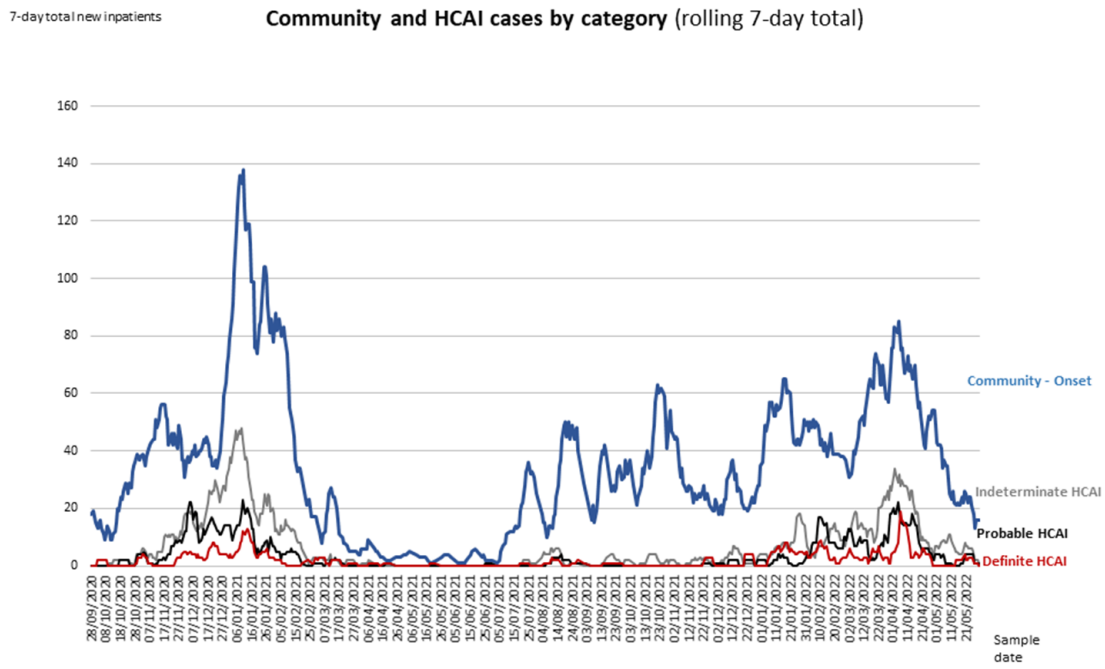


Measures Taken To Protect Patients from Hospital-Acquired COVID-19 Infection

Throughout the pandemic, we have actively reviewed and responded to the many changes in national guidance, putting in place a very wide range of measures to prevent and control the spread of infection. In 2021-22 this included the following:

- Regularly reviewed where we place patients with confirmed or suspected COVID-19 infection, to keep them separated as far as possible from those who do not have COVID-19.
- Hand hygiene messages are reinforced regularly to encourage staff and patients to clean their hands more often than normal. Alcohol hand gel is readily available in all areas.
- Our staff are required to wear surgical masks in all settings within the Trust to protect patients and we have trained our staff in the correct use of surgical masks and other protective equipment.
- Patients are requested to wear surgical masks if they can, and posters have been put up reinforcing this.
- We have maintained social distancing wherever it is possible, in line with changing national guidance.
- We have maintained clear plastic curtains between beds, and in some wards have continued to install fixed partitions, to reduce further the risk of transmission of COVID-19.
- We are cleaning all of our wards and departments more often than usual, and we use disinfectant products that are effective against the COVID-19 virus.

- We are installing special air scrubbers in key areas to help to reduce the risk of airborne transmission of COVID-19.
- We swab patients in line with guidance to identify anyone who has COVID-19 infection.
- The Infection Prevention Nurses visit our wards regularly and perform COVID-19 checklists to ensure our standards remain high.
- We take rapid action if an outbreak of COVID-19 is detected to stop further spread of infection. This includes deep cleaning the ward, and swabbing of staff and patients in the affected area.
- In 2020-21 we installed a drive-through swab pod, and in 2021-22 we have continued to use this to good effect for patients who require swabbing pre-operatively. This has prevented people needing to park and come into our buildings for out-patient appointments for swabbing. We have also utilised the pods for patient assessments for non-COVID conditions where this is clinically safe and effective, such as for some of our cardiology clinic reviews.

Outbreaks of COVID-19 Infection
Despite our efforts, in line with many other trusts, we were unable to fully contain this highly transmissible virus and reported 32 ward outbreaks during 2021-22. Each outbreak was reported and managed in line with national requirements.

Review and Learning
In 2020 we implemented a robust process of review for all patients with probable or definite hospital-acquired COVID-19 infection, in line with national guidance. We collated and shared the learning widely on how we can improve from these reviews as well as the learning from outbreaks of COVID-19, and a summary of this was contained in the annual report for 2020-21. These reviews continued in 2021-22.

Moving Beyond COVID-19
Whilst we continue to focus on the prevention of COVID-19 infection, as we go into 2022-23 we are also focussed on moving beyond the pandemic to restore normal services. Recommended control measures will continue in place, and we will review these regularly and amend them as required in line with changing national guidance.

Compliance with the Health & Social Care Act (2008): Code of Practice on the Prevention and Control of Infections and Related Guidance (2015)

The 'Hygiene Code'

Declaration of Compliance

Following self-assessment against the criteria in the Hygiene Code, the Trust is able to declare our compliance with the Hygiene Code for the year 2021-22.

Further, based upon our self-assessment in 2021-22 we are able to declare our compliance with the COVID-19 Board Assurance Framework.

Criterion 1: Systems to manage and monitor the prevention and control of infection.

Leadership Arrangements

The *Health & Social Care Act (2008) Code of practice on the prevention and control of infections and related guidance (2015)* (known as the Hygiene Code) sets out the arrangements all Trusts should have in place to prevent and manage infections.

A COVID-19 specific Board Assurance Framework was also issued in May 2020, and has been updated in 2021-22, most recently in December 22. Regular self-assessment of compliance has been completed, with scrutiny via the Infection Prevention and Control Steering Group (IPCSG), and then via the governance structure to the Quality Governance Committee on behalf of the Trust Board. This has enabled the Trust to report a high level of assurance that we comply with the COVID-19 specific framework, as well as the Hygiene Code.

In March 2022 NHS England & Improvement (NHSEI) completed a review of infection prevention and control systems, processes and practices. They visited our 2 largest sites and reviewed our infection outcomes and governance systems. Following this we have been awarded a GREEN rating, confirming assurance in relation to our leadership and governance arrangements, our embedded infection prevention practices and our significant improvements in cleanliness and antimicrobial stewardship. They will meet with us quarterly during 2022-23 to monitor our progress in reducing *Clostrioides difficile*, as this remains as a concern.

The Trust Board remains committed to the prevention of infection as a priority, ensuring quarterly scrutiny by the Quality Governance Committee on behalf of the Board. The Chief Nursing Officer is the lead Executive Director for the prevention of infection, with the role of Director of Infection Prevention & Control (DIPC) held by our expert lead infection prevention nurse. Reporting arrangements are in line with the requirements in the Hygiene Code.

WAHT has a multi-disciplinary Infection Prevention Team led by the DIPC. The team has dedicated resources available to support its work, and received support for implementation of a number of measures during the year to support the response to the pandemic.

The Trust's Clinical Microbiologists support the team in all aspects of infection prevention including outbreak management, surveillance for and management of health-care associated infections and policy development. This support is led by the Infection Control Doctor, a role currently shared between two Consultant Microbiologists. In addition, the Trust's clinical microbiology laboratory facilitates screening for and detection of key infections (known as alert organisms) both from clinical and environmental samples, as well as supporting the COVID-19 swabbing programme for our patients and staff.

The Trust also has an Antimicrobial Pharmacist who works alongside clinical teams, Consultant Microbiologists and the Infection Prevention Team to support improved use of antibiotics as part of our antimicrobial stewardship work.

Divisional Leaders remain committed to providing strong and visible leadership in relation to the prevention of infection. The responsibility of all staff to ensure they adhere to expected standards of infection prevention practice is set out in Trust job descriptions, and has been reinforced on a regular basis throughout 2021-22 via a range of communications. Awareness of individual and managerial responsibilities has increased significantly as a result of the pandemic.

Governance and Assurance

The DIPC reports to the CNO, the Chief Executive and onwards to the Board on all matters relating to infection prevention and control.

The Infection Prevention and Control Steering Group is chaired by the CNO and meets monthly: an IPCSG business meeting is held once every 3 months, and an IPCSG Scrutiny and Learning Meeting is held on the other 2 months IPCSG has formally established terms of reference and a cycle of business, in line with requirements in the Hygiene Code. It reports to the Clinical Governance Group, and onwards to the Trust Management Executive, and to the Quality Governance Committee, which scrutinises performance and actions being taken on behalf of the Board.

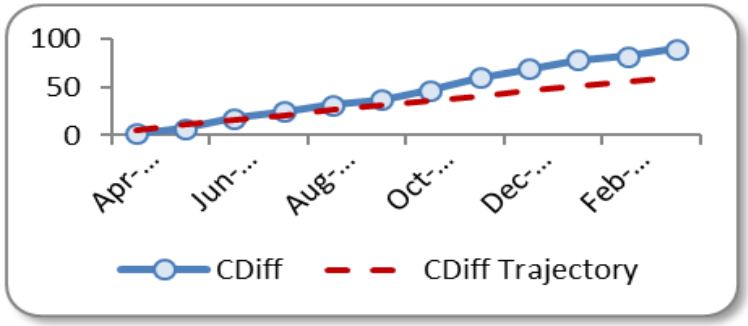
The IPCSG Scrutiny and Learning Meetings provide an opportunity for detailed scrutiny of patients with *Clostridioides difficile* and MSSA bacteraemia resulting in shared learning across the Trust, and enabling focus on the key issues needed to achieve improvement.

Divisions and key services such as Estates and Facilities report to IPCSG on the actions they are taking to reduce infections and improve standards. The reporting framework ensures Divisions review and understand variations in practice and hotspots requiring focused action.

Infection Performance

In 2021-22 we achieved 4 of our 5 national infection reduction targets, demonstrating improved safety for patients. We did not achieve the national target for *Clostrioides difficile* infection reduction, or our internal target for MSSA bacteraemia reduction.

HCAI National Targets 2021-22	Outcome Against Target
MRSA = 0	✓
E coli BSI = 36 vs 128 target	✓
Klebsiella species BSI = 17 vs 32 target	✓
Pseudomonas aeruginosa BSI = 10 vs 15 target	✓
Clostridioides difficile infection = 90 vs 61 target	✗

***Clostridioides difficile* Infection (CDI)**	**How Are We Doing?**
	We did not meet our improvement target this year. We reported 90 vs 61 full-year target.

To Reduce These Infections We Have….

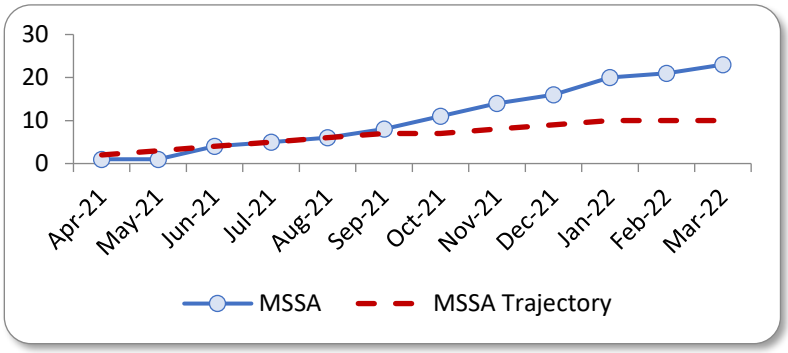
- Ensured all cases have been reviewed in detail by clinical teams, and shared the via our Scrutiny & Learning Meetings. We have drilled into the detail and shared learning for improvement for all cases detected during the year, as well as identifying trends and themes for trustwide action. These themes include antimicrobial prescribing, cleanliness and mandatory training compliance, as well as the detection and management of diarrhoea.

- Antimicrobial prescribing and stewardship (AMS) is well-recognised as a significant factor in development of CDI. Throughout the year we have had a major focus on AMS, including monthly audits to monitor our compliance with the national *Start Smart Then Focus* principles. We have achieved significant improvements in AMS this year, and plan to build on this in 2022-23.

- As a result of enhanced cleaning during the pandemic we have continued our improvement in cleanliness standards during 2021-22, as evidenced by our cleaning monitoring scores. We have continued focus on estates cleanliness issues through Cleanliness Scrutiny Meetings, and have implemented the new National Standards of

Cleanliness (2021). We will continue to build on this in 2022-23 with a focus on areas with star ratings of 3 and below.

- We have focussed education and awareness raising activities with our clinical teams on the detection and management of diarrhoea, to reduce the risk of infection spread. This includes short tutorials available via the Trust YouTube channel, and will continue into 2022-23.

Meticillin-Sensitive *Staphylococcus aureus* (MSSA) Bacteraemia	**How Are We Doing?**
	Though no national target was set in 2021-22, we continued our focus on reducing MSSA bacteraemia and set an internal reduction target of no more than 10 cases. We did not meet this internal target reporting 23 vs 10 full-year target.

To Reduce These Infections We Have….

- Progressed with our Quality Improvement Project to reduce *Staphylococcus aureus* bacteraemia (both MSSA and MRSA). This has engagement by all divisions, and has a series of working groups which are taking forward key work-streams which will collectively reduce the number of infections.
- Refreshed our ANTT programme, and ensured ANTT is included within competency training packages and policies. Towards the end of 2021-22 this became part of 'essential to roll' training, making monitoring of completion much easier.
- Trialled and agreed a revised procedure pack for insertion of peripheral vascular devices (PVDs), and a revised record form to document their insertion and management. During 2022-23 we will complete this piece of work with implementation in clinical areas.
- Reviewed the dressing being used for central vascular devices, and replaced it with an improved dressing which is better suited to protecting the CVC insertion site.
- Raised staff awareness of the issues and good practices required by issuing educational materials with key practice points highlighted.
- In 2022-23 we will progress this work further, as well as focussing on improved access to alternatives to PVDs, such as mid-lines.

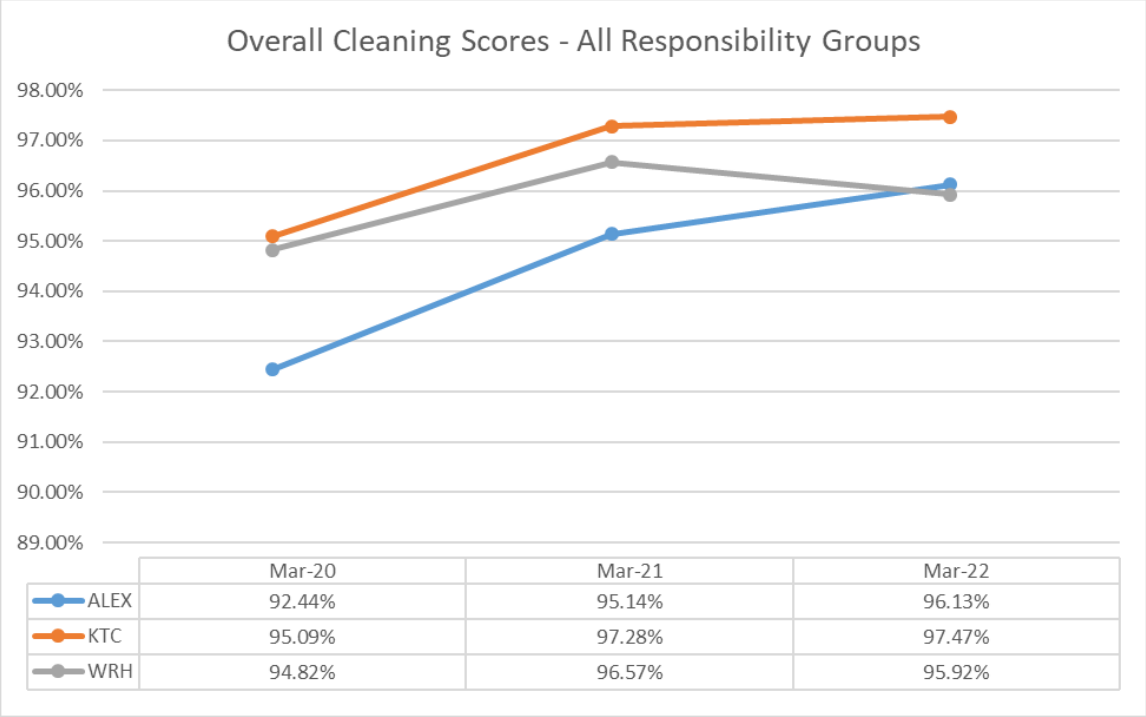
Criterion 2: Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.

Cleanliness

Our focus on cleanliness has continued throughout 2021-2022 with our approaches adapting to meet the continuing demands and challenges of Covid-19 whilst also supporting the restoration of normal activity.

The trend over the last 12 months has seen cleanliness audit scores overall continuing to increase for each site, exceeding the 92% target. The increase in scores is due to the continued scrutiny, and enhanced levels of cleaning including increased touchpoint cleaning, proactive routine Hydrogen Peroxide Vapour (HPV) and Ultra Violet-c (UV-c) decontamination of high risk areas. This includes dirty utility areas, and communal bathrooms.

