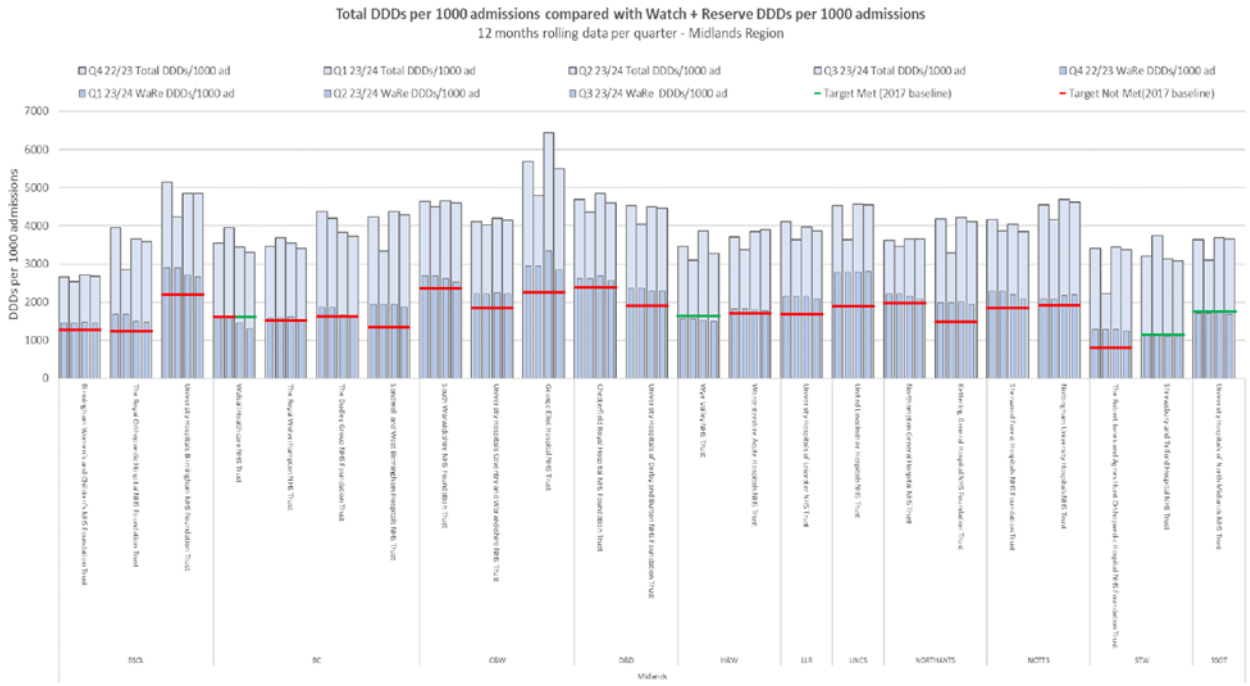
Baselines			Targets		Rolling 4 quarter performance				
Total Watch + Reserve DDDs 2017	Total admissions 2017	Total Watch + Reserve DDDs per 1000 admissions 2017	Target 10% reduction for 2023/24 in Watch + Reserve DDDs per 1000 admissions	Target in Watch + Reserve DDDs per 1000 admissions for 2023/24	Total Watch + Reserve DDDs Q4 2022-23 to Q3 2023-24	Total admissions Q4 2022-23 to Q3 2023-24 (Q3 admissions proxy)	Total Watch + Reserve DDDs per 1000 admissions Q4 2022-23 to Q3 2023-24	% difference in Watch + Reserve DDDs per 1000 admissions from 2017 baseline	MEETING or NOT YET MEETING the 10% reduction target in Watch + Reserve DDDs per 1000 admissions compared to 2017 baseline
286996	149964	1914	191	1722	274229	153866	1782	-6.9	NOT YET MEETING



There are four Trusts (previously three) achieving the target in the West Midlands and the AMS lead microbiologist has contacted colleagues to ask what they have done to achieve this.

Following an audit of the number of over-labelled packs issued by emergency departments and on FP10s by the WM AMS pharmacy group which showed a significant number of pre-packs used for discharge from ED, we have confirmed that smaller packs of over-labelled packs of antibiotics can be obtained and currently reviewing Patient Group Directions. This should reduce the number of DDDs going forward.

