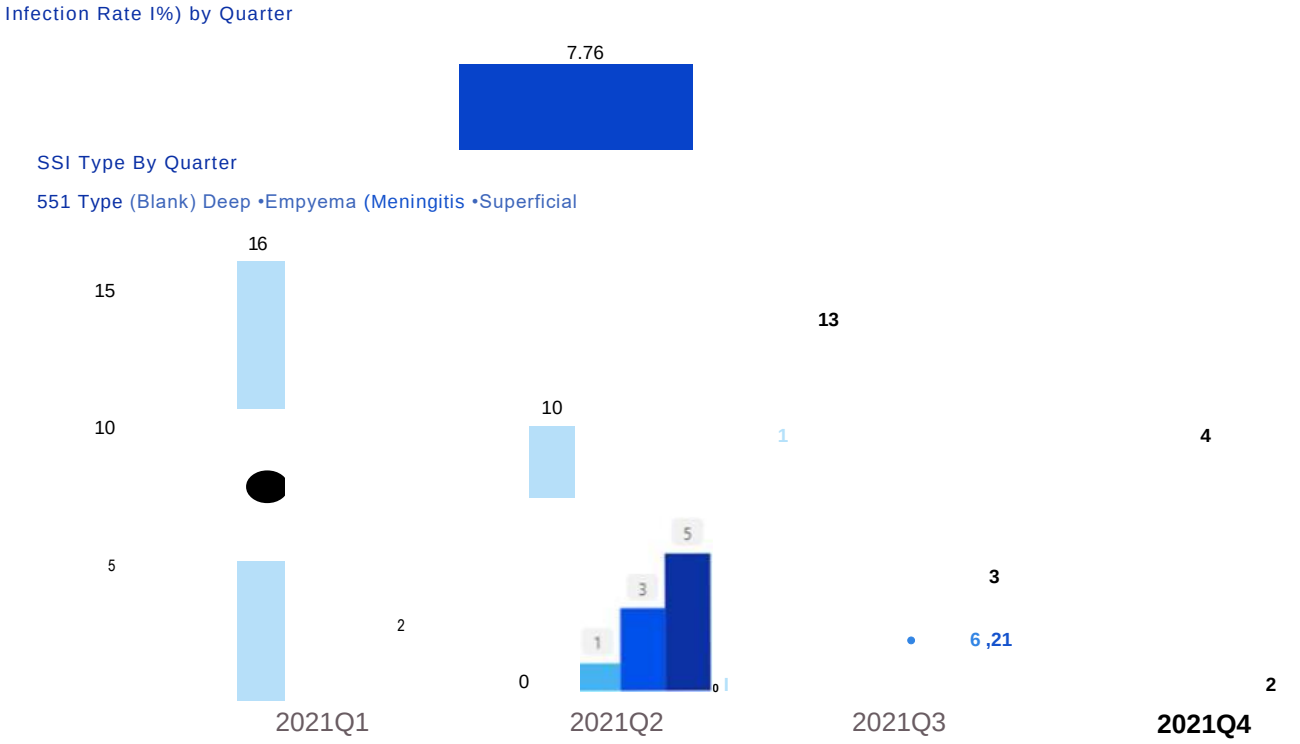
Located (Yes)	49
Not Located (No)	14

Number of Organisms Located

No Organism	6
One Organism	33
Two Organisms	9
Three+ Organisms	5
Not Recorded	8

Graphical Analysis

Infection Rate by Quarter



Quarterly Infection Totals

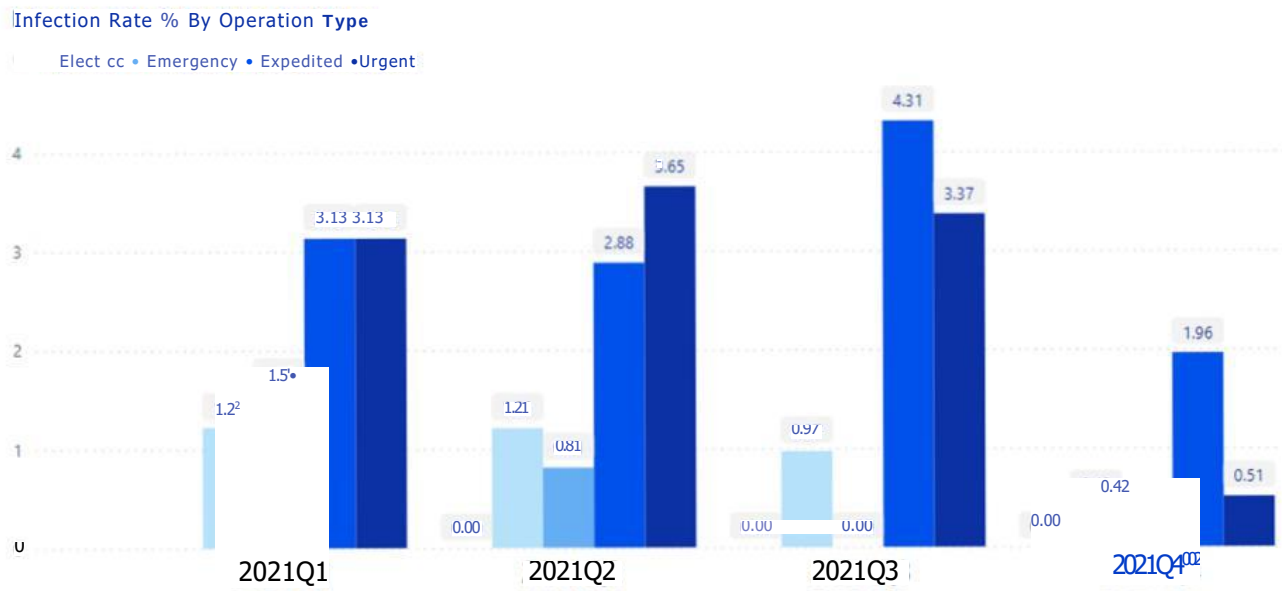
2021Q1	2021Q2	2021 Q3	:(i2 1 0-1
19	19	19	6

Operation Type by Quarter

Quarterly Operation Totals

2021Q1	2021Q2	2021Q3	2021Q4
1073	1080	1182	1134

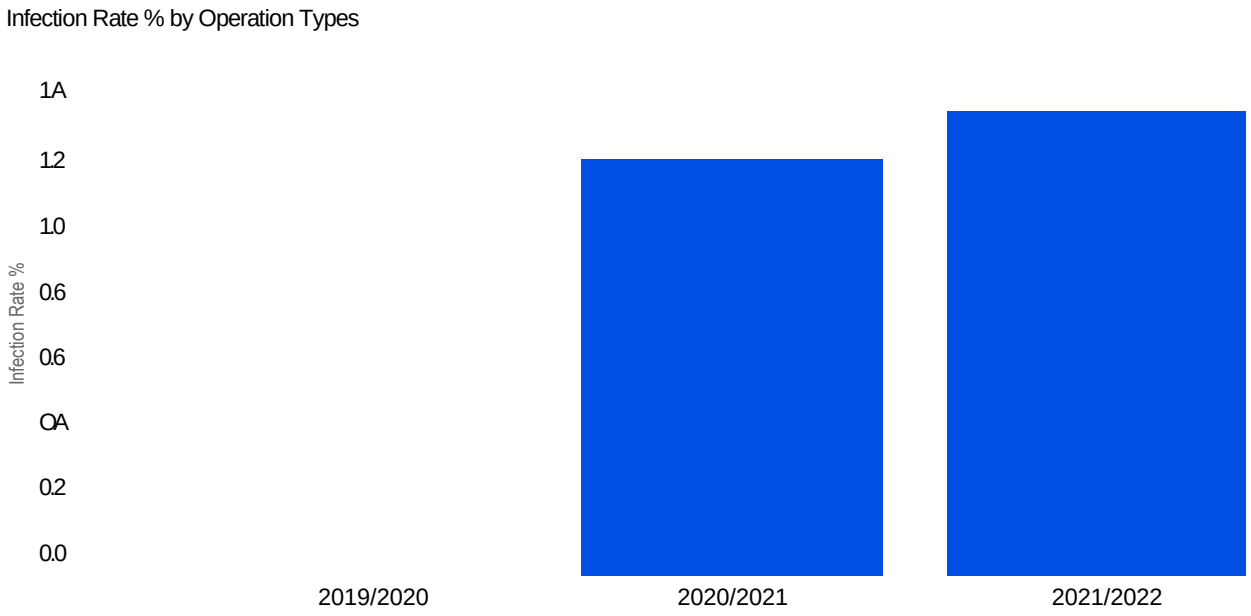
Infection Rate (%) by Operation Type



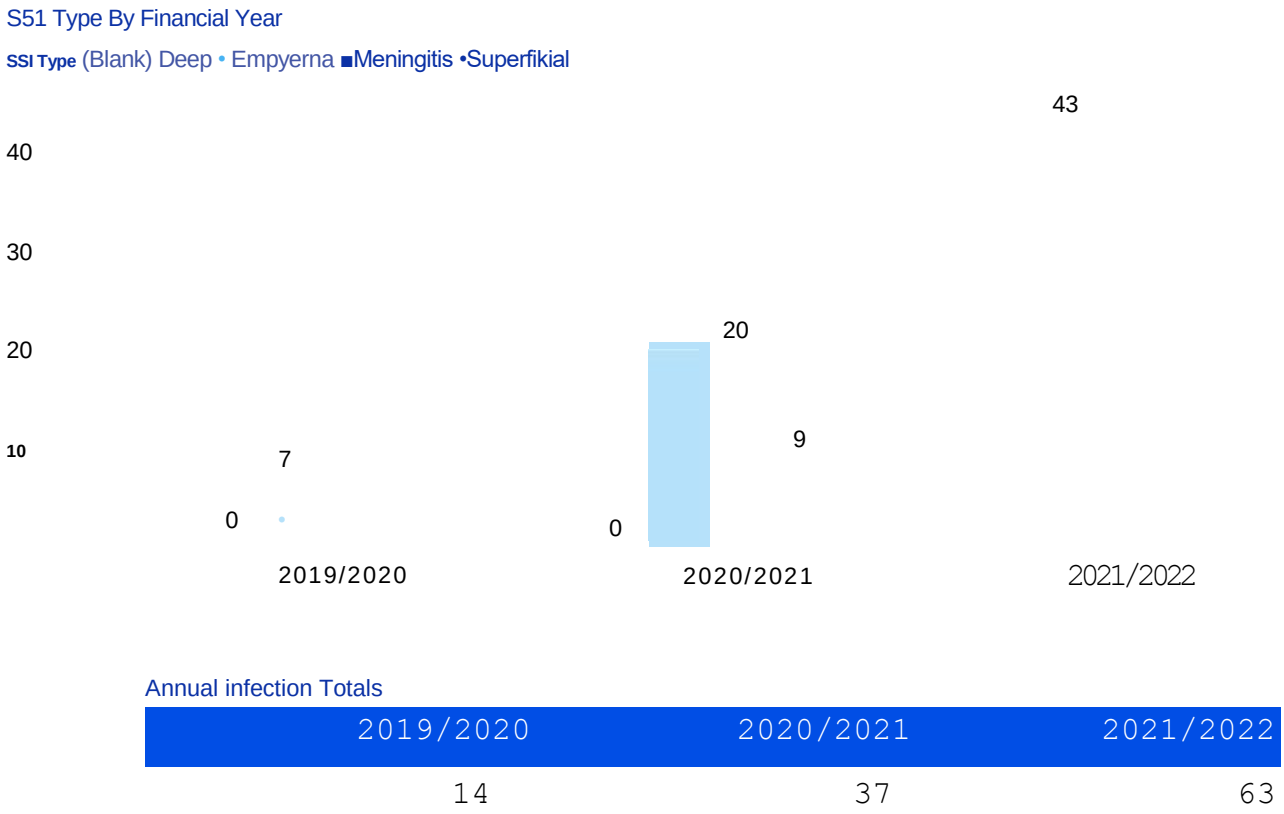
Quarterly Infection Rate % Totals

2021Q1	2021Q2	2021Q3	2021Q4
1.77	1.76	1.61	0.53

Infection Rate (%) by Financial Year



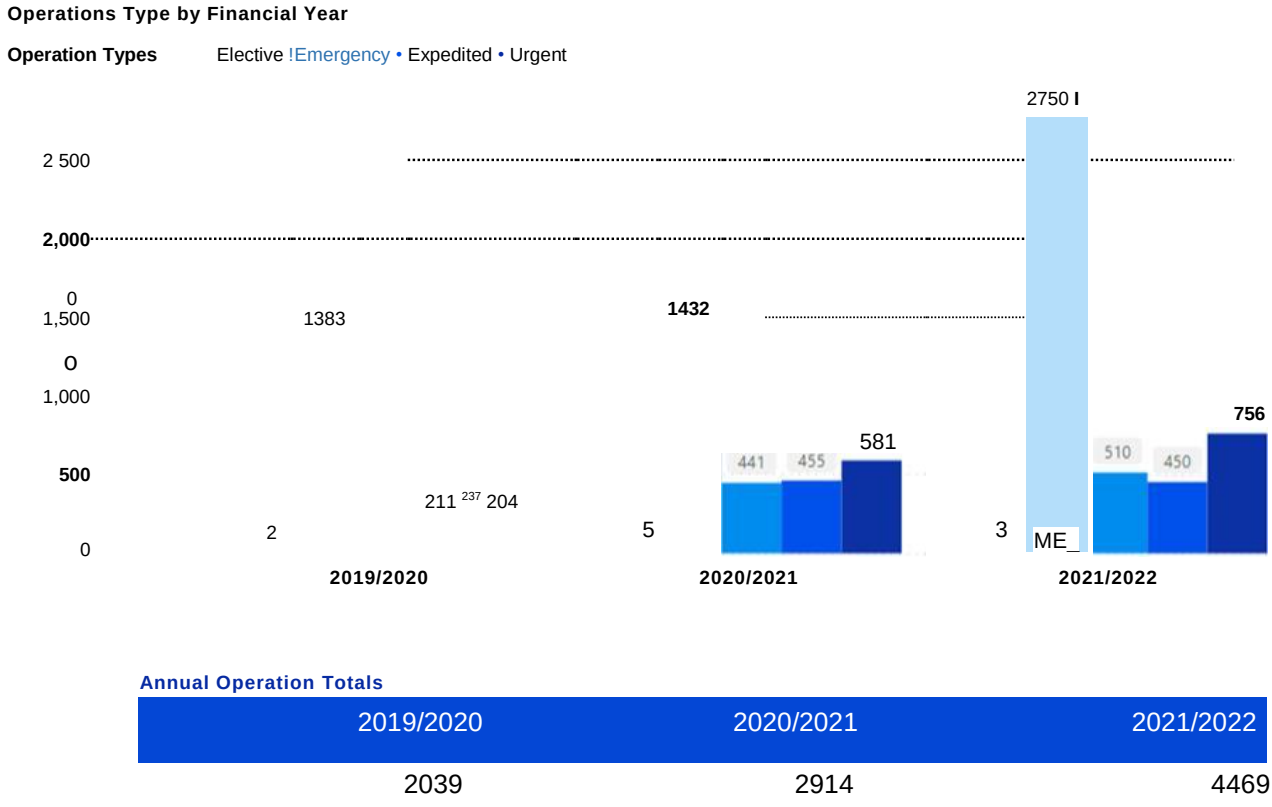
SSI Type by Financial Year



Annual infection Totals

2019/2020	2020/2021	2021/2022
14	37	63

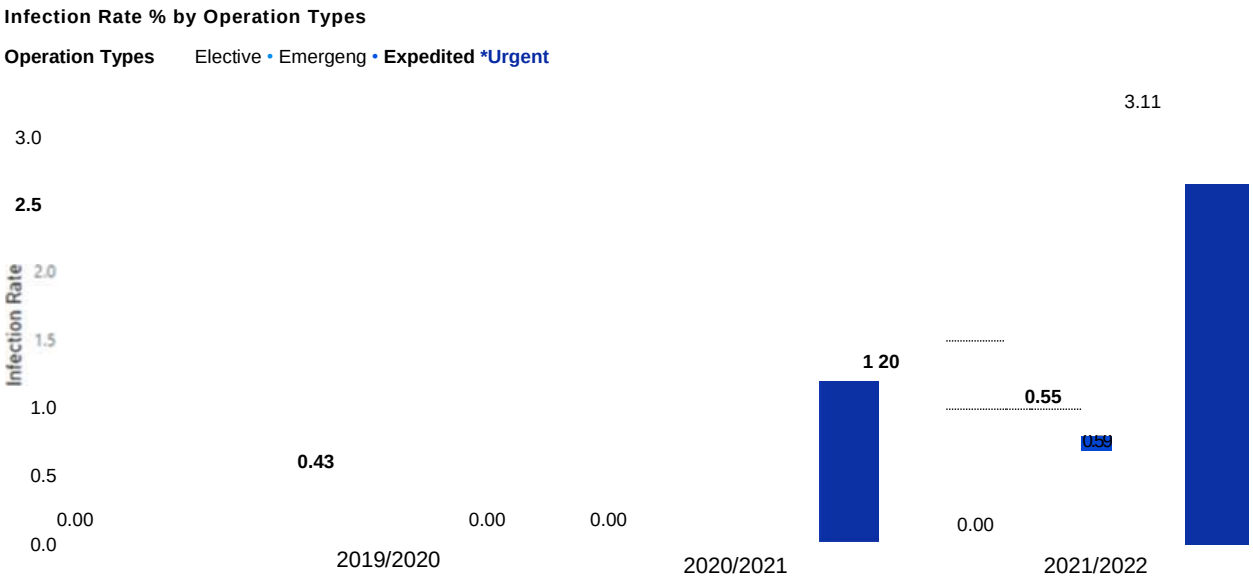
Operation Type by Financial Year



Annual Operation Totals

2019/2020	2020/2021	2021/2022
2039	2914	4469

Infection Rate (%) by Operation Type



Annual Infection Rate % Totals

2019/2020	2020/2021	2021/2022
0.69	1.27	1.41

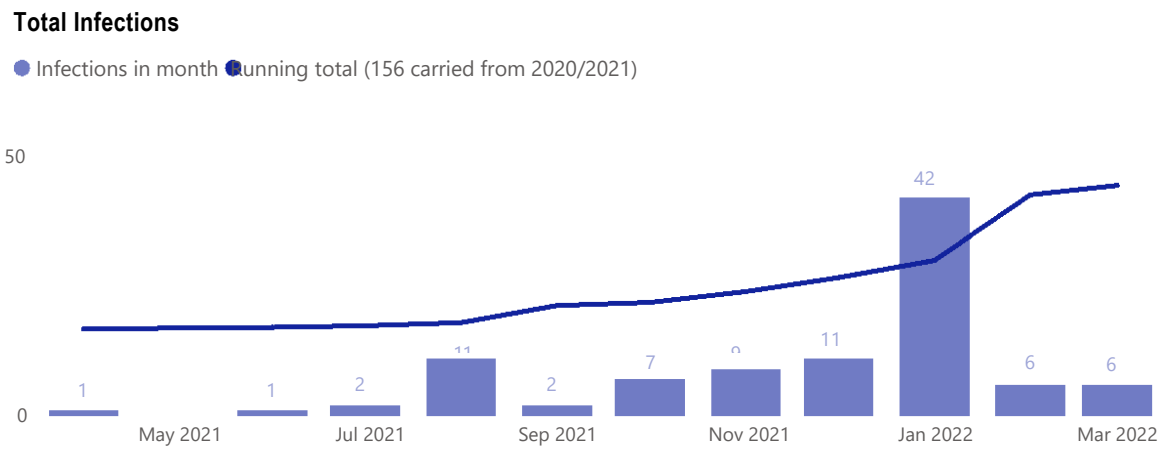
2021/2022 Covid Infection Data

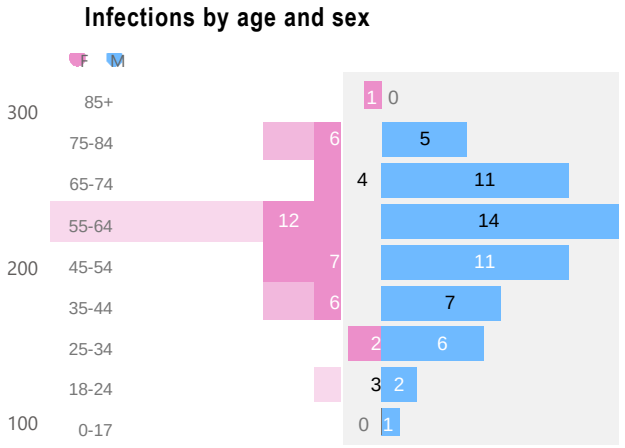
98
Total Positives

78
Discharged

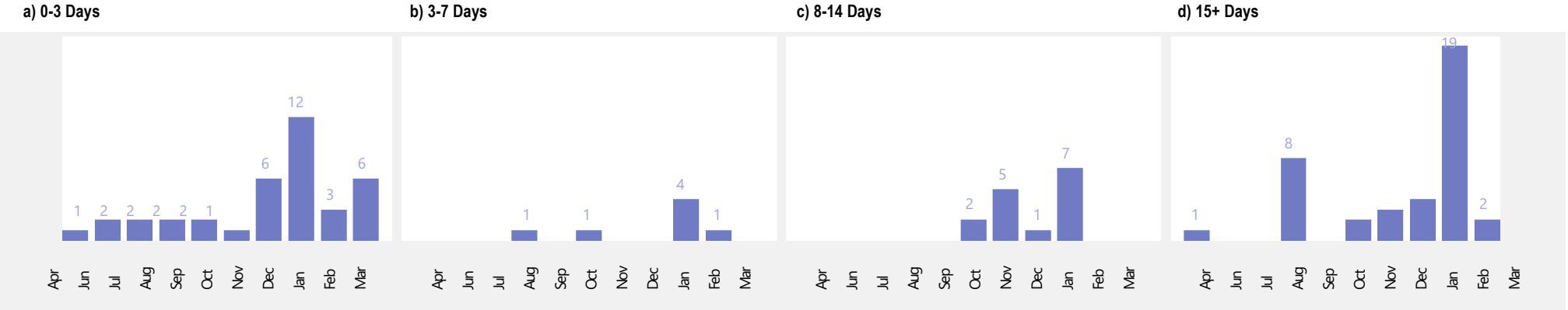
3
Died in Hospital

3
Died < 28 Days





Infections by Nosocomial Group



The Walton Centre NHS Foundation Trust

Report to Trust Board
9th June 2022

Report Title	Freedom to Speak Up Annual Report 2021/2022
Executive Lead	Lisa Salter, Chief Nurse
Author (s)	Julie Kane, Quality Manager and Freedom to Speak Up Guardian
Action Required	To note