Cleanliness by Site:

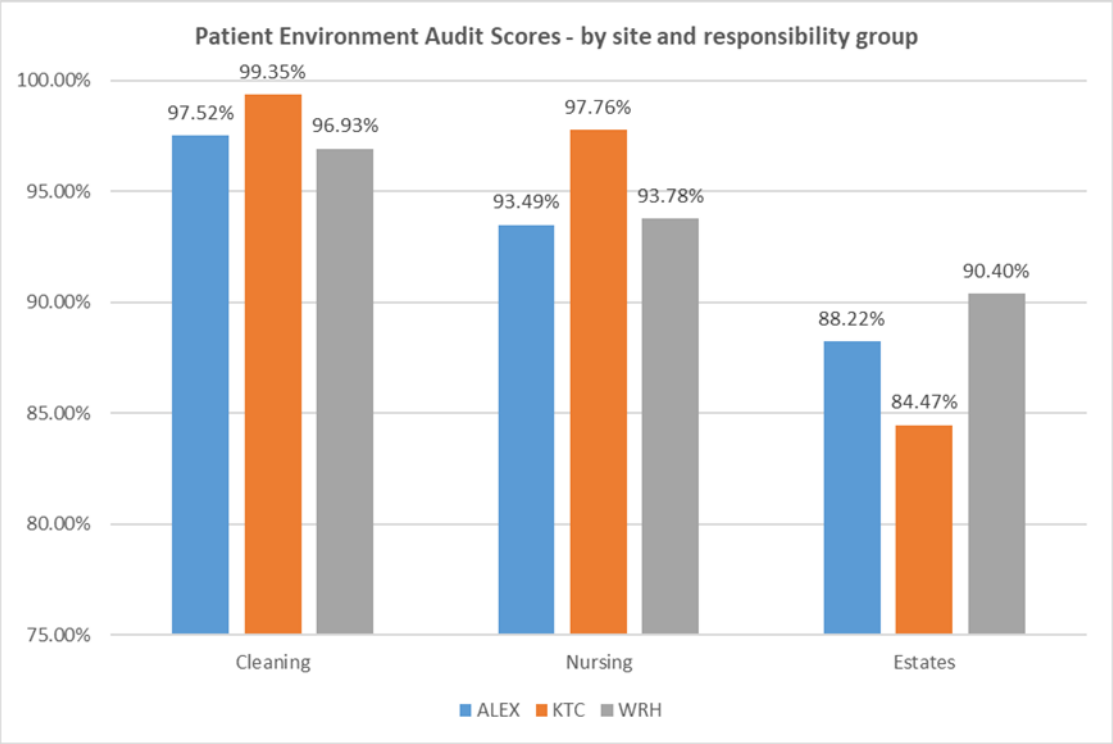


	Mar-20	Mar-21	Mar-22
ALEX	92.44%	95.14%	96.13%
KTC	95.09%	97.28%	97.47%
WRH	94.82%	96.57%	95.92%

We have continued to build on the improved working relationships and collaborative approach between the Estates and Facilities Teams with clinical teams. Regular scrutiny and review sessions are held to maintain focus on the importance of cleanliness to ensure safe environments.

In 2021-22 we have put specific focus on the estates element of cleanliness to support an increase in that element of the standards, as monitoring demonstrates this is the area needing improvement. As a result of this work we have developed clear escalation plans to support Estates staff getting access into busy clinical areas. This is supporting them to carry out the required maintenance work which helps improve the environment. We have also put focus into ensuring any issues identified which require repair are reported promptly when they occur, to support rapid repair.

The Trust Monitoring Team continue to report directly into the Head of Facilities which has enabled the team to remain independent of both cleaning services ensuring monitoring reports are objective and as accurate as possible. We have invested in increasing the size of our monitoring team on 2021-22, which has enabled increased monitoring scrutiny and flexibility to provide additional assurance where required.



A group was established during 2021-22 to implement the new National Standards of Cleanliness 2021, including the publication of new star ratings for cleanliness ahead of the national deadline. This was noted as a very positive action during the NHSEI review.

It has been another positive year for cleanliness standards across the Trust with clear actions identified to continue building upon the successes and maintaining a proactive approach to cleanliness, as well as embedding the new National Standards of Cleanliness (2021).

Safe Ventilation Systems

The Critical Ventilation Safety Group continues to meet regularly and is principally concerned with ensuring that Trust ventilation systems are inspected, tested, maintained and operated safely across all 3 sites. The group also has a remit of ensuring that clinical staff are aware of any risks these systems may pose to clinical activity.

In line with national guidance, an external Authorising Engineer (AE) Ventilation is in place to audit the management of the Trust's ventilation systems and appoint Authorised Persons (APs). APs are in place at all WAHT hospitals to manage the ventilation systems.

All critical ventilation systems are verified in accordance with HTM03-01 and systems are broadly compliant. Where there is a lack of compliance there are additional controls in place which are actively reviewed and managed via the Estates Team or our PFI partners.

Our specialist units such as theatres, endoscopy and your intensive care units have additional ventilation in line with guidance. However, one of our continuing challenges during the pandemic is that much of our hospital estate was built to have natural ventilation only. This means we cannot guarantee that the amount of fresh air entering those areas will fully dilute or remove all COVID-19 virus which may be present. As part of our work to improve

this in 2021-22 we commenced a programme of installing air scrubbers in key areas, to help minimise airborne virus risks.

Water Safety

Our Water Safety Group continues to meet, overseeing a system which is providing good assurance on water quality and governance. Our electronic system for recording water outlet flushing has been in place for over four years, with a system of escalation to management teams for any areas which do not complete their flushing and reporting.

A new Water Safety Plan (WSP) was commissioned from our Specialist Water Management contractor during 2020-21, which satisfied the latest guidance requirements in addition to HTM 04-01. The Estates department also commissioned a Legionella and Pseudomonas risk assessment, and our Authorising Engineer (Water) has been commissioned to carry out the yearly compliance audit.

A programme of sampling is in place to detect any Legionella and *Pseudomonas aeruginosa* in the water system. Sampling results have been generally good across all sites, with any adverse samples dealt with promptly in accordance with the water safety plan to ensure patient and staff safety. There have been no infections detected which link to any adverse water results.

Criterion 3: Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance.

The Trust Antimicrobial Stewardship Group have continued to provide leadership and oversight for antimicrobial stewardship (AMS) activities, further building on positive progress made in 2020-21.

Key progress made during 2021-22 includes:

- All Divisions have Divisional Board approved action plans to improve AMS and continue to provide assurance that AMS is embedded in their Quality and Governance agendas as a standing item. All Divisions have improved their assurance levels during 2021-22 with four Divisions at level 6 and one at level 5.

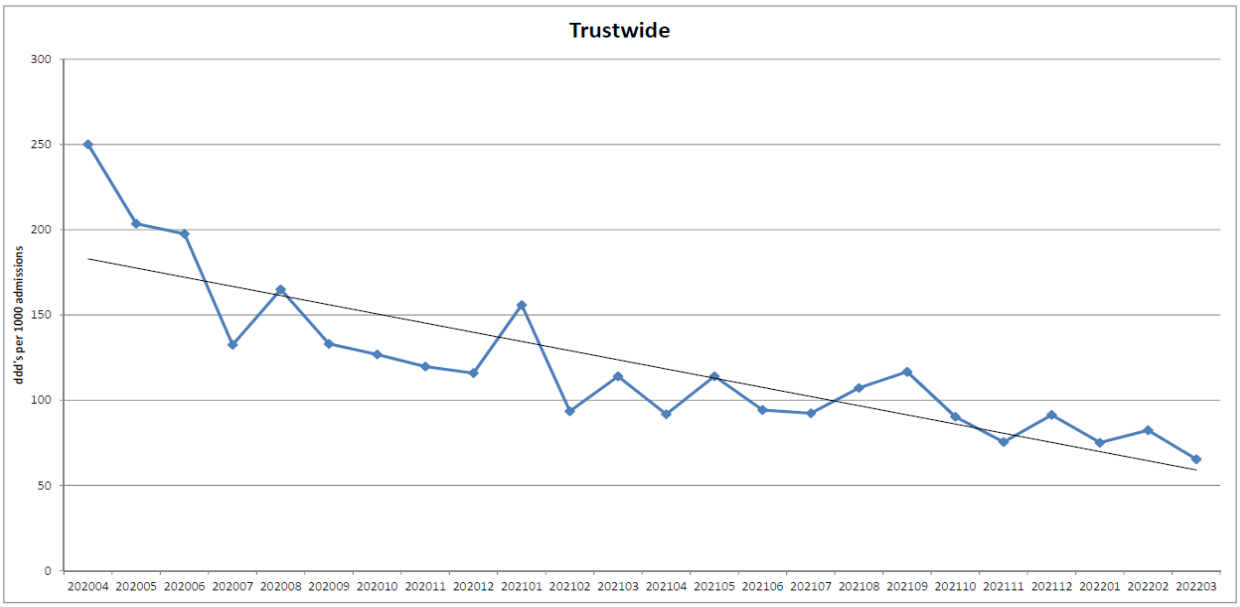
- We are seeing increasing ward and medical participation and engagement with antimicrobial stewardship reviews through our *Start Smart Then Focus* (SSTF) monthly audits, and continue to focus on ensuring all areas participate consistently.

- An extensive review and update of the Trust Antimicrobial Treatment Guidelines has been undertaken and will be published following Divisional consultation. The updates include; rationalising empirical broad spectrum antibiotic prescribing recommendations, increasing the proportion of ‘Access’ antibiotics and reducing the proportion of ‘Watch’ and ‘Reserve’ antibiotics within the guidelines.

- Following review and update of the Trust neutropenic sepsis guidelines, we have seen a significant decrease in carbapenem antibiotic usage with data demonstrating continuing reductions (see below).

Trustwide

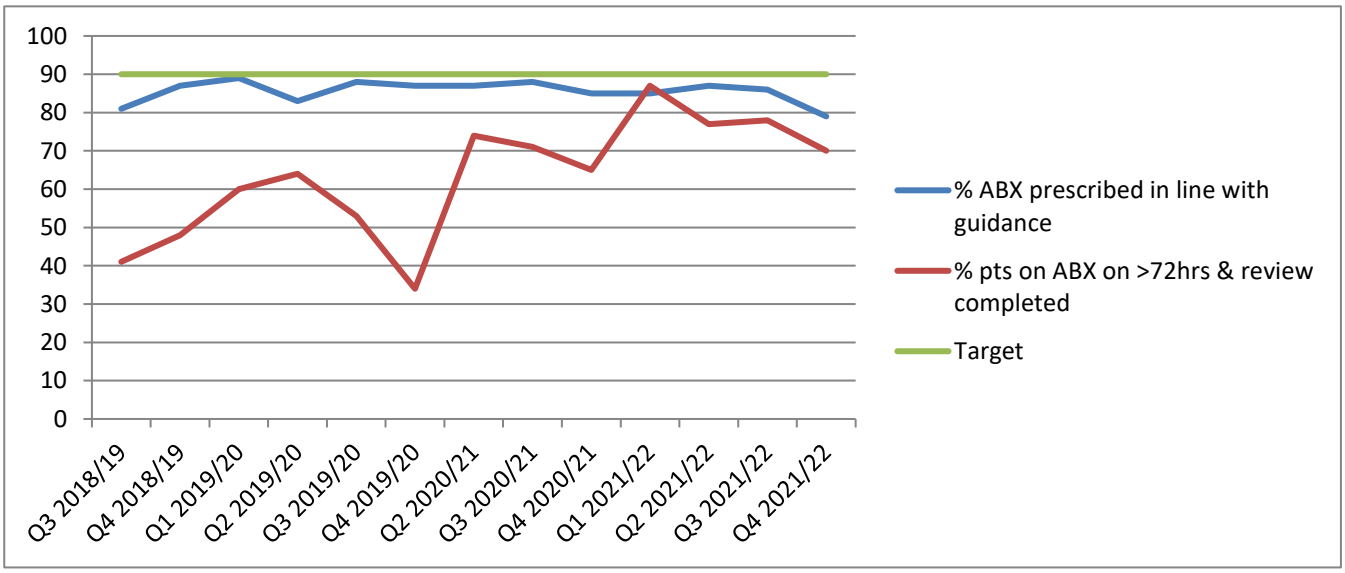
ddd's per 1000 admissions
Date range in months: 202004 to 202203



Antimicrobial Stewardship Outcomes

In March 2022 our overall compliance to the *Start Smart Then Focus* standards was measured at 87.88%, using the monthly audits.

Quarterly point prevalence surveys have highlighted overall guideline compliance and antimicrobial review at 72 hours as two key areas of focus for improvement moving forward (see below).



Overall during 2021-22 we have seen a continued improvement in our systems, processes and governance of antimicrobial stewardship. During 2022-23, in addition to working towards improving levels of compliance with AMS Key Performance Indicators, we will focus on achievement of the quality improvement criteria set out in the 2022/23 UTI AMR CQUIN along with meeting target reductions in consumption of 'Watch' and 'Reserve' category antibiotics as specified within the NHS standard contract.

Criterion 4: Provide suitable accurate information on infections to service users, their visitors and person concerned with providing further support or nursing/medical care in a timely fashion.

Our continued approach through the pandemic during 2021-22 has been to ensure open and clear communication with our patients, their carers, family and the wider public. We have used a mixed approach for this, all of which has been discussed and processed through our regular Bronze Command and Control structure.

We have continued to display information about our *Key Standards to Prevent Infection*, wards displaying information on their compliance to the standards.

Social media has been used to promote key messages about preventing infection, especially during the pandemic. Our public website contains a range of information to help inform the public, including on MRSA, *Clostridioides difficile*, and influenza.

Information on COVID-19 is available on a dedicated microsite which can be accessed by all staff and a weekly briefing continues to be issued for all staff and volunteers containing up to date information and key messages.

All volunteers recruited in the pandemic have undergone specific training in infection prevention and control which includes new online training modules and are subject to regular risk assessments to ensure compliance with the latest trust and national position and guidance.

Criterion 5: Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people.

We have a number of assessment tools available to reduce the risk of transmitting infection, and our admission process includes assessment of patients for signs of infection. This has been strengthened further during the pandemic using a daily COVID-19 symptom checklist, and COVID-19 assessment on admission.

Our Infection Prevention Team works closely on a daily basis with wards, our site management teams, and our cleaning teams, to ensure patients with infection are rapidly identified, isolated correctly, and addition cleaning is in place as required. To support this during 2021-22 we have added information on the need for isolation to our ward whiteboards, so that the information is easily available for ward staff, and the site management team.

During 2021-22 we identified and effectively dealt with a number of infection outbreaks and incidents relating to a range of infections. The detail is contained in Appendix 1 of the report.

We also managed 32 ward outbreaks of COVID-19 during 2021-22. These were all reported and managed in line with accepted guidance at the point in the pandemic at which they occurred.

Criterion 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 infections.

Strong and visible leadership by all senior clinical leaders continued throughout the pandemic in 2021-22, including leadership by the CNO and the DIPC.

Throughout 2021-22 we continued to require all staff to complete the electronic mandatory training rather than face-to-face sessions, in order to reduce the risk of COVID-19 infection. Our compliance target in 2021-22 was 90%, and at the end of 2021-22 the achievement was 89% for clinical staff, and 95% for non-clinical staff.

Ward-based training and electronic resources have remained in place to support staff respond to the pandemic during the year. This has included FFP3 mask fit-testing, and correct selection, donning and doffing of personal protective equipment. We continue to utilise national training resources which are available as well as bespoke packages tailored to the needs of our staff.

The infection prevention link staff programme recommended in 2021-22 with socially-distanced education sessions held to focus on cleanliness in key areas. As we move beyond the pandemic and into 2022-23 we will refresh the programme and recommence regular education sessions.

Our Incident Command Meetings have been held digitally through the whole of 2021-22. These meetings continue to act as a forum for rapid communication of information to our teams trust wide. This includes our PFI partners who have worked closely with the trust throughout 2021-22.

As part of our work in 2021-22 to reduce *Clostridioides difficile* infection and MSSA bacteraemia we issued briefing notes and 'Hot Topics' posters as well as recording short video tutorials on key topics including cleanliness. These are available for our staff on the Trust YouTube channel to provide ready access 24 hours a day to this training.

Criterion 7: Provide or secure adequate isolation facilities.

In general, Isolation for infection prevention reasons means caring for someone in a single room, preferably with ensuite toilet and washing facilities. At the beginning of 2020-21 we had reviewed our bed-base and confirmed we had 175 single rooms across the Trust, which is 18% of our hospital beds. Of these 134 are ensuite, which is 13% of our beds. These beds are routinely used for isolation, and this continued in 2021-22. When the number of patients with possible infection rises, then patients with the same infection/suspected infection are nursed together in cohorts.

Cohort isolation continued to be used extensively throughout the pandemic in 2021-22, with the number of wards dedicated to the care of COVID-19 patients flexing up and down as

needed to provide appropriate care. We amended our COVID-19 pathways several times during the year taking account of national guidance and the prevailing situation locally across Worcestershire. In the last few months of 2021-22 in line with national guidance, we started to introduce a more standard model of isolation, with patients being isolated in single rooms and bays within the ward most appropriate for their clinical care based upon their reason for admission (our 'presenting condition model'). We continue to move gradually from a model of COVID-19 wards, to the presenting condition model as we move into 2022-23.

We have infection assessment tools for patients on admission to detect other infections as well as COVID-19. If someone develops common symptoms of infection such as diarrhoea during admission, these tools are used by staff to identify the need for isolation.

The work completed in 2020-21 to convert bays in some departments into cubicles, and install extra pods into intensive care has been beneficial in supporting our ability to isolate patients with a range of infections during 2021-22, including COVID-19.

Criterion 8: Secure adequate access to laboratory support.

We have our own trust-wide on-site microbiology laboratory, based at Worcestershire Royal Hospital. This provides a full range of microbiology services, linking with the national reference laboratory network for specialised testing which cannot be performed locally. The laboratory has been reassessed in 2021-22 and remains UKAS accredited, confirming it operates an effective and quality controlled system.

Throughout 2021-22 the laboratory has maintained sufficient increased capacity to provide all the required testing for COVID-19 for the health system across Worcestershire, via a range of rapid and standard tests. In 2022-23 the laboratory will continue with work to further extend the range and number of rapid testing platforms available for other infections. This includes molecular based testing for enteric pathogens including a wider range of viruses to assist in the control of infection.

Criterion 9: Have and adhere to policies, designed for the individual's care and provider organisations that will help to prevent and control infections.

During 2021-22 we made some progress on revision of outstanding policies. Due to the demands and changing guidance during the ongoing pandemic our policy focus was directed at responding to changes in COVID-19 guidance. However, we were able to review almost all outstanding policies during the end of 2021-22 and the early part of 2022-23.

We monitor adherence to a number of our *Key Standards to Prevent Infection* with a programme of monthly auditing via our electronic system with reporting in real-time. The national High Impact Intervention audit tools issued by NHS Improvement have been used as the basis for the monitoring tools. The compliance information is included routinely within divisional reports to IPCSG, supporting detailed review of good practice as well as identifying areas which require further support to achieve the standards expected. As part of our annual review we have updated and reissued the *Key Standards to Prevent Infection* for 2022-23.

Our *Key Standards to Prevent Infection*

Putting Patients First

4ward

NHS Worcestershire Acute Hospitals NHS Trust

KEY STANDARDS TO PREVENT INFECTION 2022-23

Cleaning Standards Category: High ..... Date: .....

	CLINICAL PRACTICE	
1	**Hand hygiene:** minimum: • 98% compliance with standards • 100% of required audits completed • 100% staff bare below the elbows in clinical areas	
2	**Peripheral cannula care bundle:** 100% completed and compliant: insertion and ongoing care.	
3	**Urinary catheter care bundle:** 100% completed and compliant: insertion and ongoing care.	
4	**Isolation care:** 100% compliant with isolation standards for any patient requiring isolation.	
5	**Sharps safety:** Use and handling of sharps 100% compliant with sharps safety practices.	
6	**Infection Prevention & Control Safety Huddles** undertaken during 100% of shifts: all staff are fully briefed on required precautions.	
7	**Mandatory Level 2 Infection Prevention & Control Training:** Minimum 95% of all staff employed by the specialty teams/ ward/ department have completed this within the past year.	

	CLEANLINESS AND ENVIRONMENT	
8	**Domestic cleanliness:** National cleaning standard score: Cleaning Standards Category: High: 95% minimum.	
9	**Nursing cleanliness:** National cleaning standard score: Cleaning Standards Category: High: 95% minimum.	
10	**Estates:** National cleaning standard score: Cleaning Standards Category: High: 95% minimum.	
11	**Commode and raised toilet seat cleanliness:** 100% achieved.	
12	**Bed and bed-space cleaning standards:** Achieve 100% compliance on all beds and bedspaces having a completed cleaning checklist.	

We listen, we learn, we lead

Issued: 25 February 2022

Hand hygiene is audited monthly and all clinical areas are expected to participate. Audit participation has increased to 94.6% in 2021-22, up from 92.5% in the previous year. Hand hygiene practice compliance monitored via the monthly audit programme has also increased in 2021-22 to 99.7%, up from 99.5% in the previous year.

In response to the unique challenges and additional practice requirements of the pandemic we implemented a programme of ward monitoring by our Infection Prevention Nurses in 2020-21, using purpose-designed COVID-19 checklists to monitor all of the standards expected. This programme of monitoring continued in 2021-22, with the monitoring tools updated in line with changing national guidance. They focus on standard precautions and cleanliness and have provided a high degree of assurance on achievement of standards, as well as rapidly identifying any issues that require action to reduce risk of infection spread.

Criterion 10: Providers have a system in place to manage the occupational health needs and obligations of staff in relation to infection.

Our Occupational Health Service has a programme of staff health assessment to ensure staff are both protected from infectious disease by vaccination, and are screened as required on employment to ensure they do not pose an infection risk to patients. The service supports the health and wellbeing of our staff across the Trust, as well as supporting our PFI contractors' staff.

Our staff influenza vaccination programme was amended in light of COVID-19 controls in 2021-22, changes included not holding ward-based immunisations clinics in order to reduce spread of infection. We achieved 64% of staff vaccinated, which was less than in 2020-21 and did not meet the national target. A learning review of what went well and what could be improved has been completed and will be used to help planning for the flu campaign in winter 2022-23.

The requirement for all staff to have in place a COVID-19 Occupational Health risk assessment in order to protect those at risk of severe infection continued throughout 2021-22, with updates made to the content in line with national guidance changes.

The Occupational Health Service also provides action, counselling, follow up, guidelines and support when there is a needle stick injury.

Our Plan for 2022-23

In the coming year we will continue with restoration of normal services in line with guidance on living with COVID-19 as we move beyond the pandemic. We will continue to focus on protecting patients and staff from all infections, reacting to national guidance as it is released to ensure we follow recommended good practice.

Our overall aim remains to achieve excellent infection prevention standards and very low rates of infection. We made good steps towards this in 2021-22 by achieving 4 of 5 national infection reduction targets, and achieving a GREEN rating for our infection prevention standards from NHSEI. However, we know there is more work to do to ensure we reduce infections due to *Clostridioides difficile* and those linked to invasive devices in 2022-23.

We will continue our focus on hand hygiene, cleanliness, antimicrobial prescribing and the care of invasive devices. We have revised our policies and procedures in 2021-22 to ensure they are in line with the best evidence, and in 2022-23 we will strengthen further our assurance in relation to infection prevention practices.

We will continue to use our review process for cases of *Clostridioides difficile* infection, and MSSA bacteraemia to help us achieve greater improvements using this structured framework to share learning across the Trust.

To deliver these improvements and continue responding to COVID-19 we are implementing a comprehensive annual infection prevention improvement plan for 2022-23. This continues our focus on our '*Key Standards to Prevent Infection*' along with the other core actions we must take to achieve our aim. The plan is contained in Appendix 2.

References

1. The Health & Social Care Act 2008: Code of Practice on the prevention and control of infections and related guidance (2015). https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/449049/Code_of_practice_280715_acc.pdf

2. Infection Prevention & Control Board Assurance Framework 2021:COVID-19-19. https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/04/ipc-board-assurance-framework-v1.5-feb-2021.pdf

3. Start Smart Then Focus: antimicrobial stewardship toolkit for English hospitals (2015). https://www.gov.uk/government/publications/antimicrobial-stewardship-start-smart-then-focus

Appendix 1: Outbreaks and Incidents

During 2021-22 we identified the following infection outbreaks and incidents which were not related to COVID-19:

Incident date	Summary	Learning and Key Actions
June 2021	**Carbapenemase-Producing Enterobacteriaceae (CPE) Outbreak on a Surgical Ward**	- Index patient identified as CPE colonised following routine admission screening for CPE. - Seven other patients subsequently confirmed as CPE colonised on screening. No episodes of infection. - CPE isolated from toilet in bathroom utilised by the initial patient cluster, and toilet replaced. - Active control measures in place including admission and weekly CPE screening for all patients, enhanced cleaning, and active management of drains. - Further work in zonal kitchen taking place following confirmation of CPE in zonal kitchen to refit units and dishwasher (see below) - Outbreak currently in monitoring phase and not yet closed.
July 2021	**CPE Outbreak on Medical Ward (adjacent to first ward and sharing zonal kitchen)**	- Index patient identified from admission screening. One further patient identified following screening. No infections. - Concerns about possible local acquisition of CPE in the index patient; due in part to the CPE outbreak on the adjoining ward, - Full review of wards in the location undertaken including environmental assessment and swabbing in the zonal kitchen which serves 3 wards - Active control measures in place including admission and weekly CPE screening for all patients, enhanced cleaning, and active management of drains. - Further work in zonal kitchen taking place following confirmation of CPE in zonal kitchen to refit units and dishwasher. - Outbreak closed, but active monitoring remains in place.
July 2021	**Vancomycin-Resistant Enterococci (VRE) Outbreak in an Intensive Care Unit**	- Five patients identified as VRE colonised from routine screening during their admission. No infections. - Patients were isolated appropriately - Deep cleaning took place. - Typing confirmed they were all the same confirming the outbreak. - No further cases after control measures were implemented.

Incident date	Summary	Learning and Key Actions
		- Outbreak closed.
October 2021	**Outbreak of *Clostridioides difficile* on a Medical Ward**	Phase 1 - Three cases detected within short timeframe. Period of increased incidence (PII) declared, and active control measures implemented. - Incident upgraded to an outbreak on 17/11/21 when the 3 samples were all identified as being the same ribotype: 955. - Ribotype 955 is very uncommon. Specialist typing showed they were indistinguishable, confirming the outbreak. - Index patient had diarrhoea on admission and had recently arrived in the United Kingdom from another country. Hence it is presumed that this unusual ribotype has been imported. - Original outbreak closed on 17/11/21 as no further ward-attributable cases identified after 28 days Phase 2 - Further PII declared on 03/12/21 when 3 more cases of C. difficile were identified: 2 ribotyped as 955, confirming an on-going outbreak. - Detailed retrospective case finding identified a further 2 cases of ribotype 955 linked to the ward. Contributory factors to the length of the outbreak and number of patients affected: - 955 appears to be a particularly transmissible ribotype. Contact with the ward in the case of some patients was very brief. - Two patients were on the ward for a long period and had difficult to manage diarrhoea, hence there was the risk of re-contamination of the environment despite the programme of enhanced cleaning. Decision taken to keep the outbreak open until 3 months without new cases in view of epidemiology. Phase 3 - 1 further patient has been confirmed as ribotype 955 from a specimen in March 2022. - This patient had been on the ward during the initial outbreak period, so could have acquired it then.

Incident date	Summary	Learning and Key Actions
		The patient received antibiotic treatment in the intervening period. - Decision taken to keep the outbreak open for a further 3 months form the date of the positive patient as a precaution. - Active control measures remain in place.
December 2021	**Outbreak of C.difficile on a Medical Ward. Linked to the previous outbreak.**	- Six patients with C.difficile linked to the ward - Three of six typed the same as the ward outbreak running elsewhere: ribotype 955. The others were not linked. - The index patient was a transfer from the other outbreak ward, with confirmed 955 ribotype, and had been transferred for isolation as a single room was available. - Active control measures were implemented, and the outbreak was terminated and closed following 28 days with no new cases. - Active monitoring remains in place.
December 2021	**Outbreak of C.difficile on a Surgical Ward**	- Two cases of C. difficile identified. A PII was declared and active control measures implemented. - Both cases ribotype 020, confirmed as linked by MVLA typing, confirming the outbreak. - reiterated, followed by D&V risk assessments and samples for any patient with symptoms of diarrhoea - No further cases identified and outbreak closed following the 28-day period.

Appendix 2: WAHT Infection Prevention Improvement Plan 2022-23

WAHT Statement of Intent

The Trust is committed to achieving excellent infection prevention practices, and we aim to be one of the best organizations in the UK for our rates of infection.

The prevention of infection remains as a key priority for Worcestershire Acute Hospitals NHS Trust. In 2022-23. This will be achieved through continuing and determined focus on improving clinical practices, antimicrobial stewardship and the environment of care, and by continually improving the knowledge of our staff so that they can achieve excellent standards of infection prevention practice.

This improvement plan supports delivery of the WAHT Quality Improvement Strategy and plan. It sets out the objectives and actions that will be taken across WAHT to achieve our ambition to be one of the best organizations in the UK for our rates of infection, and to ensure compliance with Care Quality Commission Standards and 'the Hygiene Code' (2015), and the Infection Prevention & Control Board Assurance Framework 2021: COVID-19 – 'the COVID BAF' (2021).

WAHT Infection Prevention Priority Aims 2022-23

1. Maintain strong governance and assurance in relation to infection prevention across the Trust, to demonstrate compliance with the *Code of Practice on the prevention and control of infection and related guidance (2015)* - 'the Hygiene Code', and the '*NHSEI Infection Prevention & Control Board Assurance Framework 2021: COVID-19*'.
2. Achieve national improvement targets for healthcare-associated infections and antimicrobial prescribing, with the ambition to improve beyond these targets.
3. Benchmark within the best quartile for surgical site infections monitored through the mandatory surveillance programme.
4. Participate in other non-mandatory programmes of surveillance where possible in order to benchmark and improve across a range of areas.
5. Deliver safe, effective care whilst ensuring the prevention and management of COVID-19, in line with national guidance for the NHS on living with COVID.

Key Issues and Elements for Focus

Focus: Infections

- *Clostridioides difficile* infection
- *Staphylococcus aureus* bacteraemia, including MRSA
- E coli and other gram-negative bacteraemia
- COVID-19
- Tuberculosis, Influenza & other vaccine preventable diseases
- Multi-Drug Resistant Organisms, including Vancomycin Resistant Enterococci and Carbapenemase Producing Enterobacteriaceae
- Surgical site infections
- Urinary Tract infections, including those related to urinary catheters
- *Pseudomonas aeruginosa* in augmented care
- Preparedness for Ebola, MERS, Plague and other novel or emerging infections
- Norovirus

Priority Elements of Improvement Programme

- *Key Standards to Prevent Infection 22-23*
- Hand hygiene and bare below the elbows
- Environmental Cleanliness
- Management of the environment to minimise aerosol and droplet transmission, including improvements in ventilation
- Prescribing of antimicrobial agents and proton pump inhibitors
- Decontamination of medical devices
- Aseptic non-touch technique (ANTT)
- Policy development, staff training and competence to support implementation
- Audit and monitoring of policies, facilities and key practices
- Sharps safety & waste management
- MRSA, CPE and other MDRO screening and MRSA decolonisation, COVID swabbing
- Implementation of care bundles; specific focus on invasive devices, wounds
- Isolation facilities, including negative pressure facilities and practices
- Refurbishment of facilities; fabric of the estate
- Emergency preparedness for annual threats, and novel/emerging infections
- Public involvement and information provision for patients, visitors and the public
- Collaborative working across secondary, primary and community care
- Research & development opportunities to improve

Drivers: Guidance, Standards, Reports

- Priorities and Operational Planning Guidance (NHSEI)
- Regional and National COVID Infection Prevention & Control Guidance
- Patient feedback
- Learning from incidents and outbreaks
- CQC Standards, and the Hygiene Code (2015)
- COVID Board Assurance Framework (2021)
- National guidance including on MRSA & CPE prevention, TB, Influenza
- National guidance on infection prevention practices: epic3
- NICE Quality Standard 113 (2016), Quality Standard 49 (2013) and Quality Standard 61 (2014)
- UK Five-Year Antimicrobial Resistance Action Plan (2019-2024)
- National Standards for Cleaning (2021)
- Safer Sharps legislation, H&SaW Act

	Objective	Reporting
1.	***Clostridioides difficile* infection** • The number of new cases of Trust-attributable *Clostridioides difficile* infection will meet the national target of no more than 79 cases.	Via IPCSG and monthly performance reporting
2.	***Staphylococcus aureus* bacteraemia** • There will be no Trust-attributable cases of MRSA bacteraemia. • The number of new cases of Trust-attributable MSSA bacteraemia will meet the national target once this is announced: locally agreed target no more than 10 cases per annum	Via IPCSG and monthly performance reporting
3.	**E coli bacteraemia** • The number of E coli bacteraemia will reduce, to no more than 81 cases per annum	Via IPCSG and monthly performance reporting
4.	**Klebsiella species bacteraemia** • The number of Klebsiella sp bacteraemia will reduce, to no more than 35 cases per annum	Via IPCSG and monthly performance reporting
5.	**Pseudomonas aeruginosa bacteraemia** • The number of Pseudomonas aeruginosa bacteraemia will reduce, to no more than 23 cases per annum	Via IPCSG and monthly performance reporting
6.	**COVID-19 Pandemic** • Patients, staff and visitors will be protected from nosocomial COVID-19 infection • The number of HCAI COVID infections will be minimised; aiming to benchmark at or better than the Midlands rate.	Via IPCSG and via Pandemic Command Structures while these remain in place
7.	**Carbapenemase-Producing Enterobacteriaceae (CPE) and other multi-drug resistant organisms** • There will be no detected Trust transmission of CPE or other MDRO during the year • Screening programmes will be in place in key departments with at least 95% compliance with the screening programme	Via IPCSG
8.	**Antimicrobial prescribing** • More than 90% of antibiotic prescriptions are in line with prescribing guidance or specialist advice • More than 90% of antibiotic prescriptions are reviewed within 72 hours of initiation • Reduce consumption of 'Watch' and 'Reserve' category antibiotics by 4.5% compared to 2018 baseline • Minimum 90% participation and 90% compliance *with Start Smart Then Focus* monthly audits	Via ASG and Medicines Safety Committee; also reporting to IPCSG
9.	**Surgical Site Infections** • The Trust will achieve a 95% return rate for mandatory surveillance, and will benchmark within the best quartile for mandatory surgical site infections • Surveillance programmes will be implemented where possible, beyond the national mandatory surveillance programme; with evidence of benchmarking and improvement	Via Surgical Division governance meetings, and to IPCSG
10.	**Norovirus & Influenza Preparedness** • The Trust will be appropriately prepared for infection emergencies, including large outbreaks in hospitals, and new or emerging infections with significant public health implications. • Preparedness for high-consequence infections will be reviewed.	Via IPCSG, with link into Emergency Planning & Resilience Response Meeting

	Objective	Reporting
11.	**Key Standards to Prevent Infection** • All areas will achieve the minimum compliance set out in our WAHT *Key Standards to Prevent Infection*. • This includes hand hygiene performed consistently by staff in accordance with the World Health Organisation '5 moments for hand hygiene' at least 98% of the time	Via IPCSG and Divisional governance meetings
12.	**Cleanliness & Care Environments** • All areas across WAHT will consistently meet or be above the national minimum standards for cleanliness, as set out in the *Key Standards to Prevent Infection*. • Environments will support effective infection prevention, by complying and being maintained in compliance with relevant Health Building Notes, and Health Technical Memoranda. • Water safety and the safety of critical ventilation systems will be maintained. • Improvements will be made in ventilation in clinical areas to reduce risk of spread of airborne infections.	Via IPCSG, PEOG and Divisional governance meetings
13.	**Decontamination of Medical Devices** • Medical devices will not pose a risk of infection to patients; they will be single-use or decontaminated effectively in compliance with HTM 01-01 and 01-06.	Via IPCSG and Divisional governance meetings
14.	**Staff Training and Competence** • All staff will possess the knowledge, skills and competence needed to practice safely and minimize risk of infection, and this will be reflected in key standards audits; in particular, all relevant staff will be trained and competent in ANTT, and statutory and mandatory training: 95% minimum. • All staff will complete donning/doffing training, and relevant staff will be FFP3 mask fit-tested.	Via IPCSG and Divisional Governance Groups
15.	**Patient & Public Involvement** • Patients, visitors and the public will be informed about and involved in infection prevention. Information on the internet will be developed and improved.	Annual review by IPCSG
16.	**Research & Development** • New and novel programmes of work will be identified and progressed in support of the ambition of the Trust, to achieve very low rates of infection, and excellent standards of infection prevention practice.	Annual review by IPCSG

Governance & Management

This corporate plan underpins, integrates and influences improvement plans in the Divisions and the corporate Infection Prevention Team. Lead responsibility and accountability for local plans rests with Divisional Management Teams. A detailed delivery plan has been developed to achieve the aims and objectives set out in this summary plan.

Progress with this programme will be monitored via the Infection Prevention & Control Steering Group, chaired by the Chief Nursing Officer/DIPC and supported by the Deputy DIPC. Updates will be provided to the Clinical Governance Group, the Trust Management Executive Meeting, the Quality Governance Committee, and to the Board as part of regular reporting in place.

Progress with local plans and escalated issues will be monitored and managed via Divisional Governance Meetings, and updates will also be provided to the Infection Prevention & Control Steering Group.

Approval: Infection Prevention & Control Steering Group **Date: 20th May 2022**

NHS
Worcestershire
Acute Hospitals
NHS Trust

Assurance levels Nov 2020

Meeting	Trust Board
Date of meeting	14 July 2022
Paper number	Enc H

Safeguarding Adults, Children & Young People Annual Report April 2021 – March 2022

For approval:	x	For discussion:		For assurance:	x	To note:	

Accountable Director	Paula Gardner Chief Nursing Officer Executive Lead Safeguarding & PREVENT		
Presented by	Paula Gardner Chief Nursing Officer	**Author /s**	Deborah Narbrugh Head of Safeguarding

Alignment to the Trust's strategic objectives (x)							
Best services for local people	x	Best experience of care and outcomes for our patients	x	Best use of resources	x	Best people	x

Report previously reviewed by		
Committee/Group	Date	Outcome
Integrated Safeguarding Committee	31st May 2022	Approved – Level 6 Assurance
Clinical Governance Group	7th June 2022	Approved
Trust Management Executive	22nd June 2022 (cancelled due to operational pressures)	Progressed under Executive review
Quality Governance Committee	30th June 2022	Approved

Recommendations	The Safeguarding Annual Report highlights the work undertaken over 2021/22 to provide assurance to the Trust Board and its associated Governance Committees that Worcestershire Acute Hospitals NHS Trust (WAHT) is fulfilling its legal and statutory obligations in relation to the safeguarding of vulnerable adults, children & young people whom access services from the Trust. The Trust Board are asked to receive for assurance, the Safeguarding Annual Report 2021/22 and forward plan for 2022/23.