Level of Assurance Provided

✓ **Acceptable assurance** Systems of controls are suitably designed, with evidence of them being consistently applied and effective in practice	☐ **Partial assurance** Systems of controls are still maturing – evidence shows that further action is required to improve their effectiveness	☐ **Low assurance** Evidence indicates poor effectiveness of system of controls

Key Messages

- The purpose of this report is to provide the Board with an overview of the Freedom to Speak Up (FTSU) process and activity during 2021/2022
- The report also provides information relating to the work of the National Guardians Office (NGO)

Next Steps

- Actions have been agreed with the Executive Lead for Raising Concerns which will be progressed during 2022/2023

Related Trust Strategic Ambitions	**Impact**		
Leadership	Quality	Equality	Workforce

Strategic Risks

004 Patient Care and Experience	005 Recruitment and Retention of Staff	

Equality Impact Assessment Completed

Strategy ☐	Policy ☐	Service Change ☐

Report Development

Committee/ Group Name	**Date**	**Lead Officer (name and title)**	**Brief Summary of issues raised and actions agreed**
N/A			

Freedom to Speak Up Annual Report 2021/2022

Executive Summary

1. The aim of the annual report is to provide a summary of the activity undertaken across the Trust by the Freedom to Speak Up Guardian (FTSUG) during 2021/2022.

2. The Freedom to Speak Up process aims to encourage colleagues to speak up to stop potential harm and anything that gets in the way of patient care or that affects their working life.

Background and Analysis

3. Following the Mid-Staffordshire inquiry and the Freedom to Speak Up review Sir Robert Francis QC stated "Poor standards of care can proliferate unless both patients and staff are listened to by the leaders of our health services and their concerns welcomed and acted upon. Speaking up should be the norm, not a dangerous exception to a general practice of keeping one's head down. Every healthcare leader from ward to board level has to promote a culture where speaking up about legitimate concerns can occur without fear of harassment, bullying or discrimination".

4. All NHS trusts in England are required, by the National Guardian's Office (NGO), to submit high level, anonymised data from the Freedom to Speak Up Guardian. The National Guardian's Office publishes regular benchmarking figures of the numbers and types of concerns raised which provides an opportunity to compare The Walton Centre FTSU activity with other trusts.

5. Freedom to Speak Up is for anyone who works in health. This includes any healthcare professionals, non-clinical workers, senior, middle and junior managers, volunteers, students, locum, bank and agency workers, and former employees

6. The National Guardian's Office is jointly funded by the Care Quality Commission (CQC) and NHS England and Improvement (NHS E/I).

7. The National Guardian for the NHS reports annually to the boards of CQC and NHS E/I on the work of the NGO.

Conclusion

8. The FTSUG will continue to work closely with the Executive Lead, recently appointed Non Executive Lead for Raising Concerns and other staff groups to further promote speaking up arrangements.

Recommendation

9. The Board are asked to note the FTSUG Annual Report.

Author: **Julie Kane, Quality Manager and Freedom to Speak Up Guardian**
Date: **26th May 2022**

The Walton Centre
NHS Foundation Trust
Excellence in Neuroscience

Freedom to Speak Up Guardian
Annual Report 2021/2022

1. INTRODUCTION

Freedom to Speak Up is for anyone who works in health. This includes any healthcare professionals, non-clinical workers, senior, middle and junior managers, volunteers, students, locum, bank and agency workers, and former employees.

The Freedom to Speak Up Guardian (FTSUG) plays an important role in supporting an open and transparent 'speak up' culture of improvement and learning where speaking up and raising concerns are welcomed. A positive speak up culture is essential to ensuring the organisation is well led.

All staff are encouraged and supported in raising concerns and know their concerns will be acted upon will have a positive impact on patient safety, promote good practice and ensure lessons are learnt

The FTSUG operates independently, impartially and objectively whilst working in partnership with individuals and groups throughout the organisation. The FTSUG and champion support the organisation to be open, responsive and compassionate to staff members when they speak up.

Patients and their families who have concerns or suggestions for improvement, should contact the Patient Experience Team.

This report provides data, information and updates on the activities undertaken by the Freedom to Speak Up Guardian (FTSUG) and National Guardians Office (NGO) during the year.

2. BACKGROUND TO FREEDOM TO SPEAK UP

Following the Mid-Staffordshire inquiry and the Freedom to Speak Up review Sir Robert Francis QC stated "Poor standards of care can proliferate unless both patients and staff are listened to by the leaders of our health services and their concerns welcomed and acted upon. Speaking up should be the norm, not a dangerous exception to a general practice of keeping one's head down. Every healthcare leader from ward to board level has to promote a culture where speaking up about legitimate concerns can occur without fear of harassment, bullying or discrimination". The full review and executive summary are available on via the following link http://freedomtospeakup.org.uk/the-report

The Principles for Responding to Speaking Up:

- There will be clear and accessible information on how to speak up
- Speaking up processes will be designed so that all workers can speak up easily
- Everyone who speaks up will be thanked

- Where appropriate, workers will be encouraged and supported to speak up locally
- If another organisation (e.g. another national body) better addresses a matter, workers will be supported to speak up to that organisation
- Workers will be offered information on other sources of advice and support
- Workers speaking up will be provided with a response in a timeframe that is made clear to them
- Responses to speaking up will include details setting out how the information provided was used for learning and improvement
- The confidentiality of those who speak up will be respected, subject to the need to ensure safeguarding requirements are met
- Where matters are raised anonymously, they will be responded to in accordance with these principles to the extent possible
- Workers will be given the opportunity to feedback on their experience of speaking up
- The speaking up arrangements' effectiveness will be monitored, and opportunities to improve taken

3. LEADING BY EXAMPLE

One of the key elements of the FTSUG role is to provide independent, impartial and confidential advice and support to staff that raise a concern. The FTSUG is not to investigate a concern which has been raised or to mediate.

Colleagues are reminded it is not disloyal to their colleagues to raise concerns; it is a duty to our patients and staff. Misconduct or malpractice should never be tolerated and as such mistakes and/or poor practice may reveal that a staff member would benefit from further training or support or that a change in a process/system needs to be reviewed and changed if necessary.

Each individual including permanent employees, temporary employees, agency workers and volunteers are encouraged to speak up if they feel something is wrong. We want staff to know their concerns will be dealt with in an open and supportive manner because we rely on them to ensure we deliver a safe service and ensure patient safety is not put at risk.

The last year has been an extremely challenging one for all kinds of reasons. After over two years of working through the COVID-19 pandemic, even the most resilient staff and managers are feeling the effects of the pressure. In our patient care or supporting roles staff have faced significant challenges. During this time, we recognise that it is vital for staff to be able to raise concerns and for staff to feel that Trust leaders are listening and acting on the issues that matter to them. It is also important that managers working under pressure are supported to be able to respond positively to concerns raised and to welcome them as an opportunity for improvements.

4. FTSU ACTIVITIES IN THE TRUST

The FTSUG has scheduled 'drop in' sessions across the organisation and has circulated the schedule for 2022/23 so staff are aware of when and where the sessions are taking place.

Managers are asked to invite the FTSUG to their team meetings which offers the opportunity for staff to familiarise themselves with the role of the FTSUG and to ask any

questions or raise concerns. The FTSUG also attends the junior doctors forum which occurs each month.

Following attendance at various team meetings a number of staff have made contact with the FTSUG which is encouraging. Although Covid safe practices have made visiting difficult, it has been clear that staff valued visits from the FTSUG and Executive Team. Face to face visits are scheduled throughout the forthcoming twelve months with the Executive Team and Non-Executive Directors.

The process of speaking up locally is working for most and many take the opportunity to speak up during the FTSUG visits. Most colleagues speak up if they feel their managers are not addressing their concerns. As a result managers are informed of the need to ensure staff are being listened to, actions are being taken and updates/feedback is given back to those individuals or teams raising their concerns.

Concerns regarding direct threats or concerns to patient safety have not been brought to the FTSUGs attention, although behaviour, skills and communication seem to be the theme of concerns. Addressing the underlying issue of management culture remains a task for leaders of the Trust and HR are supporting managers via a number of routes such as the Building Rapport Programme which includes leadership and coaching courses, resilience training and violence and aggression sessions.

The FTSUG meets monthly with the Non-Executive/Executive Leads for Raising Concerns to discuss concerns raised and review progress. She meets with the Head of Business HR and HR Manager for Neurology monthly to discuss concerns, review themes and provide progress updates as appropriate. Meetings are also scheduled quarterly with the Chair and Chief Executive to keep them appraised of activity.

The FTSUG continues to attend virtual regional meetings throughout the year to keep appraised of national guidance, plans going forward and to share views and learn from peers.

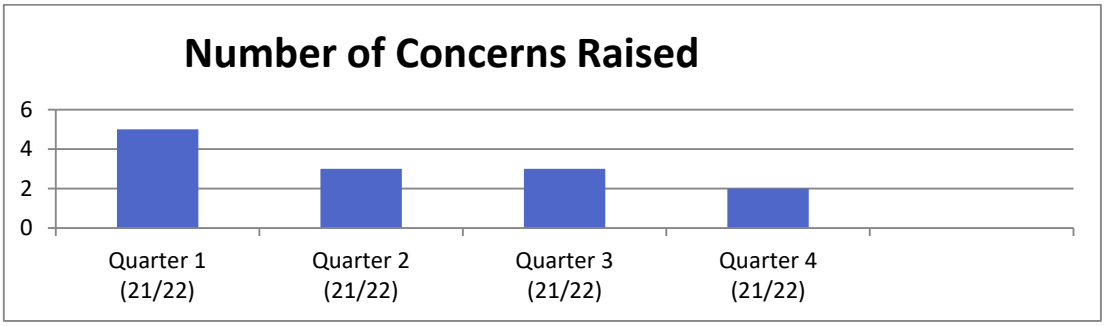
A national campaign initiated by the NGO takes place each yearly throughout the month of October. The FTSUG promoted the ‘speak up’ role which included ‘drop in’ sessions, display stands within the main hospital and Sid Watkins Building, FTSU Survey made available via survey monkey and in paper form to encourage clinical areas to complete them, raffles/games and encouraging staff members to become a FTSU Advocate.

Freedom to Speak Up Advocates have been recruited following expressions of interest. They will support colleagues in their area of work to raise concerns and signpost them to the appropriate policies/personnel. The Advocates promote speaking up and report concerns to the Guardian so the concern is logged accordingly and appropriate action taken.

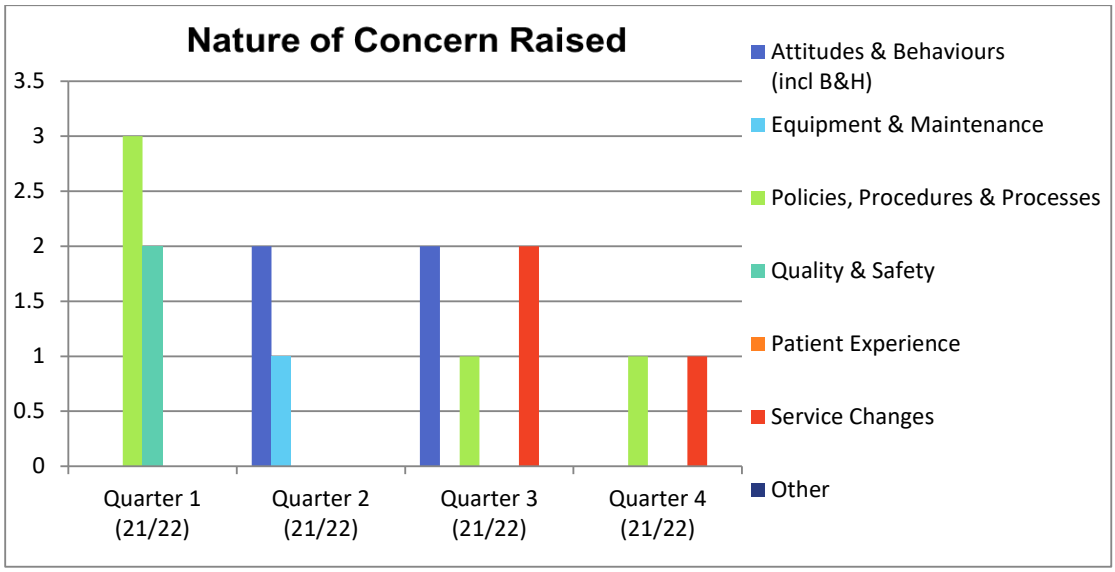
5. LOCAL ACTIVITY

The FTSUG has recorded 13 cases that were raised during this period of reporting. These cases were raised either by staff individually or in a group/team. Some cases were resolved quickly and some remain open and are being followed by the FTSUG.
Concerns were raised by colleagues from all divisions and those raising concerns included administrative staff, clinicians, nurses and AHPs.

The graph below indicates how many concerns were raised during 2021/2022.

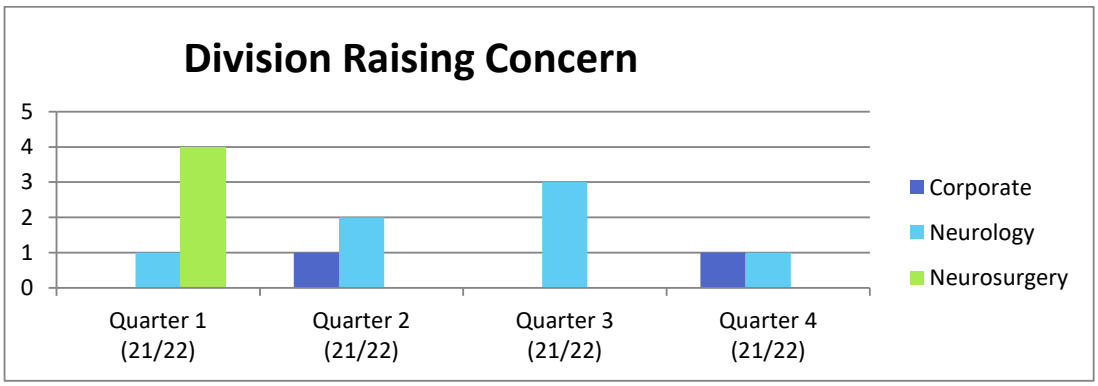


The graph below indicates the nature of the concerns raised during 2021/2022.



Note: Some concerns raised have more than one element and are displayed across a number of categories

The graph below indicates the division raising the concerns during 2021/2022.



6. How does the Trust compare within other Trusts?

All NHS trusts in England are required, by the National Guardian's Office (NGO), to submit high level, anonymised data from the Freedom to Speak Up Guardian. The National Guardian's Office publishes regular benchmarking figures of the numbers and types of concerns raised which provides an opportunity to compare The Walton Centre FTSU activity with other trusts. The full report for 2021/22 has not been published yet as the figures for quarter four are being reconciled.

The graph below provides data for quarters one, two and three during 2021/2022.

Organisation	Concerns Raised	Anonymous	Patient Safety /Quality	Attitudes & Behaviours (incl B&H)	Suffered Detriment	Worker Safety
The Walton Centre (S)	13	0	0	3	0	0
Blackpool Teaching Hospital (M)	47	12	7	25	2	3
Countess of Chester Hospital (M)	44	3	20	21	6	21
Liverpool Heart & Chest (S)	27	6	3	7	3	1
Liverpool University Hospitals (L)	131	8	54	15	5	76
Southport & Ormskirk (S)	41	3	3	9	0	1
Clatterbridge Cancer Centre (M)	3	0	0	2	0	0
Warrington & Halton (S)	14	10	0	13	0	1

It is always difficult to interpret whether a higher number of concerns is a positive or negative sign. On one level, we would want a culture where all staff feel comfortable to raise concerns with their supervisor in their day-to-day work, so it might be reasonable to think that having no concerns raised via FTSU would be a good sign. On the other hand, a larger number of concerns raised could be seen as a positive indicator that staff are aware of the FTSU process and are confident in speaking up. In general having the advocates supporting the FTSU will further raise awareness and offers the opportunity for staff to raise concerns locally.

The FTSUG would take the following actions to support cases/concerns raised with them:

- Advice given about how to respond to bullying and harassment
- Confirm what actions were being taken by the division in response to the concern
- Recommendations to contact Occupational Health, NOSS Counselling Service, ViVup, ShinyMind and Staff Side/Union for advice and support
- Review the process around exit questionnaires/meetings to ensure staff leaving the Trust take up the opportunity to take part

7. SUBMISSIONS TO THE NATIONAL GUARDIAN'S OFFICE (NGO)

The NGO issued a minimum dataset for Trust's to assist with internal and external reporting. The FTSUG follows the NGO guidance for case recording, concerns categorisation and reporting and provides this data via a portal each quarter.

The information required is listed below:

- Number of cases raised within the quarter
- Number of cases including an element of patient safety/quality of care
- Number of cases including elements of bullying and harassment
- Number of incidents where the person speaking up may have suffered detriment
- Number of anonymised cases received

The Trust's FTSUG collects information from those who have raised concerns by asking the following questions:

- Given your experience, would you speak up again
- Please explain your above response

All respondents have confirmed they would speak up again and have given positive feedback.

8. NATIONAL GUARDIAN'S OFFICE UPDATES & REPORTING

Dr Jayne Chidgey-Clark (clinical leader and registered nurse) was appointed as the National Guardian for Freedom to Speak Up in the NHS in England in December 2021 following the resignation of Dr Henrietta Hughes. Dr Chidgey-Clark has more than 30 years' experience in the NHS, higher education, voluntary and private sectors. Her most recent roles include as non-executive director at NHS Somerset Clinical Commissioning Group (CCG) where she was a Freedom to Speak Up Guardian.

The National Guardians Office undertake speak up reviews in organisations to identify learning, recognise innovation and support improvement and ultimately improve the experience or workers, patients and the public. In determining what organisation is reviewed the NGO look at a range of indicators including speak up data, staff engagement such as the NHS staff survey and what information is share with the NGO.

Reviews can be triggered by referrals to the office from individuals. The office also has the discretion to accept referrals from other sources. The office is in the process of developing the way it decides what is reviewed. These changes seek to:

- Allow more workers to inform matters that are reviewed by the office, including workers who may face barriers to speaking up
- Ensure reviews undertaken by the office have the greatest impact on the greatest number of workers by focusing on areas of priority

The case reviews are published and the collated recommendations which have been grouped thematically can be viewed via the link https://nationalguardian.org.uk/wp-content/uploads/2021/12/Learning_from_Case_Reviews.pdf

The NGO have published their revised expectations of boards and board members in relation to Freedom to Speak Up and supplementary resources and a self-review tool. The NGO want all trust boards in England to use the self-review tool.

Access to the NGO documents can be obtained via the following links:

- Speak Up Guidance to identify areas for development and improve the effectiveness of their leadership and governance arrangements in relation to Speaking Up Guidance for NHS trust and NHS foundation trust boards on Freedom to Speak Up
- Speak Up Supplementary Information (accompanies Guidance document above) Freedom to Speak Up supplementary information
- Freedom to Speak Up Self-Review Tool supports the standards laid out in the guidance. Supports the Trusts review around the eight key lines of enquiry set out in the well-led framework Freedom to Speak Up self-review tool

9. UK COVID_19 INQUIRY

The NGO responded to the proposed terms of reference for the UK Covid-19 Inquiry with the comments below.

Please explain why you think the draft Terms of Reference do not cover all the areas that the Inquiry should address. Please answer the question in the textbox below.
The draft Terms of Reference should include freedom to speak up, meaning:

- Workers' knowledge of how to speak up about anything that gets in the way of them doing a great job, feeling psychologically safe to do so, and confident that they will be meaningfully heard
- Leaders at all levels (including team, departmental, organisational, system and local/ central government) appropriately listening and following up when workers speak up.

Workers' ability, confidence, and desire to speak up and be met with an appropriate response when they speak up, is crucial for the safety and wellbeing of service users, public and workers themselves. In healthcare, freedom to speak up is crucial for patient safety.

However, workers' freedom to speak up and the responses they received were variable and sometimes poor during the pandemic. It has been a recurring issue throughout the pandemic, including regarding matters such as:

- availability and suitability of personal protective equipment (PPE)
- the disproportionate impact of the pandemic on certain groups of workers
- concerns that 'do not attempt cardiopulmonary resuscitation' (DNACPR) decisions were being made without involving people, or their families and/or carers if so wished, and were being applied to groups of people, rather than taking into account each person's individual circumstances

It is essential that lessons are identified and implemented so that we continue to embed speak up culture for the benefit of people who use services, workers and the wider public.

Do you think the Inquiry should set a planned end-date for its public hearings, so as to help ensure timely findings and recommendations?
Following up is just as important as listening, and potential lessons need to be identified and adopted. Timely findings and recommendations will promote this, notwithstanding the need for a fair and reasonable timeframe for the public hearings.

How should the Inquiry be designed and run to ensure that bereaved people or those who have suffered serious harm or hardship as a result of the pandemic have their voices heard?
Workers (including those in the health and care sector) have been at the heart of the response to the pandemic. However, some workers (including former workers) might not feel able to engage in the Inquiry. For example, we continue to hear reports about workers suffering disadvantageous and/or demeaning treatment due to speaking up, and this may discourage some workers from engaging with the Inquiry.

The Inquiry must be designed and run to ensure that workers' voices are heard, including:

- appropriate engagement
- appreciation of workers' circumstances (including fear of retaliation for speaking up)
- processes to ensure confidentiality

There should be clear communication to all leaders that those who participate in the inquiry must not experience retaliation for speaking up.

Some groups of workers may face barriers when it comes to speaking up, including workers from minority ethnic backgrounds, students and trainees, and those in non-permanent employment (e.g., agency, seasonal or casual work). We ask that meaningful consideration is given to ensuring that such groups have their voices heard.

We also suggest that explicit inclusion of freedom to speak up in terms of reference, as stated earlier in our response, will facilitate workers' voices being heard.

9. NEXT STEPS FOR THE FREEDOM TO SPEAK UP GUARDIAN

The below feedback continues to be relevant and discussions with managers have been undertaken to look at how best to address the feedback.

- Style/frequency of communication and engagement with staff, and concerns about limited feedback on issues raised by staff with managers
- Values and behaviours not seen to be fully reinforced and action not taken to challenge or address these behaviours
- Lack of support for staff development or opportunities for progression, sometimes associated with perceptions of favouritism or cliques by some managers
- Perception of inconsistent and disjointed application of HR processes by managers which is seen as unfair
- Visibility of senior leaders within the organisation
- Continue to raise awareness of the role of the Freedom to Speak Up Guardian
- Attend ward/departmental meetings and 'drop-in' sessions to promote speaking up
- Target staff who do not regularly use computers or access the Trust Intranet
- Work with Human Resources and Learning and Development to improve the confidence of managers in responding to concerns raised with them by their staff through the Freedom to Speak Up Guardian
- Roll out the e-learning modules across the organisation now that the final module has now gone live via the NGO
- Review the exit questionnaire process and current arrangements as there are missed opportunities to gather feedback
- Review the Trust Intranet system to ensure up-to-date information is readily accessible
- Support the Board, if required, to complete the revised National Guardians Office Board Self-Assessment Review

9. RECOMMENDATIONS

The Board are asked to:

Note the work done across the year by the FTSUG and confirm its assurance that the present structure of the Freedom to Speak Up Guardian role supports the Trusts objectives in regard to speaking up about patient and workers safety.

Board of Directors' Key Issues Report

The Walton Centre NHS Foundation Trust

Report Date: 17/05/22		**Report of:** Audit Committee
Date of last meeting: 17/05/22		**Membership Numbers:** Quorate
1.	**Agenda**	The Committee considered an agenda which included the following: • Draft Financial Accounts 2021/22 • Draft Annual Report 2021/22 • Draft Quality Account • Principle Risks 2022/23 • Clinical Audit Annual Report 2021/22 • Annual Cycle of Business 2022/23 • Board Register of Interests • Fit and Proper Persons Report • Non-Executive Director Independence • Informing the Audit Risk Assessment 2021/22
2.	**Alert**	• The Committee noted that the annual report was on track to be signed off on 20th June however recognised that the completion of the value of money audit was likely to be delayed to the end of June 2022.
3.	**Assurance**	• Draft financial accounts were presented and it was noted that these were in the process of being audited. Comments were welcomed and following consideration of comments received and completion of the audit the accounts would be submitted to the extraordinary Audit Committee meeting on 20th June for approval. • The draft annual report was presented and this was currently in the process of being audited. Following receipt of any comments from the auditors the report would be updated to address any comments raised and then forwarded to the communications team to improve the formatting. The annual report would then be submitted to the extraordinary Audit Committee meeting on 20th June for approval. • The draft quality account was presented and it was noted that two quality priorities had not been achieved and one quality priority had been partially achieved. These priorities would be rolled over to 2022/23 and continue to be monitored at Quality Committee. The quality account would be presented to Quality Committee on 19th May for discussion and stakeholder presentations would be held via Microsoft Teams on 10th June. Following this the quality account would be finalised and published at the end of June.

		• The approach to clinical audit was discussed and it was recognised that improvements in clinical audit had been made following a challenging two year period. Processes were being reviewed to ensure that they were fit for purpose and links with Divisional Risk and Governance meetings were also under review. An overview of work completed to ensure audits were closed down was provided and robust processes were being rolled out to ensure that all audits undertaken were a priority area for the Trust. The cycle of business would be updated to clarify reporting processes for clinical audit into the Audit Committee. • The Board register of interests was reviewed and this would be updated to ensure all declarations were included. • The fit and proper persons report was presented and all self-declarations had been completed with one outstanding due to maternity leave. • The Non-Executive Directors independence report was presented and it was confirmed that none of the declarations made were considered a conflict of independence.		
4.	**Advise**	• There were no areas to advise the Board of.		
5.	Risks Identified	• None		
6.	Report Compiled by	Su Rai, Non-Executive Director	Minutes available from:	Corporate Secretary

Board of Directors' Key Issues Report

The Walton Centre NHS Foundation Trust

Report Date:		**Report of: Neuroscience Programme Board,**
Date of last meeting: 12/05/22		**Membership Numbers:** 10
1.	**Agenda**	The Neuroscience Programme Board considered an agenda which included the following: - • GIRFT updates: Neurology & Thrombectomy • Spinal merger update • Pain Collaboration Review • All Party Parliamentary Group on Employment (MS) • Update from Healthcare Partnership (HCP) Transitional Board • CMRN review • Everton Minds update • Items for future Agendas • Neurosciences Effectives Review • Hot topics from other hospitals
2.	**Alert**	**GiRFT Updates – Neurology RANA** • To promote the RANA service a pilot service of an on-call consultant will be contacting medics directly to identify any patients that would fit the criteria and bring over for treatment where needed. This will also raise awareness of the service. Initially, three sites of LUFHT, Southport & Whiston will be contacted with the view to expanding further. • Visibility of WCFT Neurology leads at Safety Huddles/Bed Manager meetings at key pilot sites is being considered in order to highlight RANA and to ensure the correct level of support is available to other trusts.
	Assurance	**GiRFT Updates – Neurology Thrombectomy** • A 24/7-day service is in now place with the monthly average number of patients rising from 9 to 13. A number of patients are admitted out of hours. Patient pathway has been amended slightly. • There are some issues with NWAS and return transfers. However, WCFT understand the pressures affecting the ambulance service so arrangements are made for patients to be admitted to a safe location, following treatment until a transfer can be arranged. **Spinal Update** • The merger of regional single spinal service based at WCFT has now been completed. The Division are nearing the end of validating patients and all spinal referrals are now coming to WCFT. • Concerns were raised regarding some reluctance in the management of spinal patients in secondary care unless WCFT on call team has been contacted. This has been noted further work is required in this area. The Spinal Provider Board and working groups will still continue and updates of any issues will be shared. Going forwards, the Chair suggested that NSPB could lead on working through

		issues associated with the management of back pain. **Pain Collaboration Review** • Progress is being made albeit slower than anticipated. • Dr Frank is progressing the management and education of Opioids workstream with Knowsley CCG with the view to replicating this work in Sefton and Speke CCGs • As part of PMP rehabilitation, a pilot is underway with Warrington CCG investigating alternative ways to long-term prescribing for the treatment of pain.		
	Advise	**Neurosciences Effectiveness Review** • The Effectiveness Review highlighted some areas for improvement including the need for the group's purpose to be clarified and how the group links to the ICS. Both issues are points of focus for the group. Work is on-going to widen representation especially from within primary care. Plans are in place for patient representatives to join at the next meeting. • The terms of reference have been refreshed and were agreed by the group. **All Party Parliamentary Group on Employment (MS)** • The above report provides information and recommendations with regards to employment of those living with neurological conditions. The Neuro-Alliance are keen to progress the recommendations with employers and are meeting with Steve Rotherham for further support. **Update from Healthcare Partnership (HCP) Transitional Board** • It was noted that the Transformation Board provide updates to the ICS. The IRS are reviewing all of the programmes that feed into ICS at the current time • Dr Mark Griffiths presented a paper to the ICB following his review of primary psychology gaps. One particular gap was identified in neurorehabilitation for stroke patients. The paper contained a number of recommendations the development of a neuropsychology service for stroke patients with the view to extending this to other neurological conditions. All recommendations have been agreed by the ICB. **CMRN Review** • A meeting is scheduled for 16 June and attendees are being checked to ensure appropriate representation. It is envisaged that Julie Riley will be taking a more active role in order to add momentum to the review. Further information is being requested from Amanda Brookes and will be shared accordingly. **Everton Minds** • The project has moved into the design phase. Meetings are to be held with key departments (finance/procurement) at WCFT with regards to the services to be provided in the Health Zone. In addition to outpatient clinics, work is being developed on AI and immersive technology. Internal and external meetings need to be held to discuss further. This project ties in with the Prevention and Health Population work.		
3	**Risks Identified**	**Pain Collaboration** • The team were not able to recruit to the Project Manager position and instead will look within the team itself.		
4.	**Report Compiled by**	Medical Director	Minutes available from: Tracey Eaton	Corporate Secretary Katharine Dowson

The Walton Centre NHS Foundation Trust

Report to Trust Board
9 June 2022

Report Title	Neurosciences Network Programme Board (NSPB) - Terms of Reference (ToR)
Executive Lead	Andy Nicolson, Medical Director
Author (s)	Katharine Dowson, Corporate Secretary
Action Required	To note

Level of Assurance Provided

✓ **Acceptable assurance** Systems of controls are suitably designed, with evidence of them being consistently applied and effective in practice	☐ **Partial assurance** Systems of controls are still maturing – evidence shows that further action is required to improve their effectiveness	☐ **Low assurance** Evidence indicates poor effectiveness of system of controls

Key Messages

- ToR has been refreshed following the annual committee effectiveness review
- The Integrated Care System is the approving Body for these ToR

Next Steps

- N/A

Related Trust Strategic Ambitions	**Impact**		
Leadership	Not Applicable	Choose an item.	Choose an item.

Strategic Risks

Not Applicable	Choose an item.	Choose an item.

Equality Impact Assessment Completed

Strategy ☐	Policy ☐	Service Change ☐

Report Development

Committee/ Group Name	**Date**	**Lead Officer (name and title)**	**Brief Summary of issues raised and actions agreed**
NSPB	12 May 2022	K Dowson Corporate Secretary	Reviewed and proposed changes agreed. Further amendments to membership made

NSPB Draft Terms of Reference

Executive Summary

1. Following the annual review of Committee Effectiveness, the Terms of Reference (ToR) for the Neurosciences Network Programme Board were refreshed and updated by NSPB and are now provided to the Trust Board for review.

2. The constituting body of the Committee is the Integrated Care Board for Cheshire & Merseyside. The Board are therefore asked only to note the changes to the ToR. The ICS Programme Board will approve the ToR at their next meeting on 27 July 2022.

Proposed Changes

1. There were no fundamental changes to the purpose and duties of the Committee. The format and structure of the ToR have been updated.

2. An additional paragraph was included regarding the use of metrics and this is highlighted red in the ToR (Appendix 1).

3. At the meeting the following changes were proposed to the membership:

    - Patient Representative – is now in the plural as there are now four representatives (with two attending at any one time)
    - Walton Centre Chief Operating Officer and Chief Finance Officer added on as voting members
    - Clinical Lead for Transition added
    - Voluntary Sector Lead amended to Cheshire and Merseyside Neurological Alliance

Recommendation

To note

Author: Katharine Dowson, Corporate Secretary
Date: May 2022

Appendix 1

Neuroscience Network Programme Board
TERMS OF REFERENCE

Authority/Constitution

1. The Neuroscience Network Programme Board (the Committee) is authorised by the members of the Cheshire and Merseyside Health and Care Partnership Board (Integrated Care System Partnership Board (ICS) (from 1 July 2022).

2. The Committee has no executive powers delegated from the authorising or The Walton Centre NHS Foundation Trust (the Host).

3. The Committee has the authority to oversee and take decisions relating to the organisation's activities which also support the achievement of the organisation's objectives.

4. The Committee is authorised to request specific reports from individual functions within the organisation and to seek any information it requires from any member of staff in order to perform its duties.

5. The Committee is authorised to create operational sub-groups, advisory or working groups as are necessary to fulfil its responsibilities within its terms of reference. The Committee remains accountable for the work of any such group. Any of these groups will report directly to the Committee who will oversee their work.

Purpose

6. The purpose of the Committee is to improve neurology and neurosurgery outcomes for the Cheshire and Merseyside population through improving equality of access, at scale best practice pathways in neuroscience conditions via clinically led work streams that will enhance quality, reduce variation and drive efficiencies in support of the ICS Strategy and the NHS Long Term Plan.

Membership

7. The Committee shall be comprised of the following voting members:

- Senior Responsible Officer (TWC Medical Director) (Chair)
- Programme Director
- Cheshire and Merseyside Acute Trust Representatives
- Cheshire and Merseyside Neurological Alliance
- Chief Operating Officer (TWC)
- Chief Finance Officer (TWC)
- Clinical Commissioning Group Representatives (to 30 June 2022)
- Divisional Clinical Director (TWC) – Neurosurgery
- Divisional Clinical Director (TWC) - Neurology
- Finance Leads

- Local Authority Representative
- Patient Representatives
- Primary Care Clinical Lead / GP
- Public Health Lead
- Specialised Commissioner
- Clinical Lead for Transition

8. The Committee will be deemed quorate when the SRO is present (or nominated deputy) with at least six other members present, this must include clinical representation from both acute and primary care.

9. In the event that the Chair of the Committee is unable to attend a meeting, the Non-Executive Director members shall appoint one of their number to be Chair for that meeting. The Chair shall have a casting vote in the event of a vote.

10. Members may only nominate a deputy to attend on their behalf if they have sufficient understanding of the area they are representing to be able to contribute effectively to the Committee's business and have been fully briefed; however, this should only be in exceptional circumstances.

11. Colleagues from local government, NHS or external advisers may be co-opted or requested to attend for specific agenda items as necessary.

Requirements of Membership

12. Members must attend at least 75% of all meetings each financial year but should aim to attend all scheduled meetings. Attendance will be recorded and monitored.

13. Conflicts of Interest – the Companies Act 2006 defines a conflict of interest as arising when the interests of directors or 'connected persons' are incompatible or in competition with the interests of the organisation. Committee/Group members are required to exercise judgement and to declare such interests as there is a risk of implied improper conduct. The relevant interest, once declared, will be recorded in a register of interests, maintained by the Company Secretary.

Duties

14. In order to fulfil its role and obtain the necessary assurance, the Committee will:

- Establish a Strategic vision for networked neuroscience care across the ICS footprint and develop a collaborative strategic plan to implement this vision
- Support the Cheshire & Merseyside (C&M) Places by using population demographics, demand forecasts, benchmarks & capacity analysis to assess the current performance for the system identifying key issues for the local population
- Work as a system to identify key issues and their drivers, quantify the size of challenge, model impact of solutions and prioritise transformation programmes
- Ensure effective collaborative mechanisms are in place across C&M to oversee delivery of the networked neuroscience services along the whole pathway
- Act as a specialist subject matter expert reference group for the stakeholder organisations, advising on the role and strategic direction of the Neuroscience Network programme within the ICS
- Be responsible for the development of the overall Neuroscience Network programme set by the ICS Partnership Board and Programme Review group, including

recommendations on resource utilisation, effective outcomes, timescales and financial allocation

- Undertake financial modelling at both Place and STP level to identify the main drivers of current performance and quantify the impact of the 'do- nothing' versus changing scenarios
- Consider and review relevant metrics, support the development of appropriate performance measures such as key performance indicators (KPIs), and associated analysis, reporting and escalation frameworks.
- To identify opportunities and make recommendation to the C&M ICS Partnership Board and the nine Places to meet the strategic objectives of the ICS (Whole System Integration, Acute Sustainability, Mental Health and LD Sustainability, Carter at Scale, Prevention at Scale)
- Make recommendations on investment and disinvestment in Neuroscience Network programmes to the ICS Partnership Board, Places and individual organisations as appropriate
- Monitor and oversee the working of the groups to account for the delivery and outcomes of projects associated to the overall Neuroscience Network programme
- Create an environment where all organisations within the C&M footprint for Neuroscience Work Streams can facilitate delivery of the objectives

15. Ensure that governance and assurance systems operate effectively and underpin programme delivery to include the areas outlined above.

16. Provide assurance to the host on compliance with associated legislation, national reporting and regulatory requirements, best practice and progress against objectives.

17. The Committee will also keep under review any risks relevant to its remit in order to provide assurance to the Board that risks are being effectively controlled and managed

Data Privacy

18. The Committee is committed to protecting and respecting data privacy. The RIME Committee will have regard to the EU General Data Protection Regulation (Regulation (EU) 2016/679) (GDPR) and demonstrate, where applicable, compliance with data protection legislation, in particular the Data Protection Act 1998 (DPA).