Executive summary	As of 8th March 2021, following the third lockdown, restrictions started to lift across England, and the Government set out its 'roadmap' back to a more normal life, and relaxation of the strict national lockdown rules. In line with other health and social care partnerships and NHS colleagues across the country, the Trust has experienced extreme pressures as a result of an increased demand for services. Safeguarding activity during 2021/22 has focussed on ensuring robust systems and processes are in place to protect and safeguard those most at risk of/vulnerable to, abuse or neglect. In order to achieve this: ➢ The Trust has worked with Worcestershire Local Authority Adult and Children's Safeguarding Services in order to share key information

- The Trust has met its statutory obligations as a partner agency of the Worcestershire Safeguarding Children Partnership and Worcestershire Safeguarding Adult Board and associated sub groups – specific focus on backlog of cases delayed as a result of the pandemic response
- The Trust has met its obligations in accordance with the PREVENT Duty
- Achievement of the 90%Training compliance requirement remained a challenge due to COVID19 restrictions with 'face to face' mandatory training suspended and the need to move staff to support front line services and support periods of escalation
- Review of Local and National Safeguarding reviews to drive forward improvement within our own services e.g. Telford & Wrekin CQC Inspection, Ockenden, Solihull (Joint Targeted Area Inspection).

This paper PROPOSES a level 6 Assurance overall to the Clinical Governance Group (CGG) who will need to approve before onward consideration by TME/ QGC and onto the Trust Board. To inform that approval, consideration of the following levels of assurance in relation to safeguarding activity have been documented:

Subject	Level of Assurance 2021/22
Regulation – mandatory training compliance	4
PREVENT & WRAP statutory requirements	7
Female Genital Mutilation	7
Homelessness Reduction Act 2017	7
Afghanistan Refugees / Resettlement Schemes	7
Modern Slavery	7
Liberty Protection Safeguards	N/A
Mental Health Act	6
Safeguarding Supervision	7
Safeguarding Alerts	6
Domestic Violence –multi agency	7
Safeguarding Children & Young People – Get Safe	6
Partnership Working - adults & children -statutory	7
National Safeguarding Agenda	7
Quality Assurance	6
Managing Allegations	7
Policy revision	5

Risk			
Which key red risks does this report address?		**What BAF risk does this report address?**	
Assurance Level (x)	0 | 1 | 2 | 3 | 4 | 5 | 6 x | 7 | N/A		
Financial Risk	*N/A*		

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NHS Trust

Assurance levels Nov 2020

Meeting	Trust Board
Date of meeting	14 July 2022
Paper number	Enc H

Action						
Is there an action plan in place to deliver the desired improvement outcomes?	Y	x	N		N/A	
Are the actions identified starting to or are delivering the desired outcomes?	Y	x	N			
If no has the action plan been revised/ enhanced	Y		N			
Timescales to achieve next level of assurance						

1.0 Introduction/Background

On 29th September 2020, the Trust was lifted out of quality special measures by the Care Quality Commission (CQC), after a period of almost five years.
In regards to safeguarding activity, the CQC priorities remain in relation to safeguarding, MCA & DoLS training compliance (all levels).

2.0 Issues and options

2.1 Leadership Arrangements

The Chief Nursing Officer (CNO) is the Executive Lead for safeguarding adults, children, and young people and PREVENT. The Deputy Chief Nurse (Safety) leads safeguarding on behalf of the CNO.

2.2 Assurance

The Trust Integrated Safeguarding Committee is chaired by the CNO or Deputy and meets bi monthly. The Integrated Safeguarding Committee reports to the Clinical Governance Group (CGG) and Quality Governance Committee (QGC) gaining assurance on behalf of the Trust Board that its legal and statutory duties in respect of safeguarding adults, children & young people are met.
The Integrated Safeguarding Committee work in accordance with an agreed work plan. Attendance at the Committee by a representative of Herefordshire & Worcestershire CCG provides a level of oversight and scrutiny as part of the safeguarding assurance process.

2.3 Safeguarding Risk Register

The Integrated Safeguarding Committee review all risks on a bi-monthly basis and mitigation is in place. Risks held by the Integrated Safeguarding Team are reviewed via the Trust Risk Management Group (RMG).

2.3.1 Current high risks:

ID3511 Liberty Protection Safeguards implementation
ID2873 Safeguarding training compliance - also monitored via People & Culture Committee
ID4119 Policy Revision
ID3430 Safeguarding Alerts – transfer of narrative from Oasis to Patient First System
ID4701 Out of hours request for health attendance at strategy discussions
ID4277 Risk of abduction / absconding –also monitored via Women & Children
ID4621 Adoption records –also monitored via Data Quality /Health Records Group

2.3.2 Moderate risks:

ID1748 CAMHS service out of hours –monitoring Committee Women & Children

2.3.3 Risks closed during 2021/22
ID2910 CP-IS rollout

2.4 Trust Corporate Safeguarding Team Structure 2021/22
The Integrated Safeguarding team is fully recruited to. Members of the team have been deployed as part of the Corporate response to support the provision of safe care during periods of escalation as a result of the need to open additional capacity to support patient flow.

2.5 Safeguarding Champions
There have been no meetings held during 2021/22 as a result of the ongoing pandemic response and the need for staff to focus on the delivery of core services.

3.0 Care Quality Commission(CQC) Regulatory Activity Mandatory Training

Safeguarding training remains a high priority for the Trust. The regulator has, in previous inspection reports identified areas for improvement around mandatory training compliance and level of assurance:

- *The Trust must ensure staff receive mandatory training in accordance with trust Policies. Regulation 18(2)*
- *Ensure that all staff receive and complete their required mandatory training & MCA/DoLS training compliance for medical staff is in line with Trust targets*
- *The service must ensure doctors working in the ED complete their Mental Capacity Act training at a level appropriate to their role*
- *The Trust must ensure that all medical staff complete the required mandatory training including safeguarding children & adults to a level appropriate for their role*

3.1 Outturn Position as at 31st March 2022:

3.1.1 Safeguarding Adults

	Q4 2020/21	Q4 2021/22	Compliance required 90%
SGA L1	91.89%	94%	Compliant
SGA L2	90.5%	89%	Partial compliance
SGA L3	83.89% (151/180 completed)	72% (130/180 completed)	Partial compliance

Trend since 2018/19 CQC Inspection
Inadequate → Requires Improvement → Lifted out of special quality measures→ COVID→ Sustainability

Given the challenges faced by the Organisation during 2021/22 in regards to activity and workforce, Level 1 training compliance for adults has been sustained above the 90% requirement. There has been a slight decrease to 89% for Level 2. Level 3 training compliance has reduced to 72% as a result of this level of training being linked to root cause analysis training availability (face to face). Root cause analysis training ceased as of June 2021 in order to focus on the delivery of core services.
Action taken: The Integrated Safeguarding team have developed a Level 3 package (including refresher) due to commence roll out May 2022.

3.1.2 Safeguarding Children

	Q4 2020/21	Q4 2021/22	Compliance required 90%
SGC L1	93.74%	94%	Compliant
SGC L2	90.01%	90%	Compliant
SGC L3	77.39%	82%	Partial compliance

Trend since 2018/19 CQC Inspection
Inadequate → Requires Improvement → Lifted out of special quality measures→ COVID→ Sustainability

Overall during 2021/22, Level 3 training compliance for children has increased Trustwide by 5% on the previous year. The Trust has sustained compliance above 90% for Levels 1 & 2.

Telford & Wrekin CQC Inspection – Inadequate (Published 13th April 2021).
Revision of competency matrix for staff on adult wards caring for children
Further to the Telford & Wrekin CQC inspection undertaken in February 2021(published April 2021) the regulator had referenced the level of training received by staff caring for children on adult wards (irrespective of frequency). It was deemed that staff should receive Level 3 training in line with the Intercollegiate Document. In order to provide a proportionate response, Executive approval was given by the CNO to review the competency matrix for Ward Managers, B6 Deputies and medical staff in adult areas identified in the Trust as having seen children. For the period 1st April 2020 – 31st March 2021, 332 children were seen across 34 non paediatric areas of the Trust. The impact of this competency matrix revision was a temporary decrease in L3 children training compliance for some Divisions who see children more frequently than others e.g. Speciality Medicine and SCSD.

3.1.3 MCA & DoLS

	Q4 2020/21	Q4 2021/22	Compliance required 90%
MCA & DoLS L1	87.97%	90%	Compliant
MCA & DoLS L2/3	81.87%	87%	Partial compliance

Trend since 2018/19 CQC Inspection

Inadequate → Requires Improvement → Lifted out of special quality measures→ COVID→ Sustainability

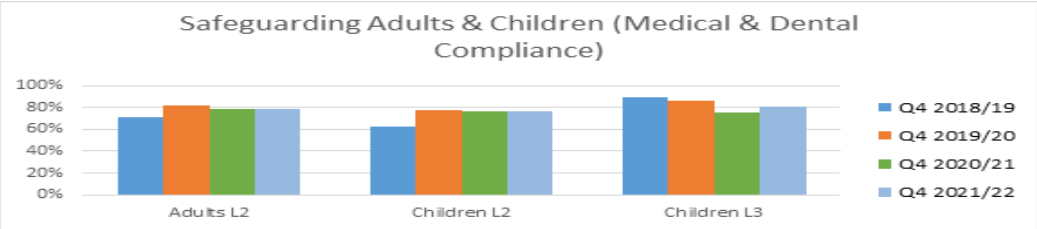
Trust compliance with MCA & DoLS training has improved significantly over 2021/22. Level 1 is now compliant with the 90% requirement and Level 2/3 (higher level) has increased by 5% on the previous year outturn position.
This has been achieved via face to face and virtual/online training availability.

3.1.4 Medical & Dental Staff Training Compliance:

Staff Group	Competency	Sum of % completed 31st Mar 2021	Sum of % completed 31st Mar 2022
Medical & Dental	SGA L2	79.02%	78.93%
	SGC L2	76.16%	76.41%
	SGC L3	75.00%	80.71%

Trend since 2018/19 CQC Inspection

Inadequate → Requires Improvement → Lifted out of special quality measures→ COVID→ Sustainability



Actions taken to improve training compliance:

- Trustwide communications in relation to training availability (all levels) via ESR and refresher options
- Programme of 'face to face' and virtual MCA & DoLS sessions
- External training opportunities circulated Trustwide via ongoing communication strategy
- Bespoke offer of training to wards/depts upon request

Level of Assurance: Level 4
What needs to happen: Mandatory training compliance of 90% across all levels of safeguarding training, MCA & DoLS

4.0 PREVENT/WRAP

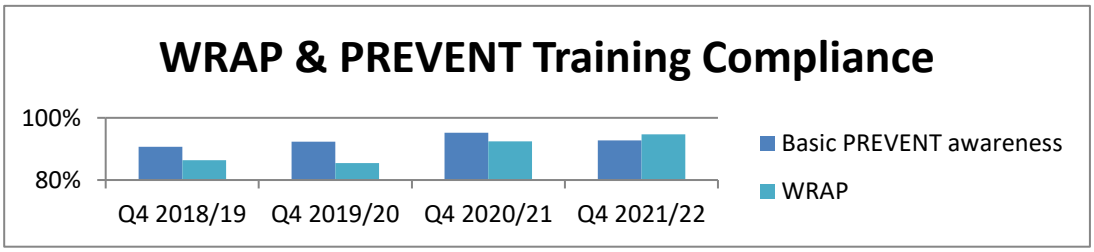
4.1 Training compliance

Section 26 of the Counter-Terrorism and Security Act 2015 (the Act) places a duty on certain bodies ("specified authorities" listed in Schedule 6 to the Act), in the exercise of their functions, to have "due regard to the need to prevent people from being drawn into terrorism". The Act states that the authorities subject to the provisions must have regard to this guidance when carrying out the duty. NHS Trusts are a health specified authority within the Act. NHS England has incorporated *Prevent* into its safeguarding arrangements, so that *Prevent* awareness and other relevant training is delivered to all staff who provide services to NHS patients. This is supported by a Prevent Training and Competencies Framework (NHSE October 2017). Trusts were required to achieve an 85% compliance rate for PREVENT basic awareness and WRAP as of March 2018.

Basic Prevent Awareness Training (BPAT)	Compliance 85%
Q4 2021/22	
92.7% (1592/1717 staff completed)	Compliant

Workshop to Raise Awareness of Prevent (WRAP)	Compliance 85%
Q4 2021/22	
94.7% (4765/5032 staff completed)	Compliant

Trend since 2018/19 CQC Inspection
Inadequate → Requires Improvement → Lifted out of special quality measures→ COVID→ Sustainability



Actions taken:

- E learning modules available via ESR for basic prevent awareness and WRAP training
- Annual prevent newsletter published January 2022
- Circulation of NHSE PREVENT newsletters/rapid reads

The Trust has sustained the national requirement of 85% for PREVENT training across all levels.

4.2 PREVENT referrals

The Chief Nurse is the Executive lead for PREVENT. The Operational Lead is the Head of Safeguarding. Compliance with the PREVENT duty is reported quarterly to NHS digital, CCG and NHSE PREVENT leads. 1 case has been referred by the Trust during 2021/22. There has also been a further general enquiry, however the individual was already known to Channel.
Current ideologies of concern remain extreme right wing and Islamist extremism. Prevent concern reporting has increased as lockdown restrictions have eased across the country. Reported concerns remain predominantly male in origin; under the age of 18yrs, and linked to online activity.

4.3 PREVENT Partnership working

4.3.1 Current National Threat Level - Joint Terrorism Analysis Centre
The current threat level was reduced to ***substantial*** in February 2022, meaning that a terrorist attack is still likely and the response level remains heightened. The threat level had been increased to severe in November 2021 as a result of the terror attack on the Liverpool Women's Hospital and murder of MP Sir David Amess.

4.3.2 Liverpool Women's Hospital Terror attack /PROTECT Duty
On 14 November 2021, an explosion occurred inside a taxi as it arrived in front of the main entrance of the Liverpool Women's Hospital. The explosion was caused by an improvised explosive device which was carried by the taxi's passenger, who was killed in the incident.
Actions taken:

- Trustwide communications in relation to preventing terrorism – identification of people acting suspiciously, maintaining a safe environment, reporting of concerns
- EPRR communications / testing of lockdown procedures
- Promoting staff to consider the risk of a terror attack on 'publically accessible places' rather than specifically large gatherings of people – this is linked to the risk of self-initiated terrorism (previously known as the 'lone wolf' style of attack).
- The Protect Duty consultation ran from 26th Feb 2021 to 2nd July 2021 with a focus on
  Section 1: Who (or where) should legislation apply to?
  Section 2: What should the requirements be?
  Section 3: How should compliance work?
  Section 4: How should Government best support and work with partners?

4.3.3 CHANNEL Panel
Channel Panel is a key part of work to prevent extremism through supporting those who may be vulnerable to radicalization by assessing the nature and extent of the potential risk and, where necessary, providing an appropriate support package tailored to an individual's specific needs. This information is requested under the terms of s38 of the Counter-Terrorism and Security Act 2015.

Action taken:

- The Trust shared information re 1 case previously known to Channel.

4.3.4 PREVENT Strategy Group

Counter Terrorism Local Profile (CTLP)

The Head of Safeguarding represents the PREVENT Executive Lead on behalf of the Trust. Actions coming from the Counter Terrorism Local Profile (CTLP) inform the Worcestershire Strategic PREVENT Strategy and associated workstreams. Outcomes are shared via the Integrated Safeguarding Committee. The Trust received the CTLP briefing in March 2022.

The Counter Terrorism Unit are currently looking at the publication of a document that can be shared more widely with practitioners due to the classified nature of the current CTLP.

Actions taken:

NHSE/I produced a 7minute briefing for practitioners about CTLP's detailing where health fits in, and why CTLP are important. This was shared Trustwide.

4.3.5 Revised Prevent Duty Guidance 2021 – Assurance Exercise

The Prevent Duty was revised on the 1 April 2021. A request was made by the Worcestershire Prevent Steering Group for agencies to review their current position since the original statutory guidance issued in 2011.

The Trust was able to offer significant assurance (Level 6) that it was meeting the revised prevent duty guidance.

Further action to reach Level 7 assurance was dependent upon national drivers:

- Revision of national prevent training package
- Protect Duty Guidance and implications for organisations

4.3.6 Herefordshire and Worcestershire STP PREVENT Health Leads

The purpose of the group being to ensure a consistent approach to PREVENT within 'health' across Herefordshire and Worcestershire in order to feed into the local and regional groups/workstreams. The Head of Safeguarding is the Trust representative.

4.3.7 ACT Early – Letters to my Younger Self

As part of their ACT Early campaign, the Counter-Terrorism Policing team have developed three new 'Letters to my Younger Self' films aimed at young people, all of which are now available to view on the ACT Early website.

Actions taken:

- Shared Trustwide during January 2022
- Uploaded to the Safeguarding Pathway for both adults and children

Level of Assurance: Level 7

The Trust is fully compliant with its statutory obligations and training compliance for PREVENT in accordance with the PREVENT Duty requirements.

5.0 Female Genital Mutilation (FGM)

The Named Midwife, Named Doctor and Consultant Obstetrician are leads for FGM within the Trust providing oversight and statutory reporting of identified cases of FGM.
The Named Midwife has responsibility for upload of the FGM indicator to the NHS Spine to alert staff that there is a family history of FGM.

5.1 FGM National Dataset reporting

There have been 5 reported cases of FGM during 2021/22. Country of origin: Malaysia, Iraq (3 cases) and Sierra Leone (self-reported).
The number of cases of FGM identified/ reported remains consistent with previous activity.

5.2 FGM awareness Day – 6th February 2022

Trustwide communications were circulated via the weekly brief.

Level of Assurance: Level 7

The Trust has robust systems and processes in place to recognise and report cases of FGM in accordance with the FGM Mandatory Reporting Duty (2015).