Equality, Diversity & Inclusion

19. In conducting its business, the Committee will at all times seek to meet its obligations under the Equality Act 2010 and promote its commitment to equality and diversity by the creation of an environment that is inclusive for both our workforce, patients and service users, including those who have protected characteristics and vulnerable members of our community.

Reporting

20. The Committee will be accountable to the ICS Programme Board and will report to the C&M Executive Team, the ICS System Management Board and The Walton Centre's Board of Directors. The Board of Directors will be informed of the Committee's work through an assurance report from the Chair submitted following each meeting.

21. Specific items for information/ action will form part of communications to the wider membership

Administration of Meetings

22. Meetings shall be held every other month with additional meetings held on an exception basis at the request of the Chair or any three members of the Committee. There shall be a minimum of five meetings per year.

23. The Corporate Secretary of the host will make arrangements to ensure that the Committee is supported administratively. Duties in this respect will include development and monitoring of a workplan, agenda setting, taking minutes of the meeting and providing appropriate support to the Chair and Committee members.

24. Agendas and papers will be circulated at least four working days in advance of the meeting.

25. Minutes will be circulated to members for comment as soon as is reasonably practicable.

26. An annual workplan will be agreed which will be reviewed at least quarterly by the Committee to ensure it is meeting its duties.

Review

27. The Terms of Reference shall be reviewed annually and approved by the Board of Directors.

28. The Committee will undertake an annual review of its performance against its work plan and the Trust's Annual Plan in order to evaluate the achievement of its duties.

Reviewed by the Committee: 12 May 2022
Reviewed by the Host: *June 2022*
Approved by the ICS: *tbc*

Review Date: March 2023

Board of Directors' Key Issues Report

The Walton Centre NHS Foundation Trust

Report Date: 11/05/22		**Report of:** Research, Innovation and Medical Education Committee
Date of last meeting: 04/05/22		**Membership Numbers:** Quorate
1.	**Agenda**	The Committee considered an agenda which included the following: • Committee Effectiveness Review 2021/22 and Terms of Reference Report • Board Assurance Framework – Q4 2021/22 • Good Clinical Practice Training Progress Update • UK Clinical Guidelines for the Diagnosis of Fibromyalgia Syndrome • Strategic Partnerships Update • Medical Education Strategy and Implementation Plan Update • Outcomes from R&D Workshop on 18/03/22 • Research and Development Finance and Performance Report • Review of SPARK Funding Applications • Sub-committee Chair's Reports for 2 sub-committee meetings
2.	**Alert**	**Committee Effectiveness Review 2021/22 and Terms of Reference Report** • Further to feedback received from members in the 2021/22 Committee Effectiveness Review, it was proposed for a working group to be convened to review the Committee's function, responsibilities and engagement encompassing terms of reference, membership and work plan and those of its sub-committees. There was agreement that the day and time of the Committee meetings should also be reviewed as are currently scheduled to be held the evening prior Trust Board which was thought to be detrimental to its effectiveness. **Outcomes from R&D Workshop on 18/03/22** • Outcomes from the NRC workshops held in March and April 2022 - Clarity on the improvements required with an emphasis that now was the time for reinvestment into research and that if this did not take place within the next 3 months, there would be critical failures for the Trust in terms of reputation, staff retention and patient outcomes. An action plan for the next 3-18 months had been developed with the key priorities identified as: o Staffing – appointment of a senior NRC manager within the next 3 months and research nursing resource o Governance and quality assurance o Communication. Recruitment to a senior manager position (Band 8a) for the NRC was approved at Executive Team Meeting on 04/05/22.

		Review of SPARK Funding Applications • An update on Liverpool Health Partners SPARK grant applications where the Trust was either the study sponsor or lead site was presented. Out of 28 applications made; 17 had been unsuccessful, 1 had been successful and 10 were outstanding. Further work was being undertaken by the NRC to identify the reasons why applications had been unsuccessful to enable lessons to be learnt. Although some of the projects had been a success in terms of creating collaborations/networks there was acknowledgement that there was a need to turn activity into successful outcomes.
3.	**Assurance**	**Good Clinical Practice Training Progress Update** • A comprehensive review of GCP training compliance had been undertaken by the NRC which showed that out of 207 research active members of staff as of the 25 March 2022: 105 GCP certifications were in date, 53 GCP certifications required renewal, 49 had either not completed their GCP training or there was no record. Committee was assured that there were no non-compliant members of staff contributing to clinical trial/investigatory work and that the risks were being appropriately managed. Follow ups were being made with those staff identified as requiring GCP certification renewal or completion of their GCP training. Risk of future reoccurrence would be managed via recent increase in the administrative capacity within the NRC which would support a more robust governance process moving forward and also strengthening alignment with the Principal Investigators Forum.
4.	**Advise**	**UK Clinical Guidelines for the Diagnosis of Fibromyalgia Syndrome** • Dr Andreas Goebel was one of the lead authors for the new UK Clinical Guidelines for the diagnosis of Fibromyalgia Syndrome along with a Primary Care colleague from the Liverpool City region, Dr Chris Barker. The guidelines were launched at the Royal College of Physicians in Liverpool on the 26 April 2022: https://www.rcplondon.ac.uk/news/rcp-publishes-new-guidance-diagnosis-fibromyalgia . These were the first UK guidelines for the condition and would have a significant contribution to the patient group. Since their launch, the guidelines had received 4,000 downloads by service providers nationally and were an excellent example of cross-sector collaboration work across primary and tertiary care. Dr Goebel had also been involved in an auto-immune basis for Fibromyalgia study in conjunction with Kings College London which was nominated in December 2021 by the Guardian as one of the top 10 science stories of the year: https://www.theguardian.com/science/2021/dec/19/the-years-top-10-science-stories-chosen-by-scientists. As a result of the study, there had already been a £10 million investment generated in the North West primarily in Liverpool, from private companies. **Medical Education Strategy and Implementation Plan Update** • As a Trust, we are continuing to grow our medical education faculty and have recently appointed a Trainee Health and Wellbeing Lead, Miss Maggie Lee, Neurosurgical Consultant. This was a one-year funded post through Health Education England as part of the national COVID Recovery training programme to provide additional support to clinical and educational leads with regards to junior doctor pastoral and professional needs. Dr Antonella Macerollo had also been appointed as Undergraduate Research Co-ordinator for the Trust.

		The Trust was also looking to appoint to an Educational Appraisal Lead role and an expression of interest had been received in response to this. Financial approval had been received for a further year's funding for the Education Fellow posts.		
5.	**Risks Identified**	• No new risks identified		
6.	**Report Compiled by**	Professor Paul May, Non-Executive Director	Minutes available from:	Corporate Secretary

Board of Directors' Key Issues Report

The Walton Centre NHS Foundation Trust

Report Date: 09/06/22		**Report of: Strategic Black, Asian and Minority Ethnic Advisory Committee (SBAC)**
Date of last meeting: 16/05/22		**Membership Numbers:** 11 attendees Quorate
1.	**Agenda**	The Committee considered an agenda which included the following: • SBAC Advisory Committee Effectiveness Review • NW SBAC Assembly update • Feedback from WCFT @ Race Forum • Feedback from E, D & Group • Measure for Improvement • Health Inequalities • Communications update • Work Plan • WRES Action Plan & Approach
2.	**Alert**	**SBAC Advisory Committee Effectiveness Review** • Whilst the response rate of the review was low, feedback was positive and highlighted areas for improvement. The main point for consideration is for the committee to review its main aims, objectives and purpose as the committee was originally established due to the inequalities highlighted by COVID. A working group is to be established to consider the Committee's scope and function in more depth and to develop a work plan for the coming year.
3	**Assurance**	**ED&I Communication update** • LGBT History month was celebrated and the stand was well attended • Awareness of the *United Nations day for the Elimination of Racial Discrimination* was raised via shared communications with Alder Hey & Clatterbridge. A joint seminar was held with around 60 people attending • Communications shared Trustwide at the start of Ramadan.
4	**Advise**	**Update on any general developments from NW SBAC Assembly** • The assembly had met on the 31 March 2022 • The key focus for the assembly for 2022-23 includes the Anti-racist Framework and a core focus on the 20% +5. The 20% relates to the most deprived in the population, and the 5 key areas of maternity, mental health, respiratory, cancer diagnostics and hypertension. • The assembly received feedback on its involvement in the recruitment to key posts in the ICS and ICB and concluded that some progress was made with the involvement of BAME applicants to key posts but it was found the suitable candidates were limited and were 'not quite ready for the roles'. The assembly will continue its work in this area. **Anti-Racist Framework** • The Anti-Racist Framework is led by the Northern Care Alliance (NCA) and there is an expectation for Trusts to have an Implementation Plan. Tara Hewitt (from NCA)

		has been invited to the next SBAC Committee meeting to showcase NCA work and to clarify expectations and requirements • The NW SBAC Assembly is offering trusts accreditation in this area and if successful this is publically known. • Ayo Barley will lead a task and finish group with the aim of an implementation plan being drafted by the end of the year **Feedback from ED&I Group** • The Group met on 24/03/22. The Gender Pay Gap report has been submitted with associated action plan. One of the recommendations is to obtain more qualitative data from female staff. Questions are being included in staff surveys in July and August to capture useful information which hopefully can be used to close the gender pay gaps • Staff Networks were discussed and on-going work is planned for these to become more established **Measures for Improvement & Health Inequalities** • A short presentation of Health Inequalities was shared providing background, information and data of current WCFT position. • Data using the Indices of Multiple Deprivation (IMD) as opposed to ethnicity was shared. For patients there was a direct correlation for Did Not Attend (DNA) and IMD for both virtual and face to face appointments. There was no correlation with IMD and waiting times but the data did indicate that the bulk of patients are from the most deprived areas. • Initial findings for staff using IMD highlighted that 40% of staff are from the most deprived areas of the city and in the lower pay bands. • Going forwards, a meeting will be held with the CEO and further discussion with Trust Board to agree next steps with regards to a Health Inequalities Project **WRES action plan and approach** • New WRES/WDES data has been received and work is underway to develop action plans accordingly.		
2.	Risks Identified	None		
3.	Report Compiled by	Su Rai	Minutes available from: T. Eaton	Corporate Secretary

The Walton Centre NHS Foundation Trust

Report to Trust Board
9th June 2022

Report Title	COVID-19 Board Assurance Framework
Executive Lead	Lisa Salter, Chief Nurse/Director of Infection Prevention
Author (s)	Helen Oulton, Lead Nurse Infection Prevention/Tissue Viability
Action Required	To note

Level of Assurance Provided

☐ **Acceptable assurance** Systems of controls are suitably designed, with evidence of them being consistently applied and effective in practice	✓ **Partial assurance** Systems of controls are still maturing – evidence shows that further action is required to improve their effectiveness	☐ **Low assurance** Evidence indicates poor effectiveness of system of controls

Key Messages

- The Trust has implemented revised national guidance on the prevention and control of respiratory infections and COVID-19 and the Board Assurance Framework has been updated to reflect this.
- New gaps in assurance have been identified and are currently under review to appropriately mitigate associated risks.

Next Steps

- To note

Related Trust Strategic Ambitions	**Impact**		
Quality of Care	Quality	Finance	Legal

Strategic Risks

001 Impact of Covid 19 on delivery of strategic objectives	016 Infection Prevention and Control	004 Patient Care and Experience

Equality Impact Assessment Completed

Strategy ☐	Policy ☐	Service Change ☐

Report Development

Committee/ Group Name	**Date**	**Lead Officer (name and title)**	**Brief Summary of issues raised and actions agreed**

COVID-19 Board Assurance Framework

Executive Summary

1. The COVID-19 framework is a tool for assessing the measures taken in line with current guidance to prevent and control COVID-19. The framework provides evidence that the Trust has effective systems in place to optimise actions and interventions to control respiratory infections including COVID-19.
2. This purpose of this report is to outline the processes in place to manage the risk of COVID-19 which include the identification of the current gaps and mitigating actions.
3. The report (see Appendix One) identifies the areas that require review and action to demonstrate areas of high and low assurance and associated mitigation within the Trust.

Key updates/changes

4. The framework was updated and published by NHSE/I in December 2021and the framework is reviewed each quarter (unless updates published). This report is a planned review and amendments have been made to reflect current national guidance which is listed below:
    - Pre pandemic sub speciality cohorting commenced 1-4-22.
    - Change to High risk and Standard pathway (previously red, amber, and green).
    - Updated testing guidance implemented.
    - Asymptomatic COVID-19 contacts managed in line with national guidance e.g., no additional screening or isolation.
    - Cessation of LAMP testing and move to staff screening by LFD.

5. New gaps in assurance
    - Monitoring and recording of patient LFD results.
    - Access to fit testers as clinical staff who are accredited to fit test have reduced time to support the ongoing programme in the move to “business as usual”.

6. Increased assurance
    - Cleaning is now in place on late shifts as part of the new domestic services Soft FM contract.
    - Ventilation group (combined with water safety) is in now in place.
    - Tendable will provide audit results electronically in real time to identify areas that require support.

Conclusion

7. The guidance to prevent and control of respiratory infections including COVID-19 is changing rapidly in the move to a “business as usual” approach in the provision of healthcare.

8. Using the Hierarchy of controls the Trust has identified and implemented measures that are compliant with national guidance; new gaps in assurance that have been identified as part of the planned review are currently under consideration to identify and implement the appropriate mitigation required.

Recommendation

- To note

Author: Helen Oulton - Lead Nurse Infection Prevention/Tissue Viability
Date: 19th May 2022

Appendix 1

IPC BAF Report

COVID-19 Infection Prevention and Control Board Assurance Framework

- **Version 1.0 of this framework was published on 4 May 2020.**
- **Version 1.4 - published in October 2020**
- **Version 1.6 - published in February 2021**
- **2nd Version 1.6 - published on 30th June 2021**
- **Version 1.8 - published 24 December 2021**

Key Lines of Enquiry	Evidence	Gaps in Assurance	Mitigating Actions
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			
• A respiratory season/winter plan is in place: • that includes point of care testing (POCT) methods for seasonal respiratory viruses to support patient triage/placement and safe management according to local needs, prevalence, and care services • to enable appropriate segregation of cases depending on the pathogen. • plan for and manage increasing case numbers where they occur.	• Patient pathways in place and reviewed in line with national guidance. Pre pandemic sub speciality cohorting commenced 1-4-22 • Winter Plan • Chavasse is designated Covid ward with cohorting capacity dependent on number of cases and pathogens • Command and Control oversight and escalation • On admission bed manager's undertake individual risk assessments to identify the risk of infection. • Each area has a documented Environmental risk assessment • NHSE/I monthly regional meeting include epidemiology updates regarding prevalence	• No POCT available. • Risk Assessments require review	• PCR testing provided by LCL • LFD on admission and PCR if LFD negative • Meet with Head of Risk & Governance to review with H & S

• a multidisciplinary team approach is adopted with hospital leadership, estates & facilities, IPC Teams and clinical staff to assess and plan for creation of adequate isolation rooms/units as part of the Trusts winter plan.	• Nosocomial data reviewed and attendance at regional and national meetings and webinars • Updated national screening policy for Covid is elective LFD day 0, 3, 7 – emergency LFD on admission if negative PCR, lateral flow day 3 and 7 • Increase COVID testing 3 x weekly in the event of rising Covid positivity rate	• Monitoring and recording of inpatient LFD results as tests done at ward level not via LCL	• Discussions underway with Head of BI
• Health and care settings continue to apply COVID-19 secure workplace requirements as far as practicable, and that any workplace risk(s) are mitigated for everyone.	• Policies available regarding social distancing and the use of PPE • Guidance for assessment of those who report difficulties wearing a surgical face mask, this is dealt with on an individual basis • Guidance when outpatients do not wear a face covering • COVID-19 precautions, social distancing & non-compliance - HR Guidance • PPE and Alternatives for Respiratory Protection for COVID-19	• Departments not completing risk assessments or not rating/reviewing them accurately	• IPC are contacted when any staff have difficulties with wearing masks to identify alternatives or movement away form a clinical area/working from home.
• Organisational /employers risk assessments in the context of managing seasonal respiratory infectious agents are: • based on the measures as prioritised in the hierarchy of controls, including evaluation of the ventilation in the area, operational capacity, and prevalence of	• Infection alerts are on EP2 for all patients with a previous IP alert organism. • Trust COVID -19 policy in line with UKHAS guidance • Each area has a documented Environmental risk assessment which includes hands, face, space, ventilation. • Covid audits/reviews • Regular opening of windows to improve ventilation	• Adherence to Policy • Adherence to guidance/patient compliance • Limited number of side rooms	• Temperature, hand gel and mask station at main entrances

infection/new variants of concern in the local area. • applied in order and include elimination; substitution, engineering, administration and PPE/RPE. • communicated to staff.	• Patient placement guidance • Clear curtains as a physical barrier in ward areas • Seating dividers in OPD		
• Safe systems of working; including managing the risk associated with infectious agents through the completion of risk assessments have been approved through local governance procedures, for example Integrated Care Systems.	• IPC daily review of clinical areas. • Risk assessments revised and agreed • Peer challenge is encouraged. • Visiting guidance agreed regionally and monitored to minimise any risk. • Both visitors and patients are encouraged to maintain social distancing, wear face masks, regular hand decontamination and keeping the environment uncluttered and clean. • Waste management and PPE stations are in place at all entrances • Other resources include: • Posters • Regular Comms • Supportive Intranet • Hand sanitisers widely available to support hand hygiene • Matrons' checklist • IPC visits • Visibility from senior leaders and IPCT		
• If the organisation has adopted practices that differ from those recommended/stated in the national guidance a risk assessment has been completed and it has been	• NOT APPLICABLE		

approved through local governance procedures, for example Integrated Care Systems.			
• If an unacceptable risk of transmission remains following the risk assessment, the extended use of Respiratory Protective Equipment (RPE) for patient care in specific situations should be considered.	• PPE is worn according to UKHAS guidelines • Staff are fit tested or considered for Hoods. • All staff receive IPC on mandatory induction/clinical health and safety. • Donning and doffing training • There are posters displayed in all clinical areas on IPC measures and guidance. The Matrons check list supports audit of staff. • Training compliance is monitored by observational visits, training compliance and audit.	• Reduction in mandatory training compliance • Availability of fit testers/compliance	• Currently under review by Divisions and Head of Risk
• Ensure that patients are not transferred unnecessarily between care areas unless, there is a change in their infectious status, clinical need, or availability of services.	• Screening policies and SOPs are in place for high risk and standard pathways.	• Potential asymptomatic patients may be in incubation phase, therefore risk of infecting other patients. • Lack of assurance with LFD/PCR testing compliance • Screening data quality sub-optimal • Significant number of patient moves often within the same ward	• National guidance implemented, Asymptomatic patients are not tested or isolated. • Re-admission policy of previous COVID + ve patients • Testing policy for day 0, 3 and 7. Increased screening 3 x weekly in response to rising Covid cases • Patients with COVID symptoms are transferred to Chavasse ward a designated area.

• The Trust Chief Executive, the Medical Director or the Chief Nurse has oversight of daily sitrep in relation to COVID-19, other seasonal respiratory infections, and hospital onset cases	Actions below implemented as required dependent on national covid cases, guidance and reporting mandates • Daily data submissions via the daily nosocomial sitrep are signed off by the Chief executive or Chief nurse who is the Director of Infection prevention and Control (DIPC) • BI receive all covid + lab reports and will pull through alerts entered on PAS/check with IPCT		
• There are check and challenge opportunities by the executive/senior leadership teams of IPC practice in both clinical and non-clinical areas.	• Senior Nurse Management Team complete monthly walk rounds of wards and departments across the trust on a Monthly basis. • Executive team carry out monthly walkabout and feedback, update provided to Quality board • Chief Nurse chairs infection prevention and control committee and carries out walkabouts challenging any practice observed		• Concerns raised by staff and those identified by the SNT are shared with staff at the time of the walk round and learning opportunities identified shared with the wider team
• Resources are in place to implement and measure adherence to good IPC practice. This must include all care areas and all staff (permanent, agency and external contractors).	• Additional funding provided for IPC team • Implementation of Tendable • Revised role of matrons		
• The application of IPC practices within this guidance is monitored, eg: • hand hygiene. • PPE donning and doffing training.	• Social distancing guidelines available with associated posters, leaflets and floor stickers • COVID PPE guidelines reflecting UKHAS recommendations for all areas • Register of staff training for fit testing	• No staff competencies for PPE (DONNING AND DOFFING) • Non-compliance with policy	• Real time audit of compliance via Tendable

• cleaning and decontamination.	• IPC Audit program • Daily IPC escalation • Visual aids of PPE guidance • patients/staff • Audit • Safety huddle notes • IPC policies/guidance • Support and advice by the IPC Team. • IPC audit programme • Implementation of Tendable April 22		
• The IPC Board Assurance Framework is reviewed, and evidence of assessments are made available and discussed at Trust board;	• BAF is reviewed and updated and shared with Trust Board, IPCC/Quality Committee		• Completion is monitored by the IPCC • Reviewed by Deputy chief nurse and approved by Chief nurse
• The Trust Board has oversight of ongoing outbreaks and action plans;	• DIPC included in minutes from outbreaks. • Outbreak updates delivered by the lead for IPC • IPC reports to Quality Committee, Trust Board		• Outbreak updates within IPC reports at monthly IPCC meeting • Outbreaks discussed
• The Trust is not reliant on a particular mask type and ensure that a range of predominantly UK Make FFP3 masks are available to users as required.	• National supply of FFP3 masks limited and unable to stipulate the model and manufacture of mask required locally • The Trust has provides staff fit testing and that there is sufficient supply and resilience	• Staff may not be tested on more than one mask • Availability of fit testing/compliance	• There is a plan/programme in place to address this (including the recruitment of additional fit testers) led by Risk & Governance
Key Lines of Enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections			

• The Trust has a plan in place for the implementation of the National Standards of Healthcare Cleanliness and this plan is monitored at board level	• Standards fully implemented April 2022 in line with national guidance by Soft FM service provider in line with Trust IPCT agreement of all clinical & nonclinical FR ratings • Place Lite undertaken January 2022 • IPC reports to Quality Committee which feeds up to Trust Board		
• The organisation has systems and processes in place to identify and communicate changes in the functionality of areas/rooms	• Contract meetings in place with Trust and Soft FM service provider • Daily safety huddle • Walton weekly • Bed repurposing action tracker		
• Cleaning standards and frequencies are monitored in clinical and non-clinical areas with actions in place to resolve issues in maintaining a clean environment.	• E&F audit programme • IPC audit programme • ISS reports to IPCC • Escalation to Senior Facilities Manager or Head of Facilities • Star ratings in sight and updated appropriately		
• Increased frequency of cleaning should be incorporated into the environmental decontamination schedules for patient isolation rooms and cohort areas.	• OCG minutes • Enhanced cleaning of 3 x day is instigated on wards where there are clusters/outbreak of infection identified. • Terminal cleaning checklist for signing off the required standards of cleaning • Clean trace in use • Additional staff employed to provide cleaning in excess of 3 times per day for all high touch areas as required • Decontamination variation submissions	• Availability of domestic staff/staff absence	• Review and prioritise areas to redeploy staff with ISS • ISS staff providing additional hours • Housekeepers added to NHSP • Cleaning guidance reviewed to provide assurance that all areas are cleaned as per National guidelines and local risk assessments

• Where patients with respiratory infections are cared for: cleaning and decontamination are carried out with neutral detergent or a combined solution followed by a chlorine-based disinfectant, in the form of a solution at a minimum strength of 1,000ppm available chlorine as per national guidance. • If an alternative disinfectant is used, the local infection prevention and control team (IPCT) are consulted on this to ensure that this is effective against enveloped viruses.	• Cleaning is carried out with combined detergent/chlorine-based products as per national guidance as required • Cleaning products discussed and agreed with ISS in non/low risk Covid areas • IPC Trust policy and procedures/flow charts. • Decontamination policy.		• Cleaning products discussed and agreed with ISS in non/low risk Covid areas
A terminal/deep clean of inpatient rooms is carried out: • following resolutions of symptoms and removal of precautions. • when vacated following discharge or transfer (this includes removal and disposal/or laundering of all curtains and bed screens).	• IPC team visit the wards to carry out spot checks and provide guidance. • Touchpoints are being attended to constantly as a `clean as you go`. • Disinfectant wipes available as stock items and monitored. • Appropriate waste management systems are in place and audited by E&F • Matron checks • IPC audit • Cleaning information shared. • Hydrogen Peroxide Vapor cleaning utilised.		• Guidance developed to ensure staff know their responsibilities in cleaning of shared equipment. • Walk rounds of the wards with supervisor and matrons/IPC • to review standards and agree actions. • IPC audits monitoring standards reported to IPCC

	• Cleaning hours extended so afternoon and evening service now provided • Late shift cover Incorporated into new domestic services within Soft FM contract		• Standards of cleaning concerns escalated to local supervisor to address • Hydrogen Peroxide Vapor cleaning utilised. • UV light cleaning utilized when necessary
• A terminal/deep clean of inpatient rooms is carried out: following resolutions of symptoms and removal of precautions.	• IPC Trust policy and procedures/flow charts. Decontamination policy. • Terminal cleaning checklist • UV light cleaning utilized when necessary • Disinfection wipes in use effective against Coronaviruses.	• Rooms not cleaned to standard required. • Variability in standards of cleaning. • Delays can occur due to availability and demand on ISS	• Terminal clean procedure checked following completion by ward manager or equivalent • Standards of cleaning concerns escalated to local supervisor to address

• a minimum of twice daily cleaning of:
  • patient isolation rooms
  • cohort areas
  • Donning & Doffing areas
  • 'Frequently touched' surfaces, e.g. door/toilet handles, patient call bells, over-bed tables and bed rails; where there may be higher environmental contamination rates, including:
	• Decontamination equipment guidelines. Increased cleaning in line with national guidance using combined detergent & chlorine disinfectant.
	• Additional cleaning implemented at ward level provided by staff and ISS
	• Enhanced cleaning including touch points is in place and monitored.
	• IPC team visit the wards to carry out spot checks and provide guidance.
	• Touchpoints are being attended to constantly as a `clean as you go`.
	• Disinfectant wipes available		

toilets/commodes particularly if patients have diarrhoea.			
• following an AGP if room vacated (clearance of infectious particles after an AGP is dependent on the ventilation and air change within the room).	• Covid polices/guidance		
Reusable non-invasive care equipment is decontaminated: • between each use • after blood and/or body fluid contamination • at regular predefined intervals as part of an equipment cleaning protocol • before inspection, servicing or repair equipment	• Decontamination policy • Medical Devices policy • Matron checks	• Decontamination form may not be completed before sending equipment for servicing or repair	
• Compliance with regular cleaning regimes is monitored including that of reusable patient care equipment.	• Clean Trace • Matron audit • Housekeeper checklist • ISS audit • IPC audit • Spot checks		• Testing is completed by the IPC Team in areas where patients with infections are nursed to test the efficacy and effectiveness of the cleaning. • Audits of cleaning standards completed
• As part of the Hierarchy of controls assessment: ventilation systems,	• Almost all in-patient areas are designed for natural ventilation and do not rely on mechanical methods		

particularly in, patient care areas (natural or mechanical) meet national recommendations for minimum air changes refer to country specific guidance. In patient Care Health Building Note 04-01: Adult in-patient facilities.			
• The assessment is carried out in conjunction with organisational estates teams and or specialist advice from ventilation group and or the organisations, authorised engineer.	• The Trust has appointed an Authorising Engineer (ventilation) and who will be involved in ventilation assessments & strategy moving forward as well as periodic attendance at ventilation group • Water safety/ventilation group in place		
• A systematic review of ventilation and risk assessment is undertaken to support location of patient care areas for respiratory pathways	• As above		
• Where possible air is diluted by natural ventilation by opening windows and doors where appropriate	• Regular opening of window/doors encouraged	• Practice varies • Patient complaints	
• Where a clinical space has very low air changes and it is not possible to increase dilution effectively, alternative technologies	• This will be discussed with AE and ventilation group		

are considered with Estates/ventilation group.			
Key Lines of Enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
3. **Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance**			
• Systems and process are in place to ensure: • Arrangements for antimicrobial stewardship are maintained • Previous antimicrobial history is considered • The use of antimicrobials is managed and monitored: • to reduce inappropriate prescribing. • to ensure patients with infections are treated promptly with correct antibiotic.	• The Trust has an antimicrobial pharmacist • Anti-microbial guidance is provided to junior doctors at induction • Antimicrobial ward round – virtual if required. • Microbiology advice available 24/7 • Antimicrobial audits presented to IPCC • IPC surveillance • Minutes of Antimicrobial stewardship meetings	• 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 maintain oversight	• The Director of Infection Prevention and Control reports to Execs weekly and Board Quarterly. • Chief Pharmacist report to Quality Committee. • Annual IPC report to Board. • Incidents are monitored through antimicrobial stewardship group		

• Risk assessments and mitigations are in place to avoid unintended consequences from other pathogens.	• Medicines optimisation review • There is a Trust approved antimicrobial formulary		
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
4. **Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance**			
• Systems and processes are in place to ensure: • Visits from patient's relatives and/or carers (formal/informal) should be encouraged and supported whilst maintaining the safety and wellbeing of patients, staff and visitors • National guidance on visiting patients in a care setting is implemented • Restrictive visiting may be considered appropriate during outbreaks within inpatient areas This is an organisational decision following a risk assessment.	• Trust wide visiting guidance developed based on national/regional guidance. • Regional guidance on visiting has been implemented and is on the Trust website. • Guidance on the visit and pre and post visit requirements is provided. • Additional restricted visiting will be implemented if an outbreak occurs as per IPC outbreak management • Divisional and trust communications. • Social media	• Staff not heeding to the guidance. • Volunteers allowing patients in the front door	• Guidance on visiting under review national as guidance changes
• There is clearly displayed, written information	• Mask holders available at all entrances to the hospital with posters asking and informing how to use	• Patients and visitors are non-compliant with policy	• Alternative arrangements are made following a risk assessment for those

available to prompt patients' • visitors and staff to comply with handwashing, wearing of facemask/face • covering and physical distancing.	• Posters advertising the requirements for staff and patients and visitors to wear surgical masks at all times • Signage at entrances		patients who cannot wear a face mask due to clinical condition • Audit patient mask wearing by Matron • Clinicians ask and encourage patients to wear a face mask when on ward rounds
• If visitors are attending a care area with infectious patients, they should be made aware of any infection risks and offered appropriate PPE. This would routinely be an FRSM.	• Discussed and recorded in patients notes		
• Visitors with respiratory symptoms should not be permitted to enter a care area. However, if the visit is considered essential for compassionate (end of life) or other care reasons (eg, parent/child) a risk assessment may be undertaken, and mitigations put in place to support visiting wherever possible. • Visitors are not present during AGPs on infectious patients unless they are considered essential	• Masks available for patients/visitors who arrive without one • Walton Weekly	• Covid policy requires updating	• Policy in process of merging with Respiratory Infection policy

following a risk assessment			
• Implementation of the Supporting excellence in infection prevention and control behaviors Implementation Toolkit has been considered • C1116-supporting-excellence-in-ipc-behaviours-imp-toolkit.pdf (england.nhs.uk)	• Included in all policies, and standard operating procedures.		
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
5. 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.			
• Patients with suspected or confirmed respiratory infection are provided with a surgical facemask (Type II or Type IIR) to be worn in multi-bedded bays and communal areas if this can be tolerated.	• FRSM provided in all ward areas • Posters to inform patients	• Patient unable to wear a face covering due to clinical condition • Patients refusing to wear mask	
• Patients with respiratory symptoms are assessed in a segregated area, ideally a single room, and away from other patients pending their test result.	• Admitted or transferred to Chavasse	• Potential delay in transfer	
• Patients with excessive	• Patient placement guidance		

cough and sputum production are prioritised for placement in single rooms whilst awaiting testing.	• Covid policy		
• Patients at risk of severe outcomes of respiratory infection receive protective IPC measures depending on their medical condition and treatment whilst receiving healthcare e.g., priority for single room isolation and risk for their families and carers accompanying them for treatments/procedures must be considered.	• Self-isolation stepdown guidance considering immune suppressed patients • Side room priority includes CEV patients		
• Where treatment is not urgent consider delaying this until resolution of symptoms providing this does not impact negatively on patient outcomes.	• Patient placement pathway • Consultant review of patient e.g., risks/benefits		
• Face masks/coverings are worn by staff and patients in all health and care facilities.	• In place and monitored.	• Patients may refuse to wear mask • Staff compliance	• Weekly Covid audit • IPC walk rounds
• Where infectious respiratory patients are cared for physical distancing remains at 2	• Bed spaces 2 metres apart measured from the middle of the bed where the patient would lie	• Socially distanced bed are in continual use	• Clear curtains in inpatient areas

metres distance.			
• Patients, visitors, and staff can maintain 1 metre or greater social & physical distancing in all patient care areas; ideally segregation should be with separate spaces, but there is potential to use screens, eg, to protect reception staff. •	• In place as part of the IPC and Covid management pathways, Amber and Green. • Screens in reception areas • Screens in place between chairs in OPD		
• 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. • Isolation, testing and instigation of contact tracing is achieved for all patients with new-onset symptoms, until proven negative.	• Standard operating procedures and policies in place. • Asymptomatic contacts managed in line with national guidance e.g. no screening (outside of day 0,3,7) or isolation	• Delay or omissions in testing	
• Patients that attend for routine appointments who display symptoms of COVID-19 are managed appropriately.	• Screening policy developed for all patients, in patients or out patients. • Information available on Internet/Social Media pages	• No records kept centrally on how many people present who have COVID symptoms	• Patients are asked at the start of their appointment and on admission to the trust if they have symptoms of COVID or if they have been in contact recently with anyone who has COVID

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions
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			
• Appropriate infection prevention education is provided for staff, patients and visitors.	• Training and information leaflets. • Signage, social media and advice on internet page • When contractors attend site, they undertake a Trust contractor induction process, during which, they are offered specific advice relating to the specific risks associated with their visit. • Contractors, currently based permanently on site e.g., James Mercer Group, are offered the same protection measures as Trust staff.	• Emergency contractor visits	• Contractor induction, where possible
• Training in IPC measures is provided to all staff, including: the correct use of PPE including an initial face fit test/and fit check each time when wearing a filtering face piece (FFP3) respirator and the correct technique for putting on and removing (donning/doffing) PPE safely.	• IPC mandated training for all employees. • On line video donning and doffing and latest guidance available on intranet and in clinical areas. • Don/Doff education sessions • Daily monitoring of application of PPE standards. • IPC standards communicated to all contractors. • Policies reviewed and revised to reflect national guidelines • Resources are available on the COVID19 intranet page • Local records available • Tendable Audit	• Not all training records are held centrally and not all electronic • Gaps in assurance for FITT testing including staff new to the Trust	• Manual records in place, plan for development of ESR for live recording of training records • FITT test Plan in place led by R&G
• All staff providing patient care and working within the	• PPE policy. • Training records. Training video on how	• Unable to provide assurance that all staff	• Observation of PPE protocols completed by

clinical environment are trained in the selection and use of PPE appropriate for the clinical situation and on how to safely put it on and remove it	to Don and Doff PPE is available for all staff to view. • H&S hold a list of competent Fit Test trainers and Fit tested staff. • Donning and doffing bitesize sessions delivered • Tendable means as a trust we can start providing audit results electronically in real time	are trained in donning and doffing	IPC team when visiting every ward and advice and support given in real time. • Additional training provided by IPCT
• Adherence to national guidance on the use of PPE is regularly audited with actions in place to mitigate any identified risk;	• Practice monitored during walkabout (SNT, IPC and exec) • Matron audits • Tendable	• Potential gaps in documented evidence of review of staff practices as Tendable is rolled out • Hand hygiene competencies required	• Competency work stream
• Gloves are worn when exposure to blood and/or other body fluids, non-intact skin or mucous membranes is anticipated or in line with SICP's and TBP's.	• PPE policy • Blood borne virus policy		
• 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.	• Communications on going posters/trust messages. • The trust does not use hand dryers • Paper towels available in all visitor toilets • Hand hygiene posters displayed above hand hygiene sinks/in bathrooms to advise staff and patients/visitors on how to correctly wash and dry hands. • Posters on visitor's toilets regarding the need for hand hygiene following using the toilet.		
• Staff maintaining physical and social distancing of 1	• Social distancing guidelines available • Guidance written and verbal to all staff		• Rotas introduced to minimise staff

metre or greater wherever possible in the workplace	regarding staff maintaining social distancing (2m+) when travelling to work (including avoiding car sharing) and remind staff to follow public health guidance outside of the workplace		attendance when working from home is not an option. • Screens provided at receptions to provide separation between patients and staff and • in some offices to provide separation between desks.
• Staff understand the requirements for uniform laundering where this is not provided for on site	• Staff are aware of the provision where available however the majority of staff launder their own uniform. • Staff are aware of the requirement to launder uniforms separately at 60 degrees. • There is a dress code policy. • Changing facilities have been revisited and match current staff need.	• Staff may not wear a uniform.	• Scrubs issued to staff who do not wear uniform if required • Comms issued to staff in relation to laundering.
• All staff understand the symptoms of COVID-19 and take appropriate action if they or a member of their household display any of the symptoms (even if mild) in line with national guidance. • To monitor compliance and reporting for asymptomatic staff testing	• Comms circulated from silver and via comms are timely and cascaded. • SOP Covid return to work guidance • Fit to work checklist • Guidance and the intranet share point is updated and distributed through Silver/Risk & Governance when any changes are made. • All Covid related absence recorded on ESR and reported daily or on agreed days via Safety huddle	• Staff do not follow guidance • Staff attend work with symptoms • Staff are not aware of symptoms • Uptake of LFD testing	• IPC advice • Daily Safety huddle • Staff are asked at every safety huddle if they have had symptoms – low threshold • Lessons learnt resulting from staff absences /outbreaks when staff have attended work with symptoms is shared with Teams • Encouraged via safety huddle