6.0 Homelessness 'Duty to Refer'

6.1 Homelessness Pathway Project

The Worcestershire Homeless Pathway Project (WHPP) delivers a service to hospital in-patients throughout Worcestershire either being threatened with homelessness or already homeless on admission. The project also addresses prevention of homelessness through early intervention and liaison with landlords and Local Authorities. Through referrals to local hostels and shelters as well as general needs housing, sheltered schemes and Extra Care schemes the project can alleviate time spent in hospital waiting for a suitable discharge option. WHPP educates NHS staff about homelessness, housing policy and procedure and local services available. WHPP is the single point of contact to refer homeless cases on to local authorities under 'Duty to Refer', Homelessness Reduction Act 2017.

- Of the 115 cases managed by the Homeless Pathway Liaison Officer during 2021/22, 90 cases were within the Acute Trust:
  26 cases at the Alexandra Hospital and 64 Worcester Royal Hospital
- Of the 115 cases, 28 patients had safeguarding concerns (24%)
- Discharge outcomes – interim or emergency accommodation highest

Age Categories

18-25	26-35	36-45	46-55	56-65	65+
7	11	19	23	21	34

Referral sources

Onward Care Teams/Social Workers	45
Hospital Ward Staff	30
Hospital OT and Physio	9
Mental Health Liaison	2
Substance Misuse Liaison Nurses	9
Bed Manager/Matron	4
Outside Agency	16

Action taken:

- Regular contact detail updates are provided to clinical areas to support frontline practitioners

Service Delivery Risk:

- Funding for the Liaison Pathway Officer is due for review April 2023. The service is currently hosted by Herefordshire and Worcestershire Health and Care NHS Trust in line with the rest of the Onward Care Team

Level of Assurance: Level 7
The Trust has in place systems and processes to meet the requirements of the Homelessness Reduction Act 2017.

7.0 Bridging Hotels - Afghanistan Refugees / Resettlement Schemes

The chaotic evacuation of Afghanistan after the Taliban takeover since May 2021, led to thousands of Afghans fleeing to Britain. Some of these refugees are currently placed within 'bridging hotels' within our locality.

Action taken:

- Dedicated GP practice identified to generate NHS numbers etc
- Pregnant women - visits are undertaken at the hotels
- Staff reminded of need for interpreting services as this group of individuals are already potentially vulnerable to safeguarding concerns
- Arrangements put in place for pregnant women to have copy of electronic and hand held set of notes due to relocation by the Home Office often happening very quickly
- Weekly Afghanistan Resettlement Assistance Programme(ARAP) meeting attendance by Named Midwife to review situation /update and internal review
- Key links with CCG and partners to share information/concerns

Level of Assurance: Level 7
The Trust is working with partners to ensure 'health' needs for refugees are addressed as indicated.
The Head of Safeguarding and Named Midwife/Nurses meet bi weekly to review any concerns to ensure appropriate action has been taken.

8.0 Modern Slavery / Human Trafficking

8.1 Modern Slavery Statement

The annual review of the modern slavery statement was undertaken during January and published on the public facing pages of the Trust website in accordance with the requirements of the Modern Slavery Act 2017.

8.2 Home Office – Modern Slavery Statement Registry

The Trust was required to register as an organisation prior to 14th March 2022. The revised annual statement will be uploaded to the Home Office in due course (deadline 30th Sept 2022).

8.3 Operation Aidant

On 23rd April, Officers from across North Worcestershire together with partner agencies took part in a multi-agency operation targeting modern day slavery. Operation Aidant is run nationally throughout year and involves local police forces working alongside partner agencies to focus on vulnerability, exploitation, modern slavery and human trafficking. The campaign works to highlight the signs of modern slavery which people may encounter in their everyday lives, and encourage them to report their concerns. The operation forms part of the disruption activity undertaken in relation to organised crime group activity.

Action taken:

- The Trust contributes to this work via the Operational and Strategic GetSafe groups and associated workstreams.
- Key messages in relation to the recognition of the signs of modern slavery / human trafficking are included in mandatory training packages
- The Safeguarding Pathway contains a number of resources to support Trust staff
- Promotion of the training programme offered by the West Midlands Violence Reduction Unit in relation to high sophistication offending of sexual exploitation (Sept 6-17th)

8.4 Supplementary awareness raising activity

- West Midlands Anti-Slavery Network Newsletter circulated
- NHS COVID19 Modern Slavery & Human Trafficking Rapid Read circulated
- Emerging theme –climate change and migration and links to modern slavery
- Nationality & Borders Bill – making it a criminal offence for asylum seekers to enter Britain without permission. People smugglers will also face much heavier jail terms

Level of Assurance: Level 7

The Trust has in place systems and processes to meet the requirements of the Modern Slavery Act 2017.

9.0 Liberty Protection Safeguards(LPS) / Mental Capacity (Amendment) Act 2019

Work has continued over 2021/22 as new information has become available.
The open consultation on changes to the MCA Code of Practice and implementation of the LPS opened on 17th March 2022 and closes on 7th July 2022(12 weeks). It has been confirmed that the CQC and OFSTED will be the 2 bodies in England to monitor and report on LPS.

Action taken:

- The Chief Executive has written to Worcestershire County Council advising that an SLA to cover the Approved Mental Capacity Practitioner(AMCP) role is the preferred option for the Trust
- NHSE/I have advised of regional LPS leads to support system transformation
- There will be a transition period from DoLS to LPS
- Training will be free with accredited modules delivered by Health Education England
- Worcestershire LPS Forum attendance by Head of Safeguarding to review current position and actions required
- Gap analysis updated and circulated as new information emerges

Current potential risks identified:

- Training capacity
- Pre authorisation reviews – volume (for those not objecting)

- Timeliness of process – potential delays in discharge as process has to be completed once started
- No current go live date

Level of Assurance: N/A

10.0 Mental Health Act

The Mental Health Act 1983 (amended in 2007) is the law which sets out when a person can be admitted, detained and treated in hospital for a mental disorder. The Act is supported by a 2015 Code of Practice.
All applications for admission are made out to the 'Hospital Managers', meaning the organisation in charge of the hospital. In practice, most decisions are delegated to clinicians. Providers require specific registration with the Care Quality Commission to deliver care.

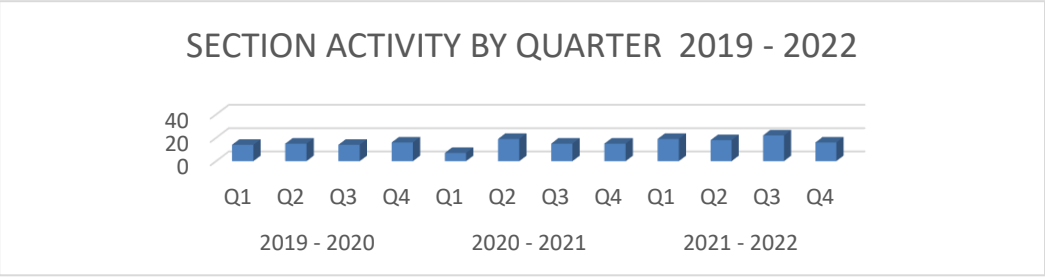
10.1 Types of Detention

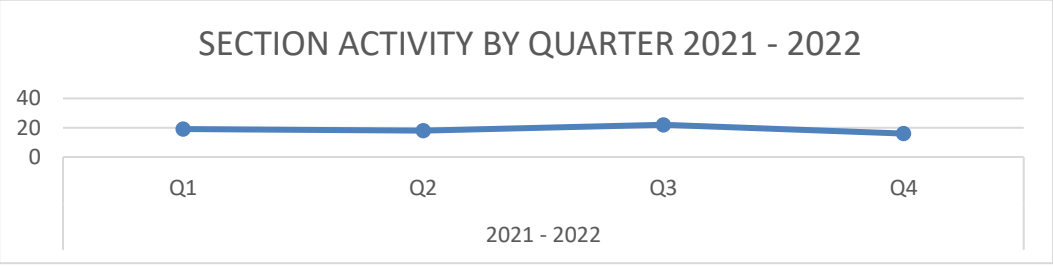
Section 2	detention in hospital for up to 28 days for assessment and/or treatment
Section 3	renewable treatment section which lasts for up to 6 months initially. Once renewed twice, the section duration becomes one year
Section 4	Admission for assessment in cases of emergency where only one doctor is available; lasts up to 72 hours. Can be converted to a section 2
Section 5(2)	Doctors' holding power, allows detention for up to 72 hours for the purposes of assessment. Patients must already have been admitted to hospital

10.2 Uses of Section

The Trust were Hospital Managers to 75 MHA detentions throughout 2021/22 comprising of 55 individuals. This was a significant increase on previous years activity (n59/56).

There were 2 sections open as at 31st March 2022.





As can be seen above, the number of sections taking place in each quarter in 2021/ 22 has been much more consistent than has been seen before. They are also regularly higher than that seen previously.

The following wards handle the majority of sections accepted by the Trust;

- Alexandra – AMU, MSSU, Ward 2 (18 in year)
- Worcester Royal – MAU, Riverbank (16 in year)
  These represent 45% off all sections held in the year.

- Section 5 (2) holding powers were used 13 times within the year. Of those 13, 3 were subsequently declared invalid when scrutinised by MHA Administration.
- 30 individuals were sectioned whilst receiving inpatient treatment at WAHT. Of those, 6 were on Riverbank.
- 38 cases were transfers into the Trust with the highest number from older adult wards

10.3 Time Spent on Section

In total, sectioned patients spent 557 days on section within WAHT in 2021 /22, up from 383 in 2020/21.There were four individuals whose duration of stay on section accounted for 215 bed days.

10.4 Gender and Ethnic Breakdown of Detained Patients

Of the 55 individuals detained:

- 33 were female
- 22 were male.
- 'White British' accounted for 87% of individuals

10.5 Age

- 12 were over 65yrs
- 3 were under 18yrs

10.6 Rights & Hearings

Patients who are detained under the Act are encouraged to appeal to the First Tier Tribunal and to the Hospital Managers. Patients are entitled to legal aid for the former, but not the latter. The Associate Hospital Managers (AHMs) are delegated the right of discharge by the Hospital Managers. In addition to appeals, the AHMs hold a review when a patient's section is renewed or when a Nearest Relative is barred from exercising their power of discharge.

Whenever a patient is detained within WAHT, they will receive information relating to the section and their rights of appeal in accordance with the MHA 1983 and the Code of Practice 2015.

10.6.1 First Tier Tribunal (Mental Health) (FTT)

Patients have the ability to apply to the FTT once in every period of detention and are legally aided to obtain representation in doing so. At certain junctures, the Hospital Managers are obliged to make an application to the FTT if the patient themselves has not done so.

There was 1 FTT hearing held in 2021/22. The patient was not discharged from section.

10.6.2 Associate Hospital Managers (AHM)
The AHMs are specially trained lay people who sit on hearings panels and work to ensure that patients have hearings on appeal and at the renewal of a section.

There were no AHM hearings within WAHT within 2021/22.

10.7 Sections Declared Invalid
4 Sections (3 holding powers, 1 patient transferred in from another provider) were declared invalid in 2021 /22. In these cases, the wards have been advised and the person notified that administrative scrutiny had identified an error.
Action planned:
Further communications on the requirements of S5(2) holding power documentation for medical staff

10.8 Care Quality Commission Notifications
There was 1 death notification to the CQC required within the year.

Action taken:
Training takes place in a variety of different ways and discussions are ongoing between WAHT, the HWHCT mental health liaison team and MHA Administration about the best way to embed MHA training into WAHT in a way that is accessible and easy for professionals who do not often have to use its provisions.

Reports are regularly shared between HWHCT and WAHT which allow for triangulation of data. Specific issues are either raised within regular meetings between the Trusts, or at the wider Mental Health Partnership Group – an interagency group operating in Worcestershire.

10.9 Section 136 Place of Safety
Section 136 of the Mental Health Act is an emergency power which allows an individual to be taken to a place of safety from a public place, if a Police Officer considers that they are suffering from mental illness and in need of immediate care. Section 136 is used on average, 70 times per quarter.

10.10 Approved Mental Health Practitioners(AMHP) Service Changes
As of 1st April 2021, the Approved Mental Health Practitioners (AMHP) transferred back to the Local Authority.

10.11 Telford & Wrekin CQC Targeted Inspection Report, Children & Young People – Mental Health & Learning Disability (published 13.04.2021) Gap Analysis
The CQC undertook an unannounced inspection into acute mental health and learning disability services provided to children & young people by the Trust during an unannounced inspection during February 2021. The inspection resulted in an overall rating for the Trust of 'inadequate' and enforcement action.
Action taken:
- A full gap analysis was undertaken and an action plan formulated.
- Regular monitoring meetings are being held to review progress with Women & Children Division

- Advice sought from the CQC in relation to what good de-escalation training looks like to support paediatric patients who may have behaviours that challenge – this will be incorporated into personal safety training going forward

10.12 Service Development – Mental Health Liaison Service Expansion Bid
The Commissioners have approved the expansion of the liaison service to provide a 24hr service. Implementation date /how this will work in practice to cover both sites awaited.

Level of Assurance: Level 6
Further system wide work required regarding delays to Tier 4 placement and placement of children in the care of the Local Authority who do not need to be in an Acute Hospital setting.

11.0 Safeguarding Supervision

Safeguarding supervision continues to be delivered across the Trust. The primary focus of supervision has been to support frontline practitioners during the ongoing pandemic. 68 staff members have received safeguarding supervision in relation to safeguarding children during 2021/22. A well-established process of supervision has been in place in midwifery & maternity for several years.

Action taken:

- The CCG funded further places for accredited safeguarding supervision training attended by the Named Doctor and Named Nurse Adult Safeguarding May 2021
- The Safeguarding Supervision Policy was reviewed and updated June 2021
- Safeguarding Supervision Newsletters published to circulate key messages to staff in areas that have not been able to take up the offer of supervision due to clinical activity with a focus on Early Help, Multi Agency Levels of Need, Appropriate language, Dog bites
- Rolling 'drop in' virtual programme of adult safeguarding supervision commenced January 2022
- Named Doctor using peer review meetings to deliver safeguarding supervision e.g. a complex case involving surrogacy

Level of Assurance –Level 7
The Trust has systems & processes in place to deliver safeguarding supervision in relation to Midwifery & Maternity, Children & Adults.

12.0 Safeguarding Alerts

The Safeguarding team has continued to develop the robustness of safeguarding alerts within the Trust over the last 12 months through:

12.1 Out of Area Looked After Child (LAC) Alert review
During August 2021 a full review was undertaken of the alerts held in Oasis for out of area children with the alert 'Looked After Child'. In total, 91 out of area children LAC alerts were reviewed /updated as required.
Review of safeguarding alerts held in Oasis is key to ensuring practitioners are in receipt of the most up to date information regarding the child's current legal status to inform decision making /patient care. Having this information readily available also ensures that there are not delays in having to make contact with services to ascertain key information .
Action proposed:

This will be undertaken twice yearly as 'business as usual'

12.2 Child Protection Information Sharing System (CP-IS)
Work has continued over the last year to ensure all staff that require access to CP-IS have it, and are using the system effectively for any child who may present for unscheduled care. The NHS Long Term Plan is committed to the roll out of CP-IS across all health settings by 2023.

Outturn position:

- Trustwide compliance for staff groups requiring access to CP-IS in high priority areas
  91% as at 31.03.2022
- 464/508 identified staff Trustwide now have access to CP-IS
- Will now become 'business as usual' for any new starters requiring access in high priority areas
- Risk register ID2910 closed March 2022.

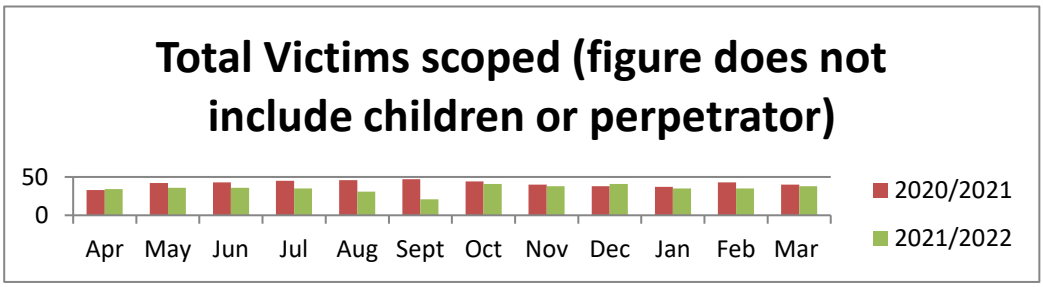
12.3 Strategy Meetings – sharing health information: forthcoming OPD attendance
A newly agreed process with H&WHCT commenced Sept 2021 whereby the Trust is notified of any child for whom a strategy discussion has taken place. The Integrated Safeguarding team then check whether the child has any forthcoming outpatient appointments with the Trust and ensure the respective clinician is made aware. Prior to this, practitioners would not have been aware that concerns around the child had met the threshold for a strategy discussion as some parents/carers do not disclose such information in order to avoid detection. A significant number of these cases result in child protection enquiries (s47) being undertaken.
Since commencement the Trust has been notified of 895 strategy discussions involving in excess of 1600 children. Of the notifications received,123 children had forthcoming OPD with the Trust.

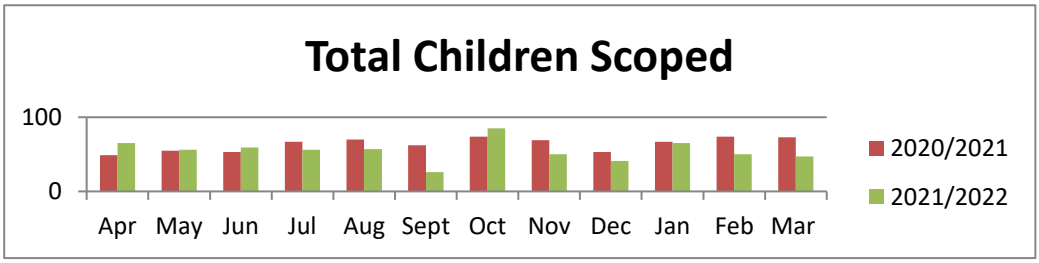
12.4 Out of Hours Strategy Discussions
The Named Doctor continues to work with his peers to ensure any strategy discussions held out of hours are notified to the Integrated Safeguarding team.
Where notification takes place, the relevant alert is added to clinical systems, a check for any forthcoming OPD is undertaken and other 'health' partners are notified e.g. GP, School Nurse etc. During Q4, 9 out of hours' strategy discussions (involving 17children) were notified.