• There is 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).	• Covid data portal on Minerva • IPC review of results • Regional/national webinar/meeting	• Outbreak may not be detected at an early stage e.g., patients discharged • Asymptomatic transmission may delay identification of outbreak as no requirement to screen	
• 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.	• All positive cases have a case or cluster review in line with national guidance • Outbreaks - 2 cases or more linked or unknown transmission/contact are reviewed daily OCG implemented. • Minutes of OCG • Major outbreak plans are in place supported by Gov.uk publications, UKHAS guidance, NHSE/I communications.	• Review & dissemination of lessons learnt	
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
7. 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			
Systems and processes are in place to ensure: • That clear advice is provided, and monitoring is carried out of inpatients compliance with wearing face masks (particularly when	• Posters in place • Monitored by IPC daily review and highlighted to staff	• Patients non-compliant	

moving around the ward or healthcare facility) providing it can be tolerated and is not detrimental to their (physical or mental) care needs.			
• Separation in space and/or time is maintained between patients with and without suspected respiratory infection by appointment or clinic scheduling to reduce waiting times in reception areas and avoid mixing of infectious and non-infectious patients.	• Risk assessments completed on all patients on admission or for outpatient appointments. • installation of screens in OPD		• Patient appointment • Rescheduled if necessary
• Patients who are known or suspected to be positive with a respiratory pathogen including COVID-19 where their treatment cannot be deferred, their care is provided from services able to operate in a way which minimise the risk of spread of the virus to other	• pathways and risk assessments available to implement these robustly. • All patients have individual rooms for isolation/or cohorted • IPC guidance, policy and SOPs are all revised, approved and implemented in line with national guidance in managing patient access to care provision safely. • Management of patient placement pathway • Isolation policy	• Limited availability of side rooms on general wards • Not all side rooms or cohort areas have en-suite facilities.	• Designated toilet for patients with known or suspected infections • Management regularly communicated to their teams about the need to open windows to introduce fresh air into areas without mechanical ventilation

patients/individuals.			
• Ongoing regular assessments of physical distancing and bed spacing, considering potential increases in staff to patient ratios and equipment needs (dependent on clinical care requirements).	• Chavasse respiratory isolation ward and can increase bed base to become admission ward for contacts/patients with respiratory infections • Cohort areas are identified when no single rooms are available • Staffing reviewed daily		
• Standard infection control precautions (SIPC's) are used at point of care for patients who have been screened, triaged, and tested and have a negative result	• IPC guidance, policy and SOPs are all revised, approved and implemented in line with national guidance in managing patient access to care provision safely.		
• The principles of SICPs and TBPs continued to be applied when caring for the deceased	• IPC guidance, policy and SOPs are all revised, approved and implemented in line with national guidance		
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
8. Provide or secure adequate isolation facilities			
• There are systems and processes in place to	• SOP in place for testing, authorized by the Clinical Director, the process has	• Staff are observed; standards of	• Laboratory has accreditation and

ensure: • Testing is undertaken by competent and trained individuals	been validated (to UKAS accreditation standard) and staff have been trained appropriately and this has been logged. • LCL guidance on testing and packaging of samples • SOP for staff testing/return to work	documentation vary regarding competencies	ongoing site visits by external organisations to assess standards, labs are on Aintree /Royal site. SLA in place
• Patient and staff COVID-19 testing is undertaken promptly and in line with PHE and other national guidance;	• Patient placement guidance based on national and local data • Our trust patient, Staff testing/return to work follows national guidance which includes: ▪ Diagnostic testing of patients ▪ Discharge screening of patients to care homes and CRX/WNRU ▪ Screening of elective surgeries ▪ Screening of staff ▪ Screening of emergency admissions • Criteria for rapid testing	• Rapid testing availability is limited • Patients may not be screened at appropriate timeframe	
• Regular monitoring and reporting of the testing turnaround times with focus on the time taken from the patient to time result is available;	• Monitored by Lab and escalated if required • Move to LFD testing (excluding admission screening for emergency patients)		
• Regular monitoring and reporting that identified cases have been tested and reported in line with the testing protocols (correctly recorded data);	• IPC review all COVID positive patients to ensure that they managed appropriately • Covid 19 policy		
• Screening for other potential infections takes	• All admissions are screened in line with the local screening guidance.	• Limited compliance data	

place	• Routine diagnostics operational in lab • Systems and SOPs exist in Laboratory for screening all alert organisms (e.g., MRSA, VRE, C-difficile, CPE, etc •		
• That those inpatients who go on to develop symptoms of COVID-19 after admission are retested at the point symptoms arise; • That emergency admissions who test negative on admission are retested on day 3 of admission, and again between 5-7 days post admission • That sites with high nosocomial rates should consider testing COVID negative patients daily; • That those being discharged to a care home are tested for COVID-19 48 hours prior to discharge (unless they have tested positive within the previous 90 days) and result is communicated to receiving	• Screening updated/implemented in line with national guidance • Those patients that go onto develop symptoms are screened immediately. • During periods of high nosocomial transmission screening frequencies are discussed by an MDT team • Patients discharged to a care home are tested for COVID-19 48 hours prior to discharge (unless they have tested positive within the previous 90 days) • Patient Placement pathway outlines screening and isolation requirements		

organisation prior to discharge;			
• That patients being discharged to a care facility within their 10 day isolation period are discharged to a designated care setting, where they should complete their remaining isolation;	• Patients discharged to a care home are tested for COVID-19 48 hours prior to discharge (unless they have tested positive within the previous 90 days)		
• There is an assessment of the need for a negative PCR and 3 days self-isolation before certain elective procedures on selected low risk patients who • are fully vaccinated, asymptomatic, and not a contact of case • suspected/confirmed case of COVID-19 within the last 10 days. Instead, these patients can take a lateral flow test (LFT) on the day of the procedure as per national guidance.	• Elective patients tested by LFD in line with national guidance		

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions
9. Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections			
• Systems and processes are in place to ensure that: • The application of IPC practices are monitored and that resources are in place to implement and measure adherence to good IPC practice. This must include all care areas and all staff (permanent, agency and external contractors). • Staff are supported in adhering to all IPC policies, including those for other alert organisms. • Safe spaces for staff break areas/changing facilities are provided.	• All IPC Policies and COVID related Policies (including SOPS) are available to all staff via intranet, and these are also cascaded when first ratified by communications • Mandatory health and safety training • Induction training • Ward manager meetings / IPC Committee / PNF • Staff break areas have been reviewed by Estates and number of staff at any one time is on the door	• Staff may not always follow Policies and guidance • Staff may not always view the intranet • Staff break areas are limited in size • Staff may not comply with guidance • Limited changing rooms for staff	• Annual mandatory IPC training • Ad hoc learning sessions take place with staff as and when required • Refer to appropriate policy during education sessions, signpost to intranet page • PC reviews • Matron checks • Safety huddle
• Robust policies and procedures are in place for the identification of and management of outbreaks of infection.	• All OCG meetings recordings and minutes. • Command structure. • COVID -19 policy • PPE posters • COVID 19 intranet page		• Safety huddles • Links available on the intranet • Discussion at Trust safety huddle • Staff support and education

• This includes the documented recording of an outbreak.	• Communicated via Command and Control/daily COVID-19 comms		• Mandatory Health and Safety
• All clinical waste related to confirmed or suspected COVID19 cases is handled, stored and managed in accordance with current national guidance	• Waste disposal policy based on national standards. • Covid 19 policy • Waste audits • Health and safety committee minutes	• Waste contractor cannot meet unprecedented demand. • Staff do not follow the policy • Non-compliance to correct waste segregation	• Safety huddles • Links available on the intranet • Discussion at Trust safety huddle • Staff support and education • Mandatory Health and Safety
• PPE stock is appropriately stored and accessible to staff who require it	• Stock issues and receipts are managed electronically any concerns escalated at trust daily safety huddle • PPE stocks are topped up • PPE Distribution Hubs have been created to manage regionally and control the distribution of those PPE items in limited supply (specifically FFP3 masks) whilst ensuring staff have access to PPE when required.	• Stock deliveries via the national PPE Dedicated Distribution channel are regular. • Inability to request a preferred manufacturer and model of FFP3 masks from the center has meant that there is a requirement for staff to be fit tested on available stock.	• CMHP has also established a Mutual Aid programme and is developing a system to ensure a more equitable distribution of stock across the region based on accurate daily “burn rate” data provided by each trust. • Requests for PPE in very short supply (less than 48 hours in stock) are raised via NSDR (National Supply Disruption Route). Fulfilment rates are variable and dependent on the number of

			COVID-19 patients being treated and the volume of stock held by the Trust. • Ongoing fit testing programme in place by a dedicated team to ensure staff are tested on the current stock. • Any concerns are escalated and also use daily safety huddle
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection			
Appropriate systems and processes are in place to ensure that: • Staff seek advice when required from their IPCT/occupational health department/GP or employer as per their local policy.	• IPC team advice and support • OH if required • Other staff working in high-risk areas have been supported through the provision of wellbeing hubs, counselling services, night time welfare calls, distribution of food donations, wellbeing packs and	• Adequacy of the risk measures and controls not yet reviewed • Lack of assurance all are completed • Staff do not wish to engage with support	• Information has been placed on the intranet and regularly communicated to all staff within the Trust who wishes to access available

• Bank, agency, and locum staff follow the same deployment advice as permanent staff. • Staff who are fully vaccinated against COVID-19 and are a close contact of a case of COVID-19 are enabled to return to work without the need to self-isolate (see Staff isolation: approach following updated government guidance)	information as well as communications and training regarding PPE. • Information has been placed on the intranet and regularly communicated to all staff within the Trust who wishes to access available wellbeing support services. • Return to work guidance/Fit to work checklist		wellbeing support services. • Trust has health and wellbeing APP • Guidance available on the HR section of the intranet regarding vulnerable staff, working from home assessments, support for staff shielding returning to work. • Advice available for managers and employees on how to manage staff regarding COVID 19. • Risk assessments are updated as guidance changes.
• Staff understand and are adequately trained in safe systems of working, including donning, and doffing of PPE.	• IPC mandatory training records • Donning and Doffing Training • Bite size training session • Tendable introduced April 2022	• Staff noncompliance • Lack of assurance that systems are robust and adhered to • Reduced mandatory training compliance across the trust	• Walkabouts • IPC daily ward reviews
• Where there has been a breach in infection control procedures staff are reviewed by occupational health. Who will: • lead on the	• Breaches that are identified are managed locally by managers and the IPC and SNT/Divisional medical leads/Medical Director as required • Absence monitored by HR and reported through Silver to Gold and safety huddle	• Staff may not report breaches • Staff may refuse vaccination • Data may not be accurate	• There is ongoing support, teams' meetings, 1-1 conversations regarding vaccination status and availability and access to

implementation of systems to monitor for illness and absence. • facilitate access of staff to antiviral treatment where necessary and implement a vaccination programme for the healthcare workforce • lead on the implementation of systems to monitor staff illness, absence and vaccination against seasonal influenza and COVID-19 • encourage staff vaccine uptake.	• LUFT provides vaccination hub • Antivirals would be available if required via ICS agreed pathways • NIMS vaccination database		vaccination
• Staff who have had and recovered from or have received vaccination for a specific respiratory pathogen continue to follow the infection control precautions, including PPE, as outlined in national guidance.	• Policies and guidance on intranet • Return to work guidance and fit to work checklist • Guidelines and risk assessments are available regarding 'Reducing risk for BAME' staff.	• Noncompliance with policy • Managers may not complete assessment/accurately	• Daily safety huddle • Queries supported by IPCT
• A discussion is had with employees who are in the at-risk	• Risk assessments are completed by managers for all staff which includes mitigating actions and	• Staff do not complete the risk assessment with	• HR support to staff and managers • Data on BAME staff

groups, including those who are pregnant and specific ethnic minority groups;	control measures to protect those at risk	their staff • Risk assessments may not be reviewed if staff members health changes	and completion of risk assessments are escalated to senior management to enable them to support managers to complete the risk assessment with their BAME staff and all other staff who fall into the at-risk groups.
• That advice is available to all health and social care staff, including specific advice to those at risk from complications.	• Access to Occupational Health Service		
• Bank, agency, and locum staff who fall into these categories should follow the same deployment advice as permanent staff	• As above		
• Vaccination and testing policies are in place as advised by occupational health/public health.	• Vaccination and testing polices/guidance in line with national guidance	• Noncompliance with testing • Refusal of vaccination	• There is ongoing support, teams' meetings, 1-1 conversations regarding vaccination status and availability and access to vaccination. • Access to external

			consultants to discuss vaccination e.g., Liverpool Women's Hospital
• A fit testing programme is in place for those who may need to wear respiratory protection. • Staff required to wear FFP3 reusable respirators undergo training that is compliant with HSE guidance and a record of this training is maintained and held centrally/ESR records.	• All staff wearing FFP3 masks have been fit tested and shown how to wear the mask; a register is being maintained.	• Not all staff pass the "fit test" • Move to business as usual has reduced capacity of fit testers	• If staff fail the fit test alternate FFP3 masks are available and used for further testing; if no suitable mask is identified staff are advised not to undertake AGPs.
• Staff who carry out fit test training are trained and competent to do so	• Accredited fit tester training	• Staff may fit test staff without completing the competency training	• Records kept for all staff who have undertaken the fit testing competency and they are not allowed to 'fit test;' others unless there is evidence, they have completed the competency.
• 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	• All staff needing to wear FFP have been training and training provided on going • All staff retested if FFP3 masks that they have been fit tested with become unavailable • Fit testing currently taking place to		

	ensure staff have 2/3 choices of mask as per national guidance		
• A record of the fit test and result is given to and kept by the trainee and centrally within the organisation	• Records of staff, masks they have been fit tested against and the mask that they are able to use are stored centrally by the H&S team on the Fit Test Register	• Staff may use the mask that they were not fit tested to • Supply may become compromised	• All staff is given the details of the mask they are fit tested to.
• 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	• Where there is repeated failure or unable to Fit test there are areas including dentistry where positive air pressure hoods are used.		
• That where fit testing fails, suitable alternative equipment is provided. Reusable respirators can be used by individuals if they comply with HSE recommendations and should be decontaminated and maintained according to the manufacturer's instructions.	• Staff are tested on more than one mask, those that fail on all disposables are then tested on re-usable half masks, if these fail then the hood is the last option. • Personal issue reusable respirators • Inputted on database • SOP for staff testing • COVID -19 staff support helpline • Return to work assessment • Occupational health • HR COVID policy	• Capacity to test on 3-5 masks • There is no choice of model of FFP3 mask available and therefore the Trust has to use what is delivered. There is the potential to not have the mask that staff are fit tested	• C&M Mutual aid support
• Members of staff who fail to be adequately fit tested a discussion should be had, regarding re	• Return to work assessment • Occupational health • HR COVID policy • Staff who are unable to wear face protection and RPE are where		

deployment opportunities and options commensurate with the staff members skills and experience and in line with nationally agreed algorithm	possible re-assigned to other areas as per national guidelines.		
• 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	• Managers work closely with Occupational health and HR to ensure that staff that are unable to continue with their current role due to their inability to wear a mask are managed as per agreed guidelines.		
• 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	• This record is held in the staff members personal record/Occupational Health record	• Increased demand on occupational health may prevent the capacity to help each member of staff	
• Boards have a system in place that demonstrates how,	• BOD receives monthly report on RIDDORs and Serious Incidents		• Centrally held records of staff that have been fit tested

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			are available and utilized when investigations are needed as evidence of training.
• Consistency in staff allocation is maintained, with reductions in the movement of staff between different areas and the cross-over of care pathways between planned and elective care pathways and urgent and emergency care pathways, as per national guidance	• It is local policy for Staff not to move between different categorised areas to promote patient and staff safety across pathways. • Staff are reminded to adhere to IPC policies to minimise risk of transmission of infection.	• Shortages of staff may result in unplanned staff movement	• Daily safety huddle to discuss staffing and advice. • Local risk assessment completed if staff need to move. • Staff advised to move down categories not up as the risk reduces • Staff advised to change uniform if they have to move during shift • It is advised that staff go directly to the ward they have been moved to when they start duty. • Staff are only moved for clinical need and following local risk assessment.
• All staff to adhere to	• Surgical face-masks are provided for		

national guidance and are able to maintain 2 metre social & physical distancing in all patient care areas if not wearing a facemask and in non-clinical areas;	all staff in the Trust • Social distancing posters are in place across the Trust. • Policies available regarding social distancing and the use of PPE • Guidance for assessment of those who report difficulties wearing a surgical face mask, this is dealt with on an individual basis • Guidance when outpatients do not wear a face covering • COVID-19 precautions, social distancing & non-compliance - HR Guidance • PPE and Alternatives for Respiratory Protection for COVID-19		
• Health and care settings are COVID-19 secure workplaces as far as practical, that is, that any workplace risk(s) are mitigated maximally for everyone	• Risk assessments are available for all departments that are RAG rated once complete. *'COVID-19 Risk Assessment Form'*	• Departments not completing risk assessments or not rating them accurately • Outcomes of risk assessments e.g., number of staff in office will need to be mitigated as no solution identified	
• Staff are aware of the need to wear facemask when moving through COVID-19 secure areas.	• All staff wear FRSM wherever they work, except in non-clinical areas if social distancing 1 metre + can be achieved	• Noncompliance to policy	• Posters available • Staff work as a team to promote the wearing of face masks at the right time and in the correct manner • Daily safety huddle

• Staff absence and well-being are monitored and staff who are self-isolating are supported and able to access testing	• Return to work/Fit to work checklist • Keeping in touch conversations • PCR testing no longer a requirement in line with national guidance		• Absence rates are monitored via the daily COVID dashboard and discussed at daily safety huddle chaired by chief nurse
• Staff who test positive have adequate information & support to aid their recovery and return to work.	• Managers contact all staff who are on long term sick with COVID-19 to check on their welfare and establish a predicted time frame to return to work. • Policy available regarding care and management of staff who are shielding that reflects the national guidelines. • Support provided by IPC team. Any concerns and questions are addressed, and advice is given as requested. Follow up support is also available if required. • Return to Work Standard guidance • Return to work/Fit to work checklist • ESR records • Access to psychological support	• Departments not completing risk assessments/fit to work checklist or not rating them accurately	• HR team support to managers

The Walton Centre NHS Foundation Trust

Report to Trust Board
9 June 2021

Report Title	Safeguarding annual Report 2021/22
Executive Lead	Lisa Salter, Chief Nurse
Author (s)	Debbie Lee, Safeguarding Matron
Action Required	To approve

Level of Assurance Provided

☐ **Acceptable assurance** Systems of controls are suitably designed, with evidence of them being consistently applied and effective in practice	✓ **Partial assurance** Systems of controls are still maturing – evidence shows that further action is required to improve their effectiveness	☐ **Low assurance** Evidence indicates poor effectiveness of system of controls

Key Messages

- Assurance for all areas of safeguarding and associated areas.
- Identified work plans for 2022-2023

Next Steps

- Best practice care
- Be recognised in all we do

Related Trust Strategic Ambitions	**Impact**		
Quality of Care	Legal	Compliance	Quality

Strategic Risks		
003 Operational Performance	Choose an item.	Choose an item.

Equality Impact Assessment Completed		
Strategy ☐	Policy ☐	Service Change ☐

Report Development

Committee/ Group Name	**Date**	**Lead Officer (name and title)**	**Brief Summary of issues raised and actions agreed**
Quality Committee	17th May 2022	Lisa Salter, Chief Nurse	

Safeguarding Annual Report 2021/22

Executive Summary

1. The purpose of this annual report is to inform the Walton Centre NHS Foundation Trust Board, the Quality Committee and the Local Safeguarding Children and Adults Boards with an annual update on adult and children safeguarding activity across the Trust in the last year (April 2021-March 2022).

2. This report summarises the safeguarding work undertaken across the Trust and demonstrates to the Trust Board and external agencies how WCFT manages all aspects of safeguarding and can be found in appendix 1.

Conclusion

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

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

Recommendation

5. To approve the report.

Author: Debbie Lee, Safeguarding Matron
Date: 13th May 2022

Appendix 1

The Walton Centre
NHS Foundation Trust

Excellence in Neuroscience

Safeguarding Annual Report

May 2022

Presented by Debbie Lee – Matron for Safeguarding

Contents

Introduction

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

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

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

The COVID 19 pandemic has created new issues across the NHS. From a safeguarding perspective, the new issues include restrictions with visitors; the often crucial face to face communication and interactions between both patients and staff with relatives has been affected. Visiting restrictions have had negative effects on patients' well-being and has probably stifled the communication of disclosures of abuse from relatives to staff; disclosures are often made when professional relationships are forged with relatives. Both the Trust and visiting organisations e.g. Social Services or Section 12 doctors have had to adapt their processes due to the visiting restrictions which have brought about the need for remote communication. Adaptations have included the use of MS Teams, the use of iPads for assessments, enhanced communication and additional processes for identification checks of external assessors who are assessing patients remotely.

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

Purpose

The purpose of this annual report is to inform the Walton Centre NHS Foundation Trust Board, the Quality Committee and the Local Safeguarding Children and Adults Boards with an annual update on adult and children safeguarding activity across the Trust in the last year (April 2021 - March 2022).

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

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

Definition

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

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

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

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

Working Together to Safeguard Children (2018)

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

Trust Safeguarding Responsibilities

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

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

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

All staff receive safeguarding training by attending a one-off corporate induction session and 3 yearly mandatory safeguarding training via e-learning or face to face sessions, dependent upon job role and responsibilities, in line with the Intercollegiate Document 2018 for Adult Safeguarding, Intercollegiate Document 2019 for Children and Young People and Intercollegiate Document for Looked After Children 2020. All job roles within the Trust are mapped to the appropriate level of training; this information can be found in the Trust Safeguarding Training Strategy.

Safeguarding Leadership and Accountability

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

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

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

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

Quality Assurance

Safeguarding Adults at Risk in the NHS – Accountability Framework was updated in August 2019 by NHS England. It states that all health providers are required to have effective arrangements in place to safeguard children and adults at risk of abuse or neglect and to assure themselves, regulators and their commissioners that these are working. These arrangements include:

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

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

The Trust has the required full complement of safeguarding personnel.