Level of Assurance: Level 6
CP-IS roll out complete. Risk closed.
Strategy discussions out of hours – robust reporting system to Named Doctor needs to be in place

13.0 Domestic Abuse /Domestic Violence

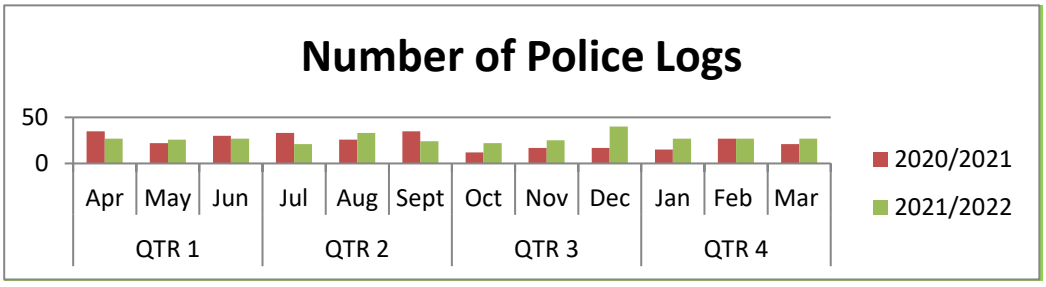
13.1 Multi-Agency Risk Assessment Conference (MARAC)
The Trust has undertaken 1078 individual scoping's for *high risk* domestic abuse during 2021/22. This intense scoping practice /adding of alerts to clinical systems, ensures that staff are alerted to high risk victims and children of domestic abuse should they fail to attend departments or appointments. Reports are provided to MARAC twice monthly. Activity overall remains relatively consistent.





13.2 Police Logs flagged:
Police Logs are received by WAHT Integrated Safeguarding Team. All victims and their children are "flagged" on Trust Information System Oasis. Police Logs are received when the victim or perpetrator is pregnant or have recently delivered. 326 Police Logs have been reviewed and flags added to clinical systems during 2021/22 for *medium risk* domestic abuse. This is an increase on 2020/21activity(n290).

During Q4, of the 81 Police Logs received, 70 were in relation to pregnant women.



13.3 Supplementary Activity

13.3.1 MARAC Information Sharing Agreement
Updated and signed on behalf of the Trust during April by the Caldicott Guardian.

13.3.2 Hospital Independent Domestic Violence Advisor (HIDVA) – Men's Helpline Launch
West Mercia Women's Aid launched a designated men's domestic abuse /violence helpline on 7th June 2021. Charities dealing with men who suffer domestic abuse have seen requests for help increase by up to 60% during lockdown. The Respect Men's Advice

Line said some victims had told them they had sought refuge by sleeping in cars or in tents in the gardens of friends or relatives to escape domestic abuse/violence.
Action taken:
The helpline details were promoted Trustwide and uploaded to the Safeguarding Pathway for both adults and children.

13.3.3 Domestic Abuse Bill (2021)
"Domestic abuse is an abhorrent crime perpetrated on victims and their families by those who should love and care for them. This landmark Bill will help transform the response to domestic abuse, helping to prevent offending, protect victims and ensure they have the support they need". (Victoria Atkins MP, Minister for Safeguarding).
The Trust will start to see the impact of the Bill over the coming months in relation to work streams associated with domestic abuse/violence.

13.3.4 Cranstoun – Male/Masculinity Programme
A 24-week programme which focuses on behaviour of perpetrators. Three core modules with a focus on coercion, control, consequences
Action taken:
Promoted to staff as part of 'toolkit' of domestic abuse resources.

13.3.5 White Ribbon Event (Herefordshire) 26th November 2021
The event was promoted widely across the Trust with a focus on the impact of domestic abuse on children and young people and how it can affect older people in later life.
Action taken:
A Trustwide screensaver campaign was run over the week providing key messages in relation to the Hospital Independent Domestic Violence Advisor service / domestic abuse

13.3.6 Badgernet –Routine Enquiry for Domestic Abuse
On 14th December the routine enquiry domestic abuse question became a mandated field within the Badgernet maternity system. This now allows the Trust to provide assurance that the routine enquiry is being asked at every ante natal follow up and upon postnatal discharge.

Level of Assurance: Level 7
The Trust has established systems and processes in place for the identification and reporting of domestic abuse, including support services for onward advice & support (this service covers both staff and patients).

14.0 Safeguarding Children

GetSafe – Child Exploitation
GetSafe is Worcestershire's multi-agency response to the protection of children at risk of exploitation and works in a focused and co-ordinated way to protect those most at risk.

14.1 GetSafe Portal and Weekly Triage Meetings
The Trust has provided information for 1095 children/young people during 2021/22. The workload associated with GetSafe continues to increase.
Within Worcestershire there are currently 682 children on the GetSafe Portal. Rag rating of these cases are:

- Red – 75 cases
- Amber – 162 cases
- Green – 445 cases

14.2 Trust referrals into the GetSafe Professional Portal
Trust staff have identified and referred 39 cases into GetSafe during 2021/22. 10 children per month are having their vulnerabilities identified and Trust staff referring accordingly.

Action taken:
- The Named Nurse Safeguarding Children attends the triage meetings on a weekly basis to present health information
- Submission of scoping in preparation for children presented to the weekly triage meetings
- Download of all GetSafe risk assessments, minutes and actions from the weekly triage meeting, scanned to the child's records

14.3 Multi-Agency Child Exploitation (MACE)
The Trust 'flags' on clinical systems any child for whom it receives a MACE report. This ensures practitioners are kept informed of the risks surrounding the child in the event they should attend any of our services. There has been a continued significant increase in the work associated with MACE over the last year, 242 MACE reports have been flagged during 2021/22. Pre COVID this number was in the region of 60 cases per annum.

14.4 WREN Report ED Attendances
In order to identify children/young people attending the Trust who may be at risk of exploitation a WREN report is run daily based upon key words from the attendance: gun, gang, knife etc. The report is reviewed daily by the Integrated Safeguarding Team to ensure all appropriate actions have been taken in order to protect and safeguard the individual or others.
During 2021/22, 3512 children/young people were reviewed via this process.
Action proposed:
The findings from this intense scoping/review process will inform areas for focus with practitioners in order to ensure no child accessing our services 'slips through the net'.

14.5 Knife Angel 19th March 2022
The Knife Angel is seen as a National Monument Against Violence and Aggression caused in our society by knife crime. The monument is made from over 100,000 seized knives and weapons collected from all 43 Police Constabularies across the UK. The Knife Angel was in Worcester's Cathedral Square throughout March 2022, in order to raise awareness of knife crime and associated violent and aggressive behaviour, and act as a memorial for the lives lost to knife crime.

The Trust supported this event with a stand promoting key messages /demonstrations in regards to what to do in the event you come across someone who has been stabbed /is bleeding heavily.

14.6 GetSafe: 2nd Anniversary Social Media Campaign 21-27th June 2021
Campaign materials were promoted via social media platforms.

14.7 GetSafe Problem Profile -Worcestershire
Further to work undertaken by Police, Worcestershire now has its first GetSafe problem profile. This will inform the focus and workstreams of both the strategic and operational GetSafe sub groups. The Trust is represented on both groups.

14.8 GetSafe - Guidance for Professionals working with GET SAFE risks and/or vulnerability for young people aged 16-25 years
Worcestershire considered the additional risks and vulnerability that emerge when young people become 16 years old, and how in Worcestershire we support both our SEND young people and care leavers, post 18 up to 25years who are identified as vulnerable to, or experiencing criminal exploitation.
Action taken:

- The guidance has been shared with the Transitional Lead Consultant for inclusion in the Trust Transition Policy

14.9 Hereford & Worcestershire CCG Child Exploitation Conference 21st May 2021
The conference was promoted Trustwide with a number of keynote speakers, including a victim of the Rotheram child sexual exploitation scandal, Police whistleblower exposing the poor handling of the Rochdale child sexual abuse ring.

14.10 West Midlands Police – Professional Briefings – Exploitation & Vulnerability
A programme of sessions on offer (Aug-Dec) was promoted Trustwide.

Level of Assurance: Level 6
What needs to happen: Evidence from review of WREN report that indicates all referrals are being actioned appropriately /in a timely manner in order to safeguard children and young people

15.0 Statutory Partnership Working - Children

15.1 Worcestershire Children First (WCF)

15.1.1 Early Help Offer – Increased referrals to Children's Services not meeting Level 4 intervention
During 2021/22 the number of referrals being made to Worcestershire Children First has increased significantly. However, the number of cases meeting the threshold for Level 4 Social Work intervention remains low in comparison. As an Acute Trust our conversion rate is in the region of 17% to Level 4. As a result of this, partners have been tasked with ensuring staff are aware of, and promote early help where applicable and that staff are working in accordance with the Worcestershire Levels of Need Guidance.
Action taken:

- Early Help Offer promoted via supervision, safeguarding pathway and weekly brief
- Internal quality assurance of 6 referrals made by Trust staff per month –where the quality of the referral is deemed to require improvement this is taken up with the respective practitioner as part of supervision. For the period Oct – March the ratings were as follows:
  - Outstanding – 9 referrals
  - Good – 20 referrals
  - Requires Improvement – 7 referrals

- Early Help Assessments are now submitted via the Early Help Portal
- Early Help Support Leaflet for families uploaded to the public facing pages of the Trust website

15.1.2 OFSTED Inspection Worcestershire Children First 13th &14th July 2021
The inspectors noted improvements in practice at the 'front door', an improved culture and leadership, thorough and proportionate assessments, also noting that:
"The Local Authority and wider partnership have planned and delivered a well-co-ordinated and effective response to the pandemic"

15.1.3 Audit activity
Quality Assurance Practice & Procedures (QAPP)
QAPP is a subgroup of the Worcestershire Safeguarding Children's Partnership. The purpose of the group is to quality assure multi-agency safeguarding practice on the front line and to support the embedding of local and national learning across the Partnership to support continuous improvement. The Head of Safeguarding represents the Trust on this group. Audits have been undertaken during 2021/22 in relation to:

- Service user feedback
- Application of Levels of Need
- Voice of the Child
- Peer on Peer sexual abuse

Audits completed have utilised the Joint Targeted Area Inspection(JTAI) model in preparation for a JTAI visit for Worcestershire.
Action taken:

- JTAI briefings have been given to key professionals to share with their teams to introduce the concept of a JTAI inspection

GetSafe Audit
A detailed in depth audit of 1 child was undertaken via the GetSafe Operational Group.

15.2 Multi-Agency Safeguarding Hub(MASH)
The Trust has shared information for 31 MASH requests for children during 2021/22. Themes were in relation to:

- Mental health, substance misuse
- Missing
- Domestic abuse
- Education/poor school attendance

15.3 CCG Assurance
Indra Morris (Director General, Children's Services, Communications and Strategy Group, DfE) Assurance – January 2022
Safeguarding Partners were asked in line with statutory duties as set out in Working Together to Safeguard Children (2018), to review existing COVID-19 plans and assure themselves that they reflected the nature and level of risk and harm being faced by children in their area, including increasing absences from educational settings.
Action taken:
Detailed assurance was provided to the CCG in January 2022.

15.4 Worcestershire Safeguarding Children Partnership

15.4.1 Child Death Overview Panel (CDOP)
The Named Doctor attends CDOP on behalf of the Trust.
Action taken:

- The Trust continues to support the Sudden Unexplained Death in Childhood (SUDIC) and CDOP process via information sharing and attendance at respective meetings.

15.4.2 Sudden Unexplained Death in Childhood (SUDIC)
There is evidence that a significant number of sudden unexpected deaths in infants are associated with adverse environmental conditions (such as co-sleeping with carers, passive smoking, and alcohol or substance misuse by the carers). In rare cases, parental actions or actions by third parties through abuse or neglect may have caused or contributed to the death.

- The Named Professionals have scoped and submitted reports/attended on behalf of the Trust for 9 SUDIC cases during 2021/22.
- Wider partnership work is underway looking at modifiable factors and the information parents /carers receive

Themes:

- Death by hanging
- Complex health needs, COVID+ve
- Dog attack
- Sepsis/meningitis
- Found unresponsive in cot
- Early medical abortion –baby found to be 31+ weeks gestation upon delivery
- Cardiac arrest

Supplementary activity

NHSE/I Significant Injury & Death in Children Caused by Falling Fire Surrounds – Oct 2021
The NHSE/I North West Safeguarding and Quality team received communications from Alder Hey Children's Hospital that there had been two child deaths and two children sustaining life changing traumatic injuries associated with falling fire surrounds.
Action taken:
The briefing was presented to the Integrated Safeguarding Committee in November in order for Practitioners working with parents/carers of young children to increase awareness of the risks of unsecured furniture, televisions and fire surrounds.

15.5 Rapid Review / Child Safeguarding Practice Review (CSPR)
The Trust has undertaken scoping for 4 rapid reviews during 2021/22. Of these:

- 1 case subject to single agency review
- 1 case met criteria for CSPR however no learning identified
- 1 case – the Trust had to provide assurance that the routine enquiry was being asked – incorporated as a mandated field in Badgernet maternity system –action complete

- 1 case out of area.

CSPR status:

SCR 1 'Sarah' Published 6th August 2021

'Sarah' was a child subject to looked after arrangements. The case involved several elements of child exploitation.

Action taken:

- Reflection on the case with practitioners who knew 'Sarah'
- Communications strategy agreed with partners due to wider media interest in case
- Business case development under review for psychology service for children with epilepsy
- Learning and case shared via safeguarding supervision

SCR 3 - CSPR with defined terms of reference. Report in final stages.

SCR 5 – CSPR delayed due to legal proceedings

SCR 6 – CSPR commissioned, defined areas for review

The Trust has no single agency action plans outstanding for any of the learning identified.

Level of Assurance: Level 7

The Trust is meeting its statutory requirements as a partnership agency and contributing to the work of the Worcestershire Safeguarding Children Partnership and its associated sub groups

16.0 Midwifery & Maternity

16.1 Multi Agency Safeguarding Hub (MASH)

The Trust has shared information /attended MASH for 41 unborns during 2021/22.

16.2 Urine Toxicology Screening

The programme has now been rolled out across the locality ensuring all women receive an equitable service.

Action taken:

- A 'task' has been added within the antenatal appointment in Badgernet maternity system to prompt Obstetric Consultants and Midwives to ensure screening is offered
- Lead Specialist Midwife attends the midwifery & maternity training days to discuss UTS
- Positive results have been found in the region of 35% of women tested (Q3 n103 tested, positive result n36)
- Potential outcomes: risk of premature baby and/or low birth weight

16.3 Specialist Midwife Activity

16.3.1 Referrals:

Referrals to the Specialist Midwives remain in the region of 400 cases per quarter.

*Full data / breakdown of activity unavailable for 2021/22 due to long term sickness

Reasons for referral:

- Mental health
- Substance misuse
- Past/present domestic abuse

- Past /present Children Social Care involvement
- Teenager

16.3.2 Strategy Discussions
The Named Midwife or Specialist Midwife attend strategy discussions for pregnant women. A large number of these result in s47 Child Protection enquiries being undertaken.

16.4 Final Ockenden Report (Published 30th March 2022)
Findings, conclusions and essential actions identified from the independent review of maternity services at the Shrewsbury and Telford Hospital NHS Trust were published at the end of March. Findings included:

- Patterns of repeated poor care
- Failure in governance and leadership
- Local actions for learning, and immediate and essential actions(IEA)
- The review team also identified 15 areas as IEAs that should be considered by all Trusts in England providing maternity services, including:
    - the need for significant investment in the maternity workforce and multi-professional training
    - suspension of the midwifery continuity of carer model until – and unless – safe staffing is shown to be present
    - strengthened accountability for improvements in care among senior maternity staff, with timely implementation of changes in practice and improved investigations involving families

Action taken: The Trust is currently considering the implications of the final report building on the initial NHSE/I maternity services assessment and assurance exercise undertaken by Midwifery & Maternity Division further to the initial report publication.

16.5 Black Country Child Death Overview Panel – Neonatal Briefing
A multi-agency panel from across the Black Country met on 3rd November and reviewed the deaths of 10 babies and identified a number of modifiable factors that may prevent deaths in the future.
Action taken:
Briefing shared with practitioners via the Integrated Safeguarding Committee.

16.6 Care of Next Infant (CONI) Lullaby Trust
Provides support to parents before and after the birth of their new baby following the experience of sudden and unexpected death of a previous baby or child.
Action taken:
Named Doctor contributing to the revision of the Worcestershire Guidance. Document currently out for consultation.

16.7 National Review of Non Accidental Injuries in under 1yrs
The National Child Safeguarding Practice Review Panel reported being profoundly concerned at the number of non-accidental injury of babies under 12 months old resulting in death or lifelong impairment. Of the 23 cases reviewed by the panel, 10 cases involved

domestic abuse (current partner) and a further 10 cases (historical domestic abuse). 19 of the cases involved the mental health of either/both parents.

Action taken:

The report and associated documents have been shared with professionals to inform clinical practice.

16.8 Transfer of Maternity Alerts: Mother to Baby

Safeguarding alerts are added to the mother when an unborn becomes subject to safeguarding arrangements (child protection, child in need). At the point of delivery, the alert should be transferred from the mother to the baby. There have been a number of alert failures where the Midwife registering the birth has failed to transfer the alert or has added an incorrect alert.

Action taken:

- WREN report followed up on a daily basis by the safeguarding team to check/ add any missed alerts
- Supervision is taken up by the Named Midwife with any practitioners who fail to transfer the alert and the safeguarding implications explained
- Newsletter during Q1 shared Trustwide detailing process to be followed

17.0 Safeguarding Adults

17.1 Multi-Agency Safeguarding Hub(MASH)

The Trust has shared information /attended as required 285 adult MASH requests during 2021/22.This is a significant increase when compared to the previous year's activity (n138).

17.2 Section 42 Enquiries

The Trust responded to 12 Section 42 enquiries during 2021/22. Themes in relation to:

- Physical assault
- Wound care
- Home carer provision
- Neglect
- Medication

Learning for WAHT:1 case (multiple medication patches found on patient post discharge) was managed as a joint formal complaint and safeguarding investigation and learning shared via safety huddles and ward meeting.

17.3 Worcestershire Safeguarding Adult Board (WSAB)

17.3.1 Safeguarding Adult Reviews(SAR)

Work during 2021/22 has focused on the completion and publication of a number of cases.

Current status:

	Type Title of review	**Status**	**Outcome**	**Single agency actions identified**
Case 1 X 3 adults	SAR **Joan, Kate, Laura**	Published	SAR	No single agency actions

Case 2	SAR **Mary**	Published	SAR	Learning brief developed publication complete. No single agency actions for WAHT
Case 3 X 2 adults	SAR **Mr & Mrs Jones**	Published	SAR	No single agency actions
Case 2017	SAR **Lucy**	Published	SAR	Report not for publication – learning brief published. No single agency actions for WAHT
Case 23	SAR	In progress	SAR	
Case 24	SAR	Scoping submitted 24.03.2021	SAR	
Case 29	SAR	Rapid review undertaken Oct 2021 –for SAR	SAR	
Case 58	SAR	Scoped as a joint DHR/SAR	Criteria for SAR only	

Single Agency Action Plans /Assurance
The Trust has no single agency action plans outstanding.