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

Statutory Framework and National Policy Drivers

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

Working Together to Safeguard Children 2018

This statutory guidance was updated in December 2020; key areas:

- ✓ Clarifies that the Data Protection Act 2018 and General Data Protection Regulations (GDPR) do not prevent the sharing of information for the purposes of keeping children safe
- ✓ A new section on the homelessness duty
- ✓ The updated guidance expands the list of potential threats to children and young people's safety to include domestic abuse, including controlling or coercive behaviour
- ✓ Child mental health: the importance of staff awareness that mental health can be an indicator that a child has suffered abuse, neglect or exploitation.

Lampard Report 2015

The Trust continues to provide updates on the recommendations from the Lampard report to NHS England and these actions are monitored through the Trust Safeguarding Group. Recommendation 7:

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

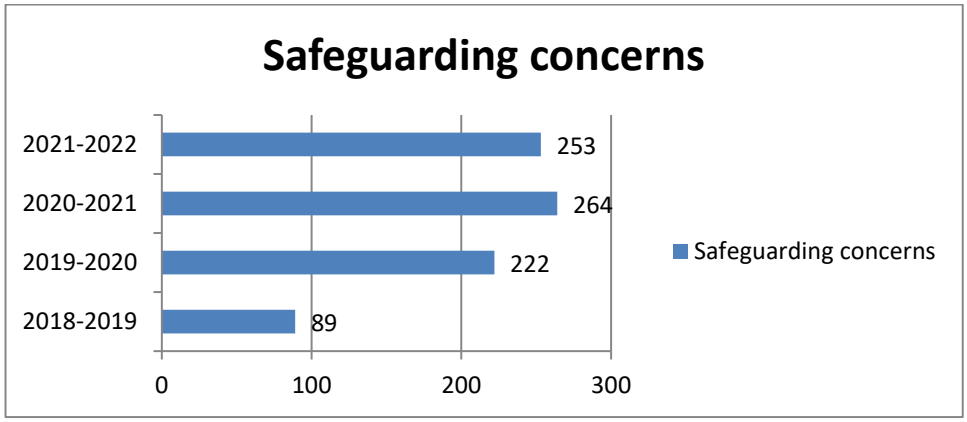
The Trust continues to undertake DBS checks for new starters and continues to require existing staff to complete an annual self-declaration regarding convictions. The DBS update service is currently offered for staff to sign up to at the point of entry to the Trust.

Adult Safeguarding Activity

It remains the responsibility of every NHS-funded organisation, and each individual healthcare professional working in the NHS, to ensure that the principles and duties of safeguarding children and adults are holistically, consistently and conscientiously applied; the well-being of those children and adults is at the heart of what we do (NHSE&I SAAF, 2019). The data collected by WCFT Safeguarding Team demonstrates the activity to evidence the above statement.

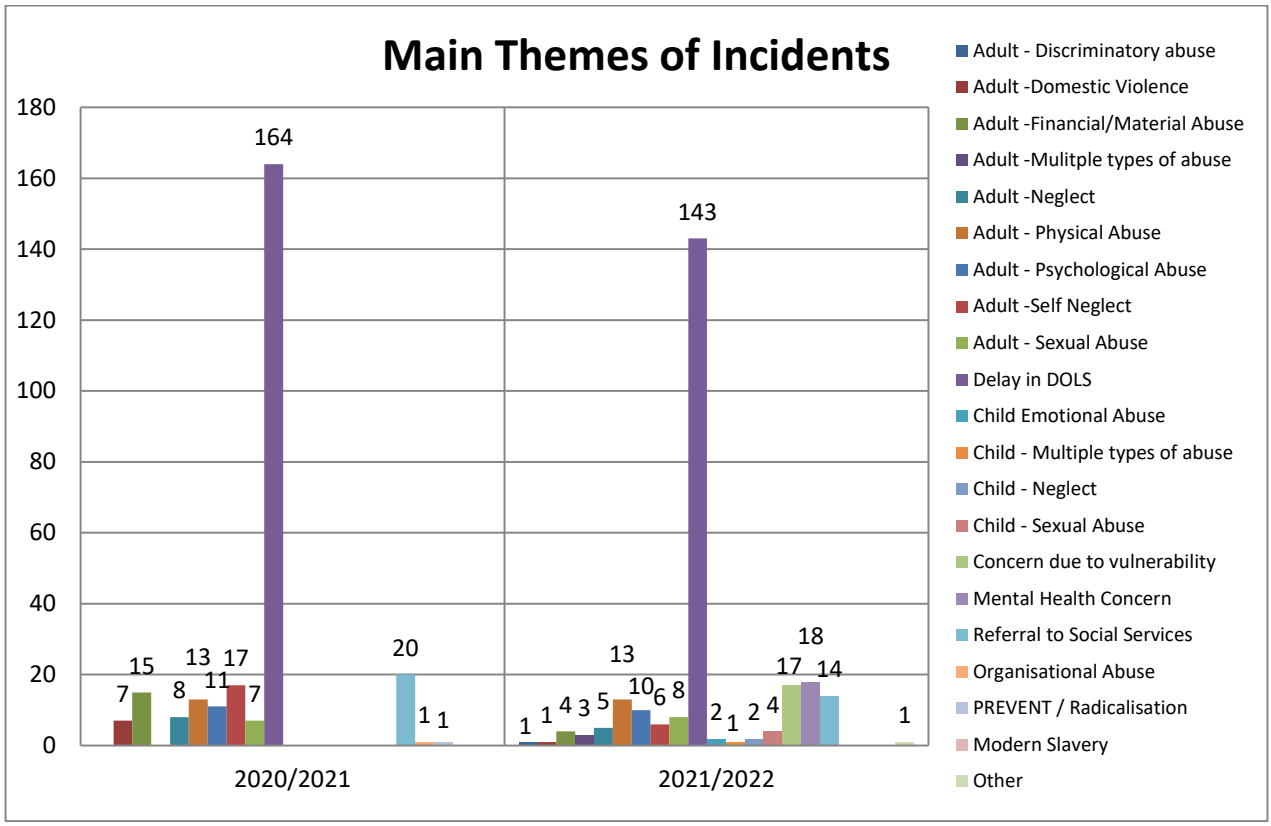
From April 2021 to March 2022, a total of 253 reported safeguarding adult incidents were noted on Datix of which the majority were categorised as minor harm.

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



The table below highlights the themes / trends that were reported in 2021/2022 in comparison to previous years.

Table 2 – Key: Adult – Main Themes of Incidents 2020/2021 and 2021/2022



The Trust saw a slight decrease in Datix reporting of safeguarding concerns in 2021/2022 compared to the previous year, however remaining higher than the penultimate year. The breach in timescales for the Deprivation of Liberty Safeguards (DoLS) assessments, remains the highest theme of incidents. This is due to the lack of timely assessment by the Local Authority due to a shortage of resources; this is a national issue. It is expected that the implementation of Mental Capacity (Amendment) Act 2019: Liberty Protection Safeguards (LPS), introducing revised governance arrangements and processes, will ameliorate the current situation regarding legal breaches.

Safeguarding Adult Reviews (SAR)

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

The Trust regularly participates in Safeguarding Adult Reviews with information sharing when requested. There have been no SARs commenced in the last twelve months that had a focussed review on The Walton Centre.

Key Achievements for 2021 – 2022

- The reporting of safeguarding incidents remains constant – demonstrating staff awareness of safeguarding responsibilities at WCFT.
- The Trust Safeguarding Training Strategy was produced and ratified. The number of staff aligned to level 3 training for adult and child safeguarding has been significantly increased to align with the Intercollegiate Documents for safeguarding competencies. The safeguarding team provided 14 x 3 hour Adult safeguarding training sessions and 10 x 3 hour Children safeguarding training sessions (total of 72 hours) to push for compliance figures - good progress has been made thus far. Increased knowledge in this area will enhance patient safety.
- Staff continue to initiate escalation of significant safeguarding issues and have had positive involvement in a range of complex cases (various themes) resulting in MDT and multi-agency engagement. Safeguarding supervision continues to be provided for Trust staff at the point of need – thus enhancing and developing bespoke knowledge and skills across various staff disciplines within the Trust.
- The Safeguarding Team are collating a repository of anonymised complex cases and examples of various areas of safeguarding to support bespoke training for Trust staff and for wider learning if suitable.

Key Priorities for 2022 - 2023

- Training: strive to reach compliance across the portfolio of safeguarding training.
- Full review of safeguarding adult training packages
- Further develop safeguarding supervision provision within the Trust.
- Re-launch the Safeguarding Champions initiative.
- Work stream to review safeguarding page on intranet.
- Safeguarding adult audit.

<u>Dementia</u>

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

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

In 2021 /2022 as part of the Quality Indicator, the Trust was required to screen all emergencies over 75 years of age with a single assessment. There were 232 patients who met the criteria for dementia screening and 116 patients were

screened. The Trust achieved 50% compliance for 12 months. The low compliance for screening demonstrates that there is further work to be undertaken to scope the process and address any issues that are affecting compliance.

There are cohorts of patients who meet the screening criteria, however, are not assessed:

- ITU patients, as the majority are sedated and therefore cannot be assessed or assessed within the timeframe
- Patients undergoing thrombectomy*
- Patients being admitted as a 'treat and transfer' case*

*The rational for these cohorts of patients not being assessed is due to the quick turnaround and discharge before the assessment is undertaken. However, there is a planned change to the process and with documentation to address the issue, in order to include these cohorts of patients for assessment in the future.

Key Achievements in 2021-2022

- Dementia awareness training continued as part of mandatory training and has now reached 91% at end of year. To maintain compliance level (90%) with Dementia training.
- Quality Indicator – screening all emergencies over 75 years of age with a single question.
- Continue to signpost Liverpool patients with a diagnosis of Dementia to access post diagnostic support service via Mersey Care NHS Trust through our memory clinics in Outpatients.
- We continue to be signed up to Johns Campaign and welcome carers of patients with dementia in all areas of the hospital, despite COVID 19 pandemic.

Key Priorities for 2022-2023

- To maintain compliance level (90%) with Dementia training.
- Review of training package.
- To complete the proposed changes to the screening process to ensure all cohorts of patients over 75 years of age, are assessed, and to monitor the changes to ensure effectiveness.
- Trust Dementia Strategy to be revised and embedded throughout the Trust.
- To offer and further develop the opportunity for staff and volunteers to become dementia friends / champions within the Trust.
- We will commit to become a dementia friendly organisation as highlighted in the Prime Minister's Challenge on Dementia 2020.
- We will promote the Dementia Friendly Hospital Charter within the Trust.

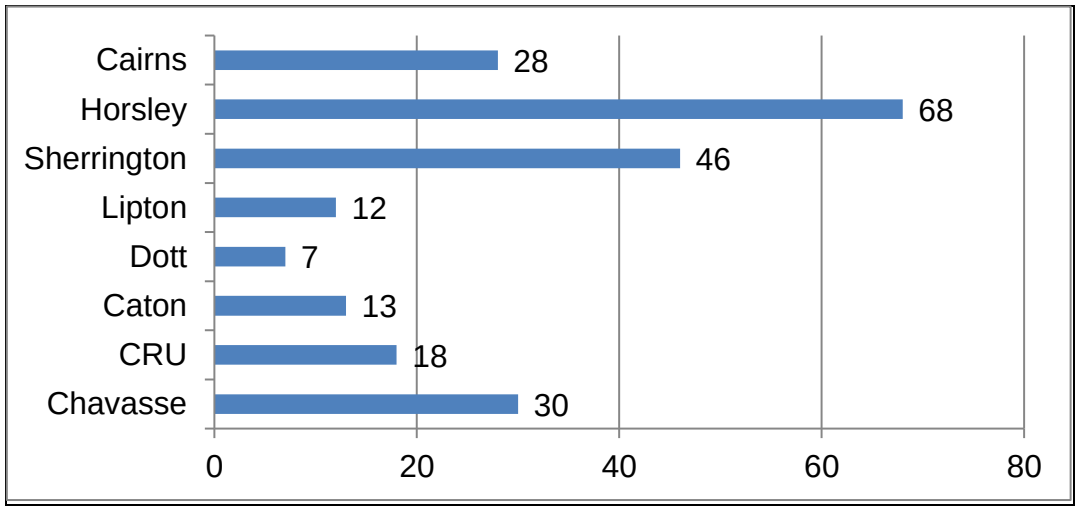
Deprivation of Liberty Safeguards (DOLS)

The Mental Capacity (Amendment) Act 2019: Liberty Protection Safeguards (LPS) is expected to be implemented in April 2023 due to the delays with COVID-19. The LPS Code of Practice is expected to be published in June 2021.

Table 3 - Yearly summary of Deprivation of Liberty Safeguards Applications

2019 – 2020	2020 – 2021	2021 - 2022
196	**257**	**222**

Table 4 - DoLS Applications from WCFT in 2021/2022



The table above highlights the ward areas submitting DoLS applications during the period from April 2021 – March 2022. Overall there were 222 DoLS applications submitted.

DoLS applications data is submitted quarterly as part of the Trust Safeguarding KPI schedule to Liverpool Clinical Commissioning Group.

- 83 applications were urgent applications and not assessed before transfer / discharge of the patient
- 111 patients were not assessed but remained an in-patient at time of the quarterly KPI submission
- 4 applications were authorised
- 4 were declined as the patient was assessed by the Best Interests Assessor (BIA) as having capacity
- 15 withdrawn as patient did not meet the criteria for DOLS
- 5 patients died before being assessed

Horsley unit had the most DoLS applications with 68 in total which would indicate that the applications are being made at an earlier point during the patient admission which remains a positive shift. This high figure demonstrates the throughput of patients with conditions that require DoLS (once the patient is stable and ready for transfer to the ward) via Horsley, and this will in turn reduce the number of ward

applications as the process has already been commenced. This demonstrates that the DoLS process is commenced in a timely manner.

Dott ward had least applications with 7 in total. Factors over the last 12 months that may have affected the applications from this ward were possibly:

- The ward was closed for four months.

The safeguarding team are planning a schedule of bitesize refresher training sessions for all wards around MCA and DoLS to maintain the quality of staffs' knowledge. The safeguarding team continue to undertake the DoLS ward rounds for all wards/units, in order to promote discussion and ad-hoc supervision to staff around MCA and DoLS, whilst ensuring that applications have been submitted for patients requiring an authorisation.

It is expected that the implementation of the LPS process will enable timely assessments and authorisations, in order to better protect the rights of the patients involved with the process, thus avoiding legal breaches of the Mental Capacity Act. The high numbers of breaches currently observed at WCFT are a national problem. The Trust is engaging with the LPS Public Consultation for LPS.

Key Achievements in 2021-2022

- DoLS OLM (E-learning) training compliance is at 90% at year end.
- Continue to develop the DoLS database; the live working document continues to be a robust and timely source of information for staff to access (read only) and for any audit/external queries or information requests.
- The Safeguarding Administrator continues to monitor all aspects/trigger points for action, with the DoLS process to ensure that the Trust is compliant with the MCA in relation to the DoLS process.
- The DoLS ward round continues: a 'real time' ward round for every area in WCFT fortnightly, to discuss every inpatient in order to identify any capacity issues: does the patient require a DoLS application? This promotes discussion of MCA / DoLS with staff to enable them to apply the principles of MCA and DoLS to their patients with support from the safeguarding team. Any agreed actions e.g. capacity assessment to be completed, are communicated back to the staff members (and ward manager for information) via email. The Safeguarding Administrator ensures that subsequent actions are completed.
- Meetings have taken place with the safeguarding team and the local DoLS teams regarding implementation of LPS at WCFT.
- Ongoing audit of compliance with documentation of DoLS applications and address any areas of concern with ad-hoc/bespoke training.
- The DoLS process has been further strengthened around home leave arrangements for patients with a DoLS application/authorisation, around the area of risk assessment and enhanced communication with the Local Authority DoLS teams

Key Priorities for 2022-2023

- Implementation of Liberty Protection Safeguards (LPS): planning for additional workload / staffing / systems / policy / procedures.
- Continue to maintain compliance with DoLS training (>90%).
- Continue to audit compliance of correct documentation of DoLS applications, ensuring correct processes are adhered to.
- The Trust's Matron for Safeguarding and the Safeguarding and MCA Specialist Nurse will continue to support the Trust's compliance with DoLS/LPS legislation, by keeping abreast of changes as they occur and translating the legislative developments into practical guidance for frontline staff.

Mental Capacity Act (MCA**)**

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

Key Achievements in 2021-2022

- MCA OLM (E-learning) training compliance is at 90% at year end.
- Positive engagement continues from Consultants and Specialist Nurses during outpatient clinics, MDT for complex cases, regarding MCA and best interest decision making, requesting input or attendance from safeguarding team to ensure robust compliance and use of the MCA and Best Interests framework with complex cases.
- Updated Best Interest form in EP2 which is now available for both inpatients and outpatients.
- The safeguarding Matron and Safeguarding/MCA Specialist Nurse will support staff in undertaking MCA assessments that are highly complex, or it is believed that there is potential for Court proceedings.
- Team arranged for Hill Dickinson to attend the Grand to present re MCA and Best Interest decision making.
- Commenced a repository of complex cases including: exemplar cases, well manged complex cases and any cases with lessons learned, to aid as a source of evidence and to inform bespoke training for the Trust.

Key Priorities for 2022-2023

- Continue to maintain compliance with MCA training (>90%).
- Re-launch the Mental Capacity Act/DoLS Champions initiative.
- Rolling annual audit to ensure knowledge and skills are maintained in order to provide assurance around practice and use of the MCA.
- Work stream to review safeguarding page on intranet – which will include MCA/DoLS/LPA information and updates.

Court Applications

There have been no challenges regarding the MCA in the last twelve months to require an application to the Court of Protection.

Domestic Violence and Abuse.

The Domestic Abuse Act 2021 provides the definition of domestic violence and abuse as: 'Any incident or pattern of incidents of controlling, coercive or threatening. behaviour, violence or abuse between those aged 16 or over who are or have. been intimate partners or family members regardless of gender or sexuality'. The landmark Domestic Abuse Bill is aimed at supporting victims and their families and pursuing offenders.

To help tackle the crime, the legislation aims to:

- ✓ Raise awareness and understanding
- ✓ Further improve the effectiveness of the justice system
- ✓ Strengthen the support for victims of abuse by statutory agencies.

Key areas:

- ✓ Provides statutory government definition of domestic abuse to specifically include economic abuse and controlling and manipulative non-physical abuse - this will enable everyone, including victims themselves, to understand what constitutes abuse and will encourage more victims to come forward.
- ✓ Establishes a Domestic Abuse Commissioner to drive the response to domestic abuse issues
- ✓ Provides Domestic Abuse Protection Notices and Domestic Abuse Protection Orders to further protect victims and place restrictions on the actions of offenders.
- ✓ Prohibits the cross-examination of victims by their abusers in the family courts
- ✓ Provides automatic eligibility for special measures to support more victims to give evidence in the criminal courts

Key Achievements in 2021-2022

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- The Safeguarding Team continues to provide bespoke support and supervision when staff raise domestic abuse/violence issues relating to patients, families and staff members; therefore supporting knowledge and confidence for staff dealing with this sensitive and complex issue.
- The level 3 face to face Safeguarding Adult training session incorporates domestic abuse and the level 3 face to face Safeguarding Children training, including assessment, MARAC process, Clare's Law and harmful practices. Again, this is providing staff with improved knowledge and confidence to enable staff to appropriately address this difficult and complex issue.

- The Safeguarding Team continue to support staff during clinics when a patient discloses domestic abuse. The team attend OPD (work permitting) to undertake the (statutory) Domestic Abuse Risk Assessment, so the running of the clinic is not interrupted, as the assessments are complex and emotional for the patient, and the duration of the assessment can be in excess of 2 hours.

Key Priorities for 2022-2023

- To continue with work, to add `Routine Enquiry` questions to Trust documentation to prompt staff to ask if patient feels safe at home.
- To continue with face-to-face training and providing ad-hoc and bespoke support and supervision for front line staff when requested or indicated.

Domestic Homicide Reviews (DHRs)

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

The Trust regularly engages with DHR information sharing when requested. There has been no focussed review into WCFT with a specific DHR in 2021-2022.