17.3.2 SAR Learning
The following cases have now been published and relevant learning briefings circulated:

SAR 'Mary'
Mary was a young adult in her early twenties at the time a SAR referral was made. Mary's GP had raised a safeguarding concern confirming that she was 99% sure that Mary was approximately 30 weeks pregnant and would not have been able to consent to sexual activity. A family member was subsequently convicted of offences against Mary.
The review identified numerous elements of good practice.
Multi agency learning identified with a focus on:

- 'think the unthinkable'
- Contraception prescribing in complex cases
- Parental role post 18yrs
- Continuing Healthcare
- Safeguarding Meeting Protocol

No single agency recommendations for the Trust as a result of the review.

SAR 'Lucy'
Lucy, at the time of her death was 19 years of age. She had complex needs from birth including cerebral palsy, severe learning disabilities, visual difficulties and challenges with communication and interaction. She required 24-hour care and support. Her primary carer was her mother with whom she was living permanently at the time of her death. Lucy died at home after being hoisted into the bath. Multi agency learning identified included:

- Mental Capacity Assessment –decision makers post 18th birthday when parental responsibility no longer applies
- Monitoring of out of area placements
- Transition planning for children with complex needs
- Hidden males within the family /household
- Assurance that family carers have the capacity and the support necessary to provide safe care to adults with complex needs within the family home

SAR 'Mr & Mrs Jones'

Mr and Mrs Jones were an elderly couple who had been resident in a South Worcestershire town for approximately 12 years. Until January 2019 they were not known to any services in Worcestershire apart from their GP. Deteriorating physical and mental health had affected their ability to care for themselves and each other. A crisis arose in July 2019 when following a further fall Mrs Jones was admitted to Hospital. Mr Jones was also admitted due to concern about his ability to care for himself and several conditions associated with self-neglect. Mr Jones was eventually discharged home after a little over two weeks. Mrs Jones was discharged into Residential Care where she remained until she died in April 2020.

Multi agency learning identified included:

- Mental capacity assessments
- Use of advocacy services
- Update and relaunch of the self-neglect Policy
- Convening of multi-agency meetings to enable co-ordinated plan of care

Joan, Kate & Laura –Published 10th Sept 2021

This review concerned the services delivered to the family over an extended period of time. The case was referred to the Safeguarding Adults Board in November 2018, after it was identified that members of the family were struggling to cope and this was resulting in neglect to such an extent that it was likely to have serious consequences for the family, particularly with their ability to maintain a tenancy and remain in their accommodation. Multi agency learning identified in relation to transition, carer assessments, dealing with neglect in children.

17.3.3 National SAB Chairs Network (NSCN) web platform

NSCN now has a web platform into which published SAR reports, resources, and materials can be posted. This resource has been promoted as a resource for staff.

17.4 Combined SAR & Domestic Homicide Review(DHR)

Current status:

	Status	Status	Outcome	Single agency actions identified
Case 7	Combined SAR & DHR	Report submitted to CSP/Home Office for approval	Combined SAR & DHR	No single agency actions identified

17.5 Domestic Homicide Reviews

Current status:

	Status	Status	Outcome	Single agency actions identified
Case 8	DHR	Report in progress	DHR	
Case 15	DHR	Scoping submitted	DHR	
Case 16	DHR –South Warks	IMR submitted	DHR	
Case 25	DHR	Scoping submitted	DHR	
Case 26	DHR	Scoping submitted	DHR	
Case 28	DHR	Scoping submitted	DHR	
Case 31	DHR	Decision suspended pending		

		Police forensic information		
Case 36	DHR	Scoping submitted		

17.5.1 Role of the Domestic Abuse Commissioner in DHR

The Domestic Abuse Bill gives the Domestic Abuse Commissioner specific powers and places legal duties on public sector bodies to cooperate with her and to respond to any recommendations that she makes to them. This will enable the Commissioner to drive forward change and hold local agencies and national government to account for their role in responding to domestic abuse.

A number of DHR are currently subject to significant delays as a result of increased workload at the Home Office following COVID and increased scrutiny of report submissions.

17.5.2 Domestic Abuse Protocol - Worcestershire

Currently under review. In final stages of consultation.

17.6 Worcestershire Safeguarding Adult Board(WSAB) - Statutory Stakeholders Annual Objectives

The Trust provided its annual assurance / contribution to the WSAB annual objectives during April 2021.

Priorities for 2022/23:

- Continuation of the work on the Rough Sleeper Thematic Review into Homelessness and Rough Sleepers and Exploitation.
- Monitoring safeguarding risks, including those presented by the pressures in health and social care particularly around the discharge pathway.
- Implementation of a communication plan.
- Launching and embedding the updated Self Neglect Policy
- Adoption and implementation of a Complex Adult Risk Management(CARM) framework, in partnership with Herefordshire.
- Developing safeguarding with the Integrated Care System

17.7 WSAB Newsletters

Circulated Trustwide quarterly to update staff on the work of the Board.

Level of Assurance: Level 7

The WSAB objectives are incorporated into all safeguarding workstreams in order to provide assurance to the Board that WAHT is fulfilling its statutory requirement as a partner agency.
WAHT either attend, or are represented on all of the WSAB associated sub groups contributing to the work of the Board
WSAB newsletters are circulated to promote the work of the Safeguarding Adult Board amongst staff groups

18.0 National Campaigns

Trustwide communications have been circulated in relation to:

- National Stalking Awareness Week -23rd April 2021
- National Slavery Week – April 2021
- National Children's Day – June 2021

- National Adult Safeguarding Week –15-21st November 2021
- Fraud Awareness Week – November 2021
- Domestic Abuse White Ribbon Campaign – Online virtual conference, November 26th 2021
- Prevent (Q3) – awareness raising due to the increased terror threat

Level of Assurance: Level 7
The Trust promotes National Campaigns to raise staff awareness of safeguarding matters

19.0 Audit /Quality Assurance

The audit plan is monitored as a standing agenda item by the Integrated Safeguarding Committee**.**
All statutory safeguarding returns have been submitted within agreed timeframes.

19.1 Safeguarding Information Filing – Neglect Audit 2019/20
Further to the findings of the neglect audit undertaken by the Named Doctor in 2019/20, an assurance exercise was undertaken during Q2 2021/22 in regards to safeguarding information being filed behind the safeguarding header sheet in the child's electronic record. 100% assurance was demonstrated by Medical Secretaries.

Level of Assurance: Level 6
What needs to happen: audit schedule completion in accordance with Audit Schedule – delays due to COVID19 pandemic response

20.0 Managing Allegations

The Trust has in place an agreed Policy and Procedure in order to manage allegations made in regards to people in a position of trust. There have been 8 cases managed during 2021/22. Outcomes:

- Police investigation
- Dismissal
- Unsubstantiated following LADO review
- S47 Child protection enquiry
- Referred to other employer

20.1 Dip Sample Audit CCG October 2021
During October a dip sample of 3 managing allegations cases was undertaken by the Head of Safeguarding and Deputy Designated Nurse CCG. The Trust offered 100% compliance and demonstrated robust systems and processes were in place.
Action proposed:
This will become an annual assurance exercise going forward.

20.2 Volunteer Action Plan – Saville & Lampard – DBS Checks & attendance at Trust Induction
Safeguarding Audit ID 10352 (July 2019) demonstrated a poor level of compliance in relation to information held on the Trust Volunteer database relating to DBS checks and attendance at Trust Induction. An action plan was created and progress to provide assurance has been communicated through the Integrated Safeguarding Committee.

Current position:
All actions on the action plan are now "green"; volunteers active on site have an up to date DBS check and have undertaken their Trust Induction. This will now be monitored annually to provide ongoing assurance.

20.3 Chaperone Training
A programme of face to face Chaperone training sessions was offered Trustwide from July-Dec 2021.

Level of Assurance: Level 7
The Trust has an agreed Policy and Procedure in place for the management of allegations and safer recruitment practices.

21.0 Policy Development

A Policy review schedule is monitored via the Integrated Safeguarding Committee.
Work undertaken over 2021/22 includes:

- MCA Policy & Procedure – updated
- Application of Mittens as a Form of Physical Restraint for Patients requiring Naso-gastric Feeding –review and update
- Use of the Mental Health Act in Hospital –review and update
- Adoption Records Standard Operating Procedure – developed
- Chaperone Policy – review and updated
- Safeguarding Supervision –review and updated

Additional Activity:
Safeguarding briefings circulated via weekly brief in relation to:

- Early Help Partnership Newsletter June 2021
- Sexual Assault Referral Service February 2022

Level of Assurance: Level 5
What needs to happen: All Policies reviewed in accordance with Policy revision schedule – 2 Policies currently overdue – Restrictive Interventions, Self-Harm (Adults)

22.0 Priorities / Forward Plan 2022/23

- Regulatory - Safeguarding mandatory training compliance -90% Trust requirement –all levels adults & children
- LPS implementation as new information emerges
- Contribute to the work /priorities of the Worcestershire Safeguarding Adults Board(WSAB), Worcestershire Safeguarding Children Partnership(WSCP) and associated sub groups
- Policy review and update in accordance with review schedule
- Deliver audit schedule in accordance with audit programme
- Continue to look for opportunities to improve safeguarding systems & processes to ensure they are robust –internal & external
- Multi-agency partnership working

Conclusion

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This report provides assurance that the Trust continues to meet its legislative and statutory requirements in the Safeguarding of Adults, Children and Young People who access services form the Trust. The report details the level of assurance offered for each of the work streams and what needs to happen to move to the next level of assurance as part of the quality improvement journey.

Recommendations

Trust Board is asked to receive, for assurance, the Safeguarding Annual Report 2021/22 and the forward plan for 2022/23

Appendices

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Nurse staffing report –May 2022

For approval:		For discussion:		For assurance:	X	To note:	

Accountable Director	Paula Gardner, Chief Nursing Officer		
Presented by	Jackie Edwards, Deputy Chief Nurse	**Author /s**	Louise Pearson, Lead for N&M workforce

Alignment to the Trust's strategic objectives (x)							
Best services for local people		Best experience of care and outcomes for our patients		Best use of resources		Best people	

Report previously reviewed by		
Committee/Group	Date	Outcome
Trust Management Executive	22nd June 2022 (cancelled due to operational pressures)	Progressed under Executive review
Quality Governance Committee	30th July 2022	Noted

Recommendations	Trust Board are asked to note: • Staffing of the adults, children and neonatal wards to provide the 'safest' staffing levels for the needs of patients being cared for throughout May 2022 has been achieved. There is consistent achievement and the level of assurance has improved to 6 • May has seen an ongoing pressure on the need for temporary staffing specifically in the emergency department and surgery due to patient acuity, dependency and short notice staff sickness. • The key area for targeted recruitment is the urgent care division due to a rise in staff leaving and recent business case approval within surgery for reconfiguration has resulted in changes to the ward establishment. Targeted International nurse recruitment will support the short to medium term gaps with a recruitment drive for domestic recruitment for September with student nurse qualifying. • There were 24 insignificant or minor incidents reported. This is similar to Aprils report. The moderate harms reported last month were reviewed within division and closed as minor harm. • The health care assistant recruitment drive is ongoing, with the opening up following covid restrictions the recruitment centres have reopened, this will support the timeline for on boarding recruits. There remains a significant number of recruits awaiting clearance with a date to on board of ASAP.

Executive summary	This report provides an overview of the staffing safeguards for nursing of wards and critical care units (CCU's) during May 2022. Maternity staffing is provided as a separate report.

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	Staffing of the wards/CCU's to provide the 'safest' staffing levels to meet the fluctuating needs of patients was achieved through May 2022. However, to note there has been a continued challenge due to the consistent pressure from patient demand and acuity through urgent care. This has impacted upon the needs for temporary staffing in areas such as urgent care. There has been an increase with children's services of therapeutic observation for patients requiring CAHMs support. There remains a reported concern of staff feeling tired and pressured in particular within urgent care and an ongoing focus on meeting the changing needs of the health and wellbeing for staff.

Risk			
Which key red risks does this report address?		**What BAF risk does this report address?**	*BAF risk 9 -If we do not have a sustainable fit for purpose and flexible workforce, we will not be able to provide safe and effective services resulting in a poor patient experience.*

Assurance Level (x)	0		1		2		3		4		5		6	x	7		N/A		
Financial Risk	There is a risk of increased spend on bank and agency given the vacancy position and short term sickness.																		

Action						
Is there an action plan in place to deliver the desired improvement outcomes?	Y	x	N		N/A	
Are the actions identified starting to or are delivering the desired outcomes?	Y	x	N			
If no has the action plan been revised/ enhanced	Y	x	N			
Timescales to achieve next level of assurance						

Introduction/Background

Workforce Staffing Safeguards have been reviewed and assessments are in place to report to Trust Board on the staffing position for Nursing for March 2022

This assessment is in line with Health and Social care regulations:
Regulation 12: Safe Care and treatment
Regulation 17:Good Governance
Regulation 18: Safe Staffing

Issues and options

The provision of safe care and treatment
Staff support ongoing

A priority for the trust remains the health and wellbeing of staff as there remains the priorities of managing the ongoing demands from the COVID 19 pandemic, the restart of elective care and increases in patient attendance through the urgent care pathway.

The provision of staff support continues to be a high priority for the teams. There is a Trust wide weekly meeting in place to assess progress with safest staffing and professional issues and to gain a professional update on health and wellbeing issues at ward/clinical level, led by the

CNO/Deputy Chief Nurse. Twice daily trust staffing huddles are in place to ensure safest staffing across the trust.

Roll out of the Professional Nurse Advocate (PNA) training programme and PNA network is in place and restorative supervision offered for staff as required and areas for targeted support.

Harms

There were 24 minor and insignificant patient harms reported for May 2022 over a variety of ward areas. No hot spot areas, with no patient related risks reported.

Good Governance

There are twice daily staffing escalation calls to cover last minute sickness and the divisions work together to cover the staffing gaps with last resort escalation to off framework agencies. There remains an assurance weekend staffing meeting held each week with the CNO and the monthly NWAG meeting.
Triangulation of data is due to commence, with Whole time equivalent data now available for Maternity leave and sickness.

Benchmarking against national data through model hospital is given below of metrics currently available.

Metric	Worcester Acute Trust	Peer – median (similar sized Trusts)	National Average
Vacancy (March 22)	6.4%	6.2%	10%
Turnover (December 21)	5.8%	5.9%	6.9%

This comparison show a position.

Safe Staffing

Nurse staffing 'fill rates' (reporting of which was mandated since June 2014)
"*This measure shows the overall average percentage of planned day and night hours for registered and unregistered care staff and midwifes in hospitals which are filled*". National rates are aimed at 95% across day and night RN and HCA fill
Mitigation in staff absences was supported with the use of temporary staffing and redeployment of staff where staff were able to do so.

Current Trust Position			What needs to happen to get us there	Current level of assurance
	Day % fill	Night % fill	The current domestic and international pipeline to be reviewed. The increase in RN fill is significant across the COVID areas and the need for additional staffing on these areas.	**6 This is an improved**
RN	94%	100%		
HCA	94%	96%		

	The HCA fill rate on days has increased slightly this month a trust wide advert is in place to fill all the HCA vacancies and support winter planning.	**position from April 22**

DATA from Here is for April 2022

Vacancy trust target is 7%
The vacancy increase from 21/22- 22/23 is built upon the business cases and surgical reconfiguration that has been agreed and approved in year.

Current Trust Position WTE			What needs to happen to get us there	Current level of assurance
Division	RN/RM WTE	HCA WTE	RN and RM vacancies ongoing recruitment to reduce vacancies both domestic and international. Rolling adverts for specialities have been ongoing. External recruitment events commence in May. Targeted international nurse recruitment is in process for Urgent Care with ED sisters interviewing. HCA recruitment continues following the recruitment drive with HEE and a centralised trust wide advert being launched in October to support winter planning. 22/23 International nurse recruitment commenced in April 2022 for the next financial year with additional funds supported by NHSEI with supporting teaching for the Hereford and Worcester Health and Care Trust.	4
Speciality Medicine	27.18	20.22		
Urgent Care	59.78	20.24		
Surgery	43.28	22.28		
SCSD	36.73	47.75		
Women's and Children's	38.42	28.21		

Staffing of the wards to provide safe staffing has been mitigated by the use of:

- Inpatient wards have deployed staff and employed use of bank and agency workers.
- Vacancies numbers has led to constraints on staffing and a need for bank or agency to keep staffing safe across all the Wards within safest levels.
- Urgent Care is currently carrying the majority of the RN vacancies.

Recruitment International nurse (IN) recruitment pipeline

Recruitment has already commenced with arrivals planned through from April 2022 to December 2022 totalling 80 with additional financial support from NHSEI.

Domestic nursing and midwifery pipeline
With the commencement of the grow our own campaign through the Best people programme, September will hopefully see new cohorts of Registered Nurse associates and Registered nurse degree apprentices.

Bank and Agency Usage

Trust target is 7%- current usage is Bank 7.59% Agency 8.24%

Bank usage has seen an increase in month and agency usage has shown a decrease in month.

Current Trust Position WTE			What needs to happen to get us there	Current level of assurance
Division WTE	Bank and agency RN	Bank and Agency HCA	In month we have seen a decrease in agency usage and an increase in bank fill.	**5 This is an improved position from April 22**
Speciality Medicine	55	47		
Urgent Care	80	22		
Surgery	53	38		
SCSD	42	20		
Women's and Children's	12 RN 20 RM	11		

Sickness –

The Trust Target for Sickness is 4%, April sickness data 5.7%which is an overall reduction from last month but still significantly higher than the same period last year.

Current Trust Position			What needs to happen to get us there	Current Level of Assurance
	RN/RM	HCA	Sickness has been changed to staff group for more assurance for RN/RM and HCA.	**4**
Spec Med	29WTE	27WTE		
Urgent care	12WTE	8WTE		
Surgery	18WTE	17WTE		
SCSD	29WTE	35WTE		
W & C's	12WTE RN 16WTE RM	7 WTE		

Turnover

Trust target for turnover 11%. April is RN 11.53%, RM 17.27%, HCA 16.47%

Current Trust Position			What needs to happen to get us to there	Current level of Assurance
Division	RN/RM	HCA	Introduction of Apprenticeships across all bands to encourage talent management and growing your own staff – Diploma level 3 – level 7 are available through the apprenticeship Levy.	**3**
Speciality Medicine	10.35%	18.9%		
Urgent Care	12.5%	19.91%		
Surgery	11.32%	13.43%		
SCSD	12.87%	15.03 %		
Women's and Children's	RN 10.17%	14.24%		

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	RM 17.27%		Work being undertaken with NHSEI to develop a recruitment and retention action plan to support HCA recruitment. To have a pool of ready to start HCAs as vacancies arise.	

HCA turnover is higher than trust target across all divisions

Recommendations

Trust Board are asked to note:

- Staffing of the adults, children and neonatal wards to provide the 'safest' staffing levels for the needs of patients being cared for throughout May 2022 has been achieved. There is consistent achievement and the level of assurance has improved to 6
- May has seen an ongoing pressure on the need for temporary staffing specifically in the emergency department and surgery due to patient acuity, dependency and short notice staff sickness.
- The key area for targeted recruitment is the urgent care division due to a rise in staff leaving and recent business case approval within surgery for reconfiguration has resulted in changes to the ward establishment. Targeted International nurse recruitment will support the short to medium term gaps with a recruitment drive for domestic recruitment for September with student nurse qualifying.
- There were 24 insignificant or minor incidents reported. This is similar to Aprils report. The moderate harms reported last month were reviewed within division and closed as minor harm.
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Midwifery Safe Staffing Report May 2022

For approval:		For discussion:		For assurance:	x	To note:	

Accountable Director	Paula Gardner, Chief Nursing Officer		
Presented by	Justine Jeffery, Director of Midwifery	**Author /s**	Justine Jeffery, Director of Midwifery

Alignment to the Trust's strategic objectives (x)							
Best services for local people	x	Best experience of care and outcomes for our patients	x	Best use of resources	x	Best people	x

Report previously reviewed by		
Committee/Group	Date	Outcome
Maternity Governance	July 2022	Noted
Trust Management Executive	22nd June 2022 (cancelled due to operational pressures)	Progressed under Executive review
Quality Governance Committee	30th July 2022	Noted

Recommendations	Trust Board are asked to note how safe midwifery staffing is monitored and actions taken to mitigate any shortfalls.

Executive summary	This report provides a breakdown of the monitoring of maternity staffing in May 2022. A monthly report is provided to Board outlining how safe staffing in maternity is monitored to provide assurance. Safe midwifery staffing is monitored monthly by the following actions: • Completion of the Birthrate plus acuity tools • Monitoring the midwife to birth ratio • Monitoring staffing red flags as recommended by NICE guidance NG4 'Safe Midwifery Staffing for Maternity Settings' • Unify data • Daily staff safety huddle • SitRep report & bed meetings • COVID SitRep (re - introduced during COVID 19 wave 2) • Sickness absence and turnover rates • Recruitment/Vacancy Rate • Monthly report to Board The birth rate in May was again lower than expected and is reflected in the acuity tool results. The escalation policy was enacted to reallocate staff internally as required however the community and continuity teams were also required to support the team throughout May. It has not been possible to achieve minimum safe staffing levels on all shifts.

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There were seven no harm staffing incidents reported on Datix. The supernummary status of the shift leader was not maintained in May. There is ongoing support required to embed the acuity app into the ward areas and the ward managers have to tasked to lead this improvement.

Sickness absence rates have reduced but continue to be higher than the Trusts target at 7.37% across all areas. COVID absence rates were low in May. The directorate continue to work with the HR team to manage sickness absence timely. The rolling turnover rate increased to 17.41%. Further recruitment events are planned. The vacancy rate remains at 3.5%.

The suggested level of assurance for May is 5. This is due to the sustained improvement in the current sickness rates, decrease in COVID absence and a maintained positon for leavers and vacancies.

However, it is acknowledged that the supernummary status of the shift leader was not achieved. Minimum safe staffing levels could not be achieved on all shits and the mitigations put in place maintained safety. Delays in care were noted but no reported harm although it is recognised that this impacts negatively on women's experience.

A higher level of assurance will be offered when there is a sustained decrease in sickness and turnover rates and a reduction in red flag reporting.

Risk			
Which key red risks does this report address?		**What BAF risk does this report address?**	*9-If we do not have a right sized, sustainable and flexible workforce, we will not be able to provide safe and effective services resulting poor patient and staff experience and premiu staffing costs.*

Assurance Level (x)	0		1		2		3		4		5	x	6		7		N/A		
Financial Risk	*State the full year revenue cost/saving/capital cost, whether a budget already exists, or how it is proposed that the resources will be managed.*																		

Action						
Is there an action plan in place to deliver the desired improvement outcomes?	Y	x	N		N/A	
Are the actions identified starting to or are delivering the desired outcomes?	Y	x	N			
If no has the action plan been revised/ enhanced	Y		N			
Timescales to achieve next level of assurance	**3 months**					

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Introduction/Background

The Directorate is required to provide a monthly report to Board outlining how safe midwifery staffing in maternity is monitored to provide assurance.

Safe staffing is monitored monthly by the following actions:

- Completion of the Birthrate plus acuity tools
- Monitoring the midwife to birth ratio
- Monitoring staffing red flags as recommended by NICE guidance NG4 'Safe Midwifery Staffing for Maternity Settings'
- Unify data
- Daily staff safety huddle
- SitRep report & bed meetings
- COVID SitRep (re - introduced during COVID 19 wave 2)
- Sickness absence and turnover rates
- Recruitment/Vacancy Rate
- Monthly report to Board

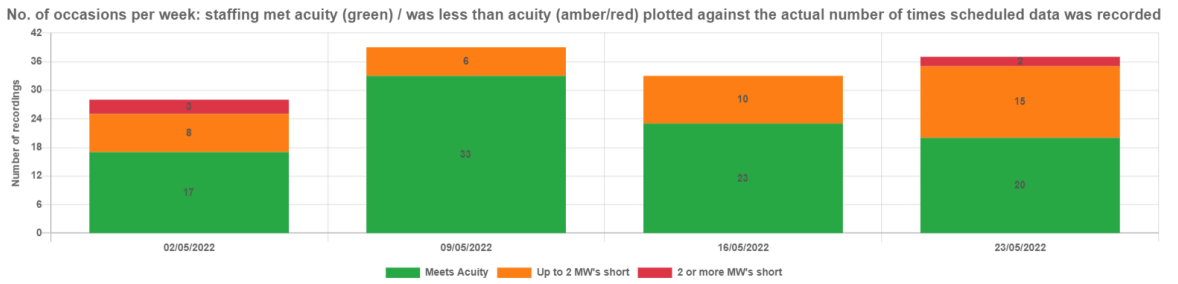
In addition to the above actions a biannual report (published in July and January) also includes the results of the 3 yearly Birthrate Plus audit or the 6 monthly 'desktop' audits. The next complete full Birthrate plus audit is currently being undertaken. A draft report has been received and a workforce paper will be submitted to Board in August 2022.

Issues and options

Completion of the Birthrate plus acuity app

Delivery Suite

The acuity app data was completed in 81.5 % of the expected intervals. The diagram below demonstrates when staffing was met or did not meet the acuity. This indicator is recorded prior to any actions taken. Despite a number of mitigations, the minimum safe staffing levels were not maintained on all shifts throughout May; where this was not achieved mitigations were put in place to maintain safety and the escalation policy was used accordingly in response to activity and professional judgment.



From the information available the acuity was met in 68% (an increase of 18% over the last 3 months) of the time and recorded at 32% when the acuity was not met prior to any actions taken.

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The mitigations taken are presented in the diagram below and demonstrate the frequency of when staff are reallocated from other areas of the inpatient service (61%) to mitigate the risk. Also to note when staff are unable to take their allocated breaks (16%) and there were no reports of staff staying beyond their shift.

The on call midwives and/or the continuity teams were required to support the inpatient service on 2 occasions – this is a reduction from the previous month.

Number & % of Management Actions Taken

From 01/05/2022 to 31/05/2022

MA1	Redeploy staff internally	31	61%
MA2	Redeploy staff from community	3	6%
MA3	Redeploy staff from training	0	0%
MA4	Staff unable to take allocated breaks	8	16%
MA5	Staff stayed beyond rostered hours	0	0%
MA6	Specialist midwife working clinically	0	0%
MA7	Manager/Matron working clinically	1	2%
MA8	Staff sourced from bank/agency	4	8%
MA9	Utilise on call midwife	2	4%
MA10	Escalate to Manager on call	2	4%

Monitoring staffing red flags as recommended by NICE guidance NG4 'Safe Midwifery Staffing for Maternity Settings'

All of the NICE recommended red flags can be reported within the new acuity app and are presented below.

Number & % of Red Flags Recorded

From 01/05/2022 to 31/05/2022

RF1	Delayed or cancelled time critical activity	1	9%
RF2	Missed or delayed care (for example, delay of 60 minutes or more in washing and suturing)	2	18%
RF3	Missed medication during an admission to hospital or midwifery-led unit (for example, diabetes medication)	0	0%
RF4	Delay in providing pain relief	1	9%
RF5	Delay between presentation and triage	0	0%
RF6	Full clinical examination not carried out when presenting in labour	1	9%
RF7	Delay between admission for induction and beginning of process	3	27%
RF8	Delayed recognition of and action on abnormal vital signs (for example, sepsis or urine output)	0	0%
RF9	Any occasion when 1 midwife is not able to provide continuous one-to-one care and support to a woman during established labour	0	0%
RF10	Delivery Suite Co-ordinator is not supernumerary	3	27%

The labour ward coordinator was not supernummary 100% of the time; it was reported that there were 3 events across the month (4 in April) when this was not maintained; there were no reports when 1:1 care in labour was not provided. Delays in the IOL pathway continued during May and there was a small reduction in the number of other delayed clinical activity with no report of associated harm.

Antenatal & Postnatal Wards

The data remains incomplete for the antenatal ward (completion rate 30%) and the postnatal ward (completion rate is 17%). Based on this rate of completion the data is not reliable and therefore cannot be included in the report.

Staffing incidents

There were seven staffing incidents reported in May via Datix and no harm was recorded. There continues to be a noticeable decrease in reported staffing incidents as these are now captured in the acuity tool. It continues to be acknowledged that any reduction in available staff results in increased stress and anxiety for the team and the staff have continued to report reduced job satisfaction and concern about staffing levels, burnout and staff health and well – being.

Staff drop in events have continued throughout May to offer support to staff and to update staff on the current challenges in maternity services and the potential impact of the publication of the Final Ockenden report.

Unify Data

The fill rates (actual) presented in the table below reflect the position of all inpatient ward areas. The rates reported demonstrate a slight improvement in fill rates from previous the month for registered midwives and maternity support workers.

	Day RM	Day HCA	Night RM	Night HCA
Antenatal Ward	78	62	90	71
Delivery Suite	75	60	73	78
Postnatal Ward	81	77	81	84
Meadow Birth Centre	62	56	62	65

Monitoring the midwife to birth ratio

The ratio in May was 1:21 (in post) and 1:20 (funded). This is within the agreed midwife to birth ratio as outlined in Birthrate Plus Audit, 2022 (1:24).

Daily staff safety huddle

Daily staffing huddles are completed each morning within the maternity department. This huddle is attended by the multi professional team and includes the unit bleep holder, Midwife in charge and the consultant on call for that day. If there are any staffing concerns

the unit bleep holder will arrange additional huddles that are attended by the Director of Midwifery. No additional huddles were completed in May.

The maternity Unit Bleep Holder and the on call manger continue to join the Trust site meeting twice per day. This has facilitated escalation of any concerns and a greater understanding of the pressures within maternity services. The maternity team have also gained an insight into the challenges currently faced across our hospital services.

Maternity SitRep

The maternity team SitRep continues to be completed 3 times per day. The report is submitted to the capacity hub, directorate and divisional leads and is also shared with the Chief Nurse and her deputies. The report provides an overview of staffing, capacity and flow. Professional judgement is used alongside the BRAG rating to confirm safe staffing. Further work on the Sitrep is ongoing and the pilot of the regional Sitrep continues.

COVID SitRep/Huddle (re-introduced during COVID 19 Wave 2)

The directorates continue to share information about the current COVID position and identify any risks to the service which includes a focus on safe staffing. The meetings are now held weekly. The national COVID SitRep continues to be completed each fortnight and there has been cause to report that safe staffing levels have not been maintained (without mitigation) throughout May.

Vacancy

There remain 9 unfilled midwifery posts – vacancy rate of 3.5%. 7WTE posts have been offered to students who qualify in September. The majority of these vacancies are within the inpatient area.

Sickness

Sickness absence rates were reported at 7.37% in month. This is a further improved position from previous months.

The following actions remain in place:

- Matron of the day to carry the bleep that staff use to report sickness to ensure staff receive the appropriate support and guidance.
- Signposting staff to Trust wellbeing offer and commencement of wellbeing conversations.
- Daily walk rounds by members/member of the DMT.
- Close working with the HR team to manage sickness promptly.
- Health and wellbeing work stream actions

Turnover

The rolling turnover remains below the Trust target at 17.41%. There were no leavers in May.

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Actions throughout this period:

- Daily safe staffing huddles continued to monitor and plan mitigations for safe staffing
- Attendance at the site bed meeting twice per day
- Non - clinical staff redeployed to clinical rota as required
- Agency staff block booked to support across summer months
- Sitrep report completed three times per day
- Maintained focus on managing sickness absence effectively.
- Further training and oversight by ward managers to improve completion rates of the acuity app agreed.
- Further recruitment event planned for May for midwives and maternity care assistants.
- Weekly 'drop- in' sessions led by the DoM continued in month.

Conclusion

The activity was reduced again in May (371 births) and there was a further increase in the % of time that acuity was met on delivery suite. To maintain safety staff were deployed to areas with the highest acuity; minimum safe staffing levels were not achieved on all shifts and the escalation policy was utilised alongside professional judgment to maintain safety.

Agency midwives and non-clinical midwives have provided additional support to all areas of the service when required. Deployment of all non-clinical staff was requested on fewer occasions to maintain safe staffing however the requirement to request support from community midwifery teams or continuity teams was also required. No training was cancelled in May.

There were reported delays in care but the number of reports was reduced from previous months. It was also noted that there were three occasions when the shift leader was not supernummary.

Sickness absence rates have been reported at 7.37% which is an improved positon. It is noted this remains above the Trust target; ongoing actions are in place to support ward managers and matrons to manage sickness effectively.

The rolling turnover rate is at 17.41% and the vacancy rate is now 3.5%. A further 7 posts have been offered.

The reduction in available staff on each shift in the inpatient area continues to impact on the health and wellbeing of the team; support is available from the visible leadership team, PMAs and local line managers.

The suggested level of assurance for May is 5 due to the improvement in the current sickness level, decrease in COVID absence and a reduction in leavers and vacancies.

However, it is acknowledged that the supernummary status of the shift leader was not achieved. Minimum safe staffing levels could not be achieved on all shits and the mitigations put in place maintained safety. Delays in care were noted but no reported harm although it is recognised that this impacts negatively on women's experience.

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A higher level of assurance will be offered when there is a sustained decrease in sickness and turnover rates and a reduction in red flag reporting.

Recommendations
Trust Board is asked to note the content of this report for information and assurance
Appendices

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Audit and Assurance Committee Report

For approval:		For discussion:		For assurance:	X	To note:	

Accountable Director	Anita Day, Audit and Assurance Committee Chair		
Presented by	Anita Day, Committee Chair	**Author /s**	Jo Wells, Deputy Company Secretary

Alignment to the Trust's strategic objectives (x)							
Best services for local people	X	Best experience of care and outcomes for our patients		Best use of resources	X	Best people	

Report previously reviewed by		
Committee/Group	Date	Outcome

Recommendations	The Board is requested to: 1. Note the report for assurance

Executive summary	This report summarises the business of the Audit and Assurance Committee at its meeting held on 10 May, 14 June and 4 July 2022. The following key points are escalated to the Board's attention: **1. External Audit Plan & Section 30** Committee received an update regarding the ongoing External Audit work and the statutory section 30 declaration. Significant risks, materiality levels and confirmation of the areas of focus for this year's Value for Money audit were highlighted. The responsiveness of the Finance Team in dealing with queries from Grant Thornton was commended. **2. VfM Audit: Recommendations Progress Update** Committee received a progress update against the Trust's work to confirm implementation of last year's VfM recommendations. Our work on resolving our Data Quality issues (see below) has been shared with Grant Thornton. Next steps will be to build a clear narrative for our progress on workforce, estates facilities and PFI- we need a summary of what has been done since last year, how they fit in to plans this year and development of the 3-year plan.

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3. Data Quality

Committee received a Data Quality update regarding good progress on data cleansing for EPR records and Holistic PTL. A new national target for errors has been set at less than 2% to be achieved by the end of March 2023. The Trust is currently at 37%, but many of these errors are understood and can be easily resolved, so we do not currently anticipate any issues in meeting this target.

4. Draft Head of Internal Audit Opinion 21/22

Committee received the Internal Audit Opinion and an overall summary of Significant assurance was given. The effectiveness of the BAF was given a level A opinion and demonstrated good practice. One Performance Indicator Management responses to draft reports within 10 days- was exceptionally poor at 12% and was escalated to Trust Management Executive by the Committee.

5. Internal Audit Draft Work Plan 22/23

Committee reviewed the draft Work Plan which had been developed with Trust Executives. A meeting is scheduled later this month between the Internal Audit Team, Finance and A&A Committee to discuss the scope of the identified audits.

6. Cyber Security

Committee received an update on cyber security detailing that work had been focused on securing the environment. Committee were informed that the Trust did not have sufficient cyber security and analyst specialists and investment was required in this area. Committee recommended seeking a system-wide solution.

7. Draft Annual Report including Annual Governance Statement 21/22

Committee reviewed the draft Annual Report and provided feedback and suggestions on its content, with particular emphasis on workforce, health and wellbeing, recovery post COVID-19 and inclusion and diversity. Committee noted non-compliance of FT4 and G6 conditions as per last year.

8. Draft Quality Account 21/22

Committee received the draft Quality Account and noted the areas exceeding targets and the priorities for the next year.

The following update is from the Committee meetings held on 14 June and 4 July 2022:

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	Annual Accounts and Report The Committee met on 14th June 2022 to review progress in finalising the Annual Report and Annual Accounts, to receive the Head of Internal Audit Opinion and Section 30 Letter. A further Committee was held on 4th July 2022, where the Annual Accounts and Annual Report were approved for submission with all other required documentation.

Risk			
Which key red risks does this report address?		**What BAF risk does this report address?**	*All – Committee's work cross cuts all underpinning BAF risks*

Assurance Level (x)	0		1		2		3		4		5	X	6		7		N/A	
Financial Risk	*None directly arising as a result of this report*																	

Action						
Is there an action plan in place to deliver the desired improvement outcomes?	Y		N		N/A	X
Are the actions identified starting to or are delivering the desired outcomes?	Y		N			
If no has the action plan been revised/ enhanced	Y		N			
Timescales to achieve next level of assurance						