Learning Disabilities and Autism

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

Key Achievements in 2020-2021

- Learning disability training figures are compliant at 91% at year end.
- The Safeguarding team co-ordinates with reasonable adjustments and provides support for patients with learning disabilities, families and carers, for in-patients and outpatients, when required.
- Process is embedded re: hospital passports and risk assessments for admissions: flagged admission, assurance of receipt/completion of passports and risk assessments within 48 hrs of admission and data logged.
- Engagement with NHSE&I Learning Disabilities Improvement Standards Collection – action plan to follow and be included in the Quality Accounts.
- The safeguarding Specialist Nurse and Safeguarding Matron continue to attend various meetings: e.g. outpatient clinics, MDTs, Best interests meetings, to support staff with complex cases or potential mental capacity issues, for patients with learning disabilities.
- Safeguarding Matron's attendance at the bi-monthly Cheshire and Merseyside Acute Liaison Network meetings.
- Use of 'Synertec' to provide easy read appointment / admission letter for patients with learning disabilities.

- Finalised and implemented Reasonable Adjustments Policy.
- Commenced a repository of complex cases including exemplar cases, well manged complex cases and any cases with lessons learned, to aid as a source of evidence and to inform bespoke training for the Trust.
- Engagement of significant services with the STOMP project (Neuropsychology, Neuropsychiatry and Pharmacists).

Key Priorities for 2021-2022

- To implement training and a process to enable the Trust to to meet and exceed our statutory responsibilities in relation to SEND requirements.
- To maintain compliance with training figures >90%.
- To develop and work on the NHSE&I Learning Disabilities Improvement Standards action plan – to be included in the Quality Accounts.
- To commence a forum to engage service users with lived experience to support with service improvement for people with Learning Disabilities and Autism or any other conditions that require a lived experience perspective.
- To develop and commence rolling audit/quality assurance activity to monitor the process regarding passports, risk assessments and care plans.
- To restart the Learning Disability Steering Group. In previous years, the Group had met on a quarterly basis with primary care learning disability facilitators as part of the membership.
- To re-launch and embed the Mencap campaign `Treat me Well` in transforming how the NHS treats people with a learning disability.
- To embed processes re: hospital passports and risk assessments Trust-wide and commence a rolling audit for admissions – to audit documentation 48 hrs after admission.
- Embed the Learning Disability Policy within the Trust and ensure staff are aware of the support required for patients with a learning disability pre-admission and on arrival.
- Offer further opportunities for staff to become Learning Disability Champions within the Trust.
- Work stream to review safeguarding page on intranet – which will include information and updates regarding Learning Disabilities and Autism.

<u>Prevent</u>

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

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

The Trust has submitted no external Prevent referrals over the last 12 months.

The Prevent Lead for the Walton Centre is the Matron for Safeguarding and represents the Trust at the city wide and regional Prevent meetings. Training is now delivered via on line modules. Training figures are submitted as part of the safeguarding KPIs on a quarterly basis.

Key Achievements in 2020-2021

- Prevent Lead has developed good links with the Prevent Officer for Liverpool.
- The Trust continues to submit the Unify data submission for Prevent on a quarterly basis.

Key Priorities for 2021-2022

- The Trust is currently not compliant with the Prevent training figures which stand at 88% and 86% for Basic Prevent Awareness (BPAT) and Workshop to Raise Awareness of Prevent (WRAP) level 3 training respectively, at year end.
- Add Prevent guidance to the (new) Safeguarding page on the Trust Intranet to allow staff easier access to relevant information.
- Raise the profile of Prevent to encourage staff to report concerns regarding Prevent, as the Trust has low reporting activity on this issue.

Safeguarding Children Activity

It remains the responsibility of every NHS-funded organisation, and each individual healthcare professional working in the NHS, to ensure that the principles and duties of safeguarding children and adults are holistically, consistently and conscientiously applied; the well-being of those children and adults is at the heart of what we do (NHSE&I SAAF, 2019). The data collected by WCFT Safeguarding Team demonstrates the activity to evidence the above statement.

During 2021/2022 the Trust has seen a reduction of activity in safeguarding children referrals in comparison with the previous years (as shown in table below). This may be a result of less throughput of patients (including 16 and 17 year olds) due to the COVID pandemic. The restrictions with visiting will have resulted in less face-to-face engagement of staff with the patients' families, which may restrict the ability to 'Think family' regarding safeguarding concerns. However, the Trust did task designated staff to undertaking daily calls to family members during the pandemic. Following the re-introduction of visiting and the effect of increased numbers of people being trained in Level 3 safeguarding children, safeguarding activity figures are already demonstrating a rise in safeguarding escalations, month on month, towards the end of the financial year.

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

2019 – 2020	2020 – 2021	2021 - 2022
24	**11**	**9**

In comparison to the figures of incidents reported, safeguarding children themed activity totalled **18** concerns raised to the safeguarding team across the year. This will be a result of proactive activity (as we do not log inappropriate calls), that the concerns raised might not meet the criteria for an incident report or referral, however, demonstrates professional curiosity from staff.

Child Exploitation

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

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

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

Key Achievements in 2021-2022

- The Safeguarding Team have developed a robust risk assessment for admissions of patients under the age of 18 years. This ensures the safety of young person and appropriate engagement of specific services where required (e.g. Local Authority, Social Worker, SEND, Court of Protection).
- The Trust Safeguarding Training Strategy was reviewed and the number of staff aligned to level 3 safeguarding children was tripled, in order to align with the associated Intercollegiate documents. The training package was reviewed and 10 x 3 hour training sessions were delivered in Q4.

Key Priorities for 2022-2023

- To strive for compliance with all levels of training figures > 90%..
- Full review and update of all relevant Safeguarding Children guidance to be uploaded onto new safeguarding page on Trust Intranet.
- To further develop supervision processes within the Trust.

Did Not Attend/Was not brought (under 18 or patients at risk)

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

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

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

Key Priorities for 2022-2023

- Trust 'Was Not Brought' pathway and guidance is awaiting further amendment and will be ratified in Q1 at the Safeguarding Group meeting.

Female Genital Mutilation (FGM)

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

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

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

During 2020/21 the Trust reported 0 cases to NHS England.

Education and Training

The Trust continues to show an on-going commitment in ensuring that all staff receives appropriate safeguarding training. The Safeguarding Training Needs Analysis (TNA) has been developed which sets out the requirements and arrangements for safeguarding training provision for all WCFT employees including those on bank, honorary contracts or volunteers. The TNA has been reviewed to ensure that staff are mapped to the appropriate levels of training as per the Intercollegiate documents 2018 for adult safeguarding and for child safeguarding 2019.

Table 7 – Safeguarding Adult Training Compliance for 2021 - 2022

Trajectory to reach 90% at year end. Year End compliance			
Safeguarding Adult Training	Safeguarding Training Compliance at end of March 2022	Number of staff compliant	Total number of staff
Adults Level 1	90%	1315	1433
Adults Level 2	91%	997	1094
Adult Level 3	33%	251	751

Adult Level 4	100%	3	3
Dementia Awareness	91%	1311	1433
Prevent Awareness	88%	1264	1433
Prevent WRAP	86%	937	1094
MCA/DOLS	90%	922	1026
Learning Disability Awareness	91%	1300	1433

Table 8 – Safeguarding Children Training Compliance for 2021 -2022

Trajectory to reach 90% at year end. Year End compliance			
Safeguarding Children Training	Safeguarding Training Compliance at end of March 2022	Number of staff compliant	Total number of staff
Children Level 1	90%	1296	1433
Children Level 2	88%	968	1094
Children Level 3	78%	83	107
Children Level 4	100%	4	4

Key Achievements for 2021-2022

- The Trust Safeguarding Training Strategy was produced and ratified. The number of staff aligned to level 3 training for adult and child safeguarding has been significantly increased to align with the Intercollegiate Documents for safeguarding competencies. The safeguarding team provided 14 x 3 hour Adult safeguarding training sessions and 10 x 3 hour Children safeguarding training sessions (total of 72 hours) to push for compliance figures - good progress has been made thus far. Increased knowledge in this area will enhance patient safety.
-

Key Priorities for 2022-2023

- Continue to provide consistency in reporting all aspects of safeguarding training to effectively monitor the delivery of training and identify gaps in training and address as it occurs in year.
- Continue to report training compliance both at clinical and non-clinical level at Committee and Trust Board.
- Monthly monitoring of the level of compliance with safeguarding training to meet and exceed target of 90%.
- To continue to provide a monthly Trust Safeguarding training report.

- Address medical staff low compliance with safeguarding training as a priority and ensure plans to accredit prior learning are in place by training and development team. To set monthly trajectories and link with clinical leads for each division and the Medical Director and present to the Trust Safeguarding Group.

Policies and Procedures

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

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

- Reasonable Adjustments – new policy
- Managing Allegations Against Professionals
- Domestic Abuse Policy
- Prevent Policy
- Safeguarding Adults
- Restrictive Interventions
- DoLS policy

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

Monitoring

External

Adult and Children Safeguarding are required to satisfy the requirements of Key Performance Indicators (KPI) as set by the Clinical Commissioning Group. These include offering assurance on safeguarding activity throughout the Trust. The KPI for Safeguarding requires a quarterly submission to the CCG Safeguarding Service. All required information for WCFT has been submitted to CCG for 2021-2022.

Internal

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

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

Safeguarding Audit

The Trust has undertaken the following safeguarding audit in 2021/2022:

- Mental Capacity Act (MCA)
- Learning Disability: NHSE&I Improvement Standards Collection
- Quality audit of safeguarding referrals – for KPIs.
- SEF submissions to CCG for: neglect; exploitation; domestic abuse; SEND.

Safeguarding Supervision

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

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

Key Priority for 2022-20223

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

Mental Health Act

The WCFT Neuropsychiatry Team has expanded service provision over a 7-day period, thus ensuring that the service offers increased accessibility, leading to improved response times and comprehensive provision with additional Consultant Neuropsychiatrist and nursing provision.

On-call psychiatry provision has been implemented with a service level agreement (SLA) to provide seamless emergency cover out of hours via Mersey Care NHS Foundation Trust – which is reviewed annually.
Mental Health Act (MHA) training commenced in 2021 and is now delivered on Trust induction and yearly on clinical facing staff members annual health and safety study day, with over 70% of clinical staff compliant in the first 12-month period. The team introduced MHA folders in each ward area with MHA papers and policies which are audited 3 monthly.

A service level agreement (SLA) has been prepared with Mersey Care NHS Foundation Trust who act as MHA (1983) Hospital Managers to ensure robust compliance and concordance with use of the MHA. This is currently in final stages awaiting finance and executive sign off.

Standardized documentation has been introduced to ensure mental health and risk assessments are consistent with those across the region. This includes an Inpatient Outcome Form which focuses on activity, interventions and use of MHA.

Key Priority for 2022-2023

- Safeguarding Team facilitate Safeguarding Group Meeting and support opportunity to review any disagreements or professional disputes raised related to MHA.
- Annually audit use of MHA.
- Continue to work towards 90% clinical staff compliance with MHA training.
- Finalise SLA to ensure Hospital Manager provision and compliance, including specialist support with MHA tribunals, rights and IMHA access.

Overall Safeguarding Key Priorities for 2022/2023

- Draft an organisational safeguarding strategy.
- Continue to progress work required to achieve KPI requirements for safeguarding.
- Continue to complete actions identified on safeguarding work plan and various action plans within the safeguarding remit.
- Continue to ensure that safeguarding mandatory training is over 90% compliance by end of 2022-2023.
- Revise and develop Trust safeguarding policies to reflect statutory requirements.
- Continue to develop the use of electronic systems to further improve and develop robust governance around safeguarding data and information sharing and storage in view of GDPR (General Data Protection Regulation).
- It is recognised that the point of transition from child to adult services is a time of risk for vulnerable young people and we will ensure that the team work involved in transition is robust.
- The Trust is committed to having robust safeguarding processes in place and once a safeguarding concern is escalated, the person is protected, and information is shared appropriately. The Trust will continue to review it's processes considering case reviews and guidance from Liverpool and Sefton Safeguarding Boards.

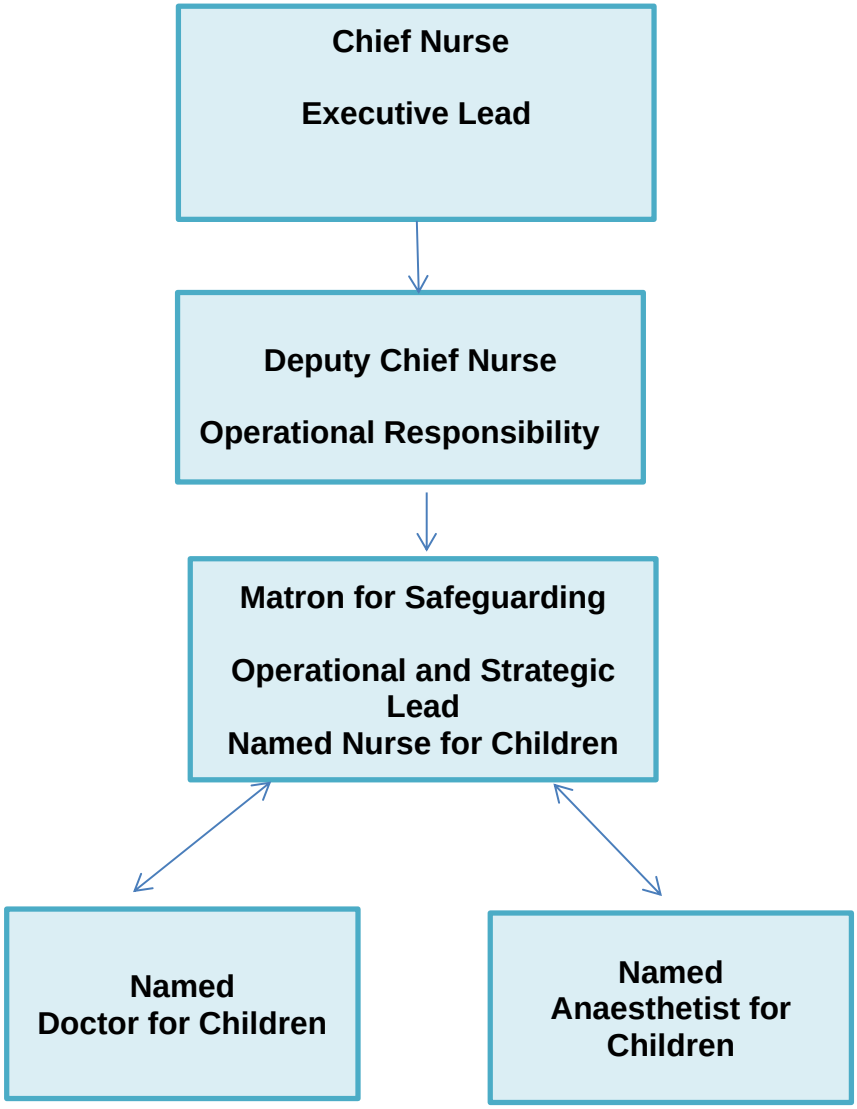
Conclusion

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

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

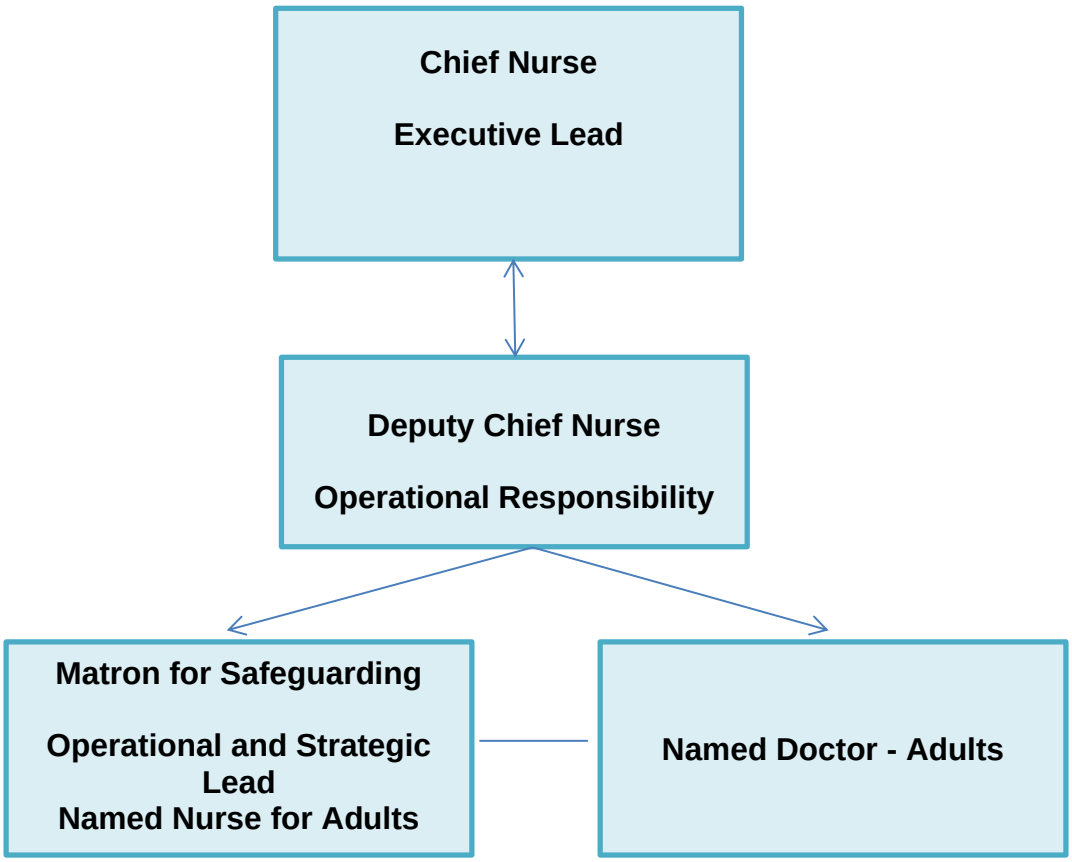
Appendix 1

Safeguarding Structure for Children



Appendix 2

Safeguarding Structure for Adults



The Walton Centre NHS Foundation Trust

Report to Trust Board
9 June 2022

Report Title	Request to Use Trust Seal
Executive Lead	Jan Ross, Chief Executive
Author (s)	Katharine Dowson, Corporate Secretary
Action Required	To approve

Level of Assurance Provided *(do not complete if not relevant e.g. work in progress)*

✓ **Acceptable assurance** Systems of controls are suitably designed, with evidence of them being consistently applied and effective in practice	☐ **Partial assurance** Systems of controls are still maturing – evidence shows that further action is required to improve their effectiveness	☐ **Low assurance** Evidence indicates poor effectiveness of system of controls

Key Messages *(2/3 headlines only)*

- The Trust Seal is required to complete the contract for the lease of The Bistro to ISS Medical
- The approval of the contract has already been agreed through the delegations set out in the Scheme of Reservation and Delegation (SORD)

Next Steps (*actions to be taken following agreement of recommendation/s by Board/Committee)*

- To apply the seal and complete the contract exchange

Related Trust Strategic Ambitions and Themes	**Impact** *(is there an impact arising from the report on any of the following?)*		
Choose an item	Not Applicable	Not Applicable	Not Applicable

Strategic Risks *(tick one from the drop down list; up to three can be highlighted)*

Choose an item.	Choose an item.	Choose an item.

Equality Impact Assessment Completed *(must accompany the following submissions)*

Strategy ☐	Policy ☐	Service Change ☐

Report Development *(full history of paper development to be included, on second page if required)*

Committee/ Group Name	**Date**	**Lead Officer (name and title)**	**Brief Summary of issues raised and actions agreed**
n/a			

Request to Use the Trust Seal

Executive Summary

1. Approval is sought to affix the Trust Seal to the contract between the Trust and ISS Medical for the lease of the Bistro for five years.

Requirement for the Affixing of the Seal

2. The Trust Seal is the instrument by which the Trust affixes its signature to legal documents and as such its use is subject to a strict process.

3. The Constitution (Standing Order 42) requires the Trust to have a seal and specifies that only the Board of Directors shall authorise its use. Every year the Board receives a report on the use of the Board Seal through the year. In practice this is seldom used except on legal documents such as contracts.

4. The authorisation is required from the Board for the use of the seal, not for the approval of the contract, which has been approved through the delegated authority given to Executive Directors.

Conclusion

5. The use of the Trust Seal must be approved by the Board of Directors.

Recommendation

To approve the use of the Trust Seal

Author: Katharine Dowson
Date: June 2022