Other ASG activities (some on-going):

- *Extensive antimicrobial treatment guideline review has been undertaken focusing on rationalising broad-spectrum recommendations and improving proportion of Access list antibiotics and reducing proportion of Watch and Reserve list antibiotics. Divisions to focus on guideline promotion and education to improve compliance.*
- *AMS representation at ICS/ICB groups to develop strategic priorities and identify actions. Five key prescribing priorities include: optimise therapy, reduce demand, reduce exposure, shorten courses and narrow spectrum. We have completed a gap analysis*

against the ICS action plan which will be reviewed along with other providers in the system in April. It is expected that priorities will be agreed.

- *The ASG terms of reference have been reviewed and identified that the group would benefit from ward-based nurses especially as they may be able to support and promote IV to oral switches, and challenge length of antibiotics courses.*

The Antimicrobial Stewardship Policy is also due for review by June and is currently being looked at.

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 during 2023-24 has been to ensure open and clear communication with our patients, their carers, family and the wider public. Information is available on the internet Trust website and signposts patients/carers to National guidance. The IPC team have produced a patient information leaflet outlining IPC practices and how to stay safe in hospital by carrying out such things as good hand hygiene and wearing the correct PPE as directed by the ward teams.

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 and other organisms is available on a dedicated section of the intranet which can be accessed by all staff. Key messages are distributed by the communication team using a variety of media that is available across the Trust.

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 several 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 and moved to a Respiratory symptom checker.

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 additional cleaning is in place as required.

During 2023-24 we identified and effectively dealt with a number of infection outbreaks and incidents relating to a range of infections.

We also managed 63 ward outbreaks of COVID-19 during 2023-24.

With the introduction of the EPR system there has been a diarrhoea risk assessment tool introduced.

The policy for Outbreaks and Isolation of patients has been updated and an updated RAG poster issued to help decision making re cleans.

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 year 2023/24, including leadership by the CNO and the DDIPC.

Throughout 2023-24 we continued to require all staff to complete the electronic mandatory training rather than face-to-face sessions. We have introduced a face-to-face session for induction for HCAs. This includes donning and doffing, hand hygiene competencies and clear instruction on where to find policies.

Our compliance target in 2023-24 was 90%. At the end of 2023-24 the achievement was 88% for clinical staff, and 93% for non-clinical staff.

Ward-based training and electronic resources have remained in place to support staff during the year.

The IPC team have successfully delivered link practitioner training covering a variety of subjects, including lessons learnt from the MRSA case.

Hand hygiene competencies are delivered at Ward level and there is a requirement for annual update.

Fit Testing
FFP3 mask fit-testing is stipulated by the Health and Safety Executive and any mask that is fit to the face must be fit tested.

This continued over 2023/24 with the withdrawal of government support in April 2023. The provision of the service was supported by NHS P staff who were previously employed by Ashfields. The fusion system was updated to enable direct booking and recording of fit tests.

Fit tests are provided for all Trust staff as well as our PFI partners. Permanent staff for the mask fit testing service will be appointed in 24/25.

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. Of our bed-base 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. When the number of patients with possible infection rises, patients with the same infection/suspected infection are nursed together in cohorts.

Cohort isolation continued to be used throughout 2023- 24 for influenza and COVID-19 cases. The number of influenza cases and COVID cases was less than the previous years.

We amended our COVID-19 pathways several times during the year taking account of national guidance and the prevailing situation locally across Worcestershire. 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’). The national guidelines were adapted to ensure that the Trust was maintaining patient safety. Within the Frailty areas we continue to isolation patients who are classified as COVID contacts. This is supported by a risk assessment agreed at TIPCC.

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.

ED at Worcester moved location and there is better provision of single cubicles in the department. However, there remains significant attendees in the department that add to the overcrowding there. Increased cleaning has been implemented in both EDs but this remains a challenging environment.

Enhanced risk assessments were completed for Aconbury 0 due to the change in function. The recommendation was to increase the toilet facilities and decrease the number of inpatients. This has been implemented and there is a longer-term plan to have capital works to increase the bathroom and toilet facilities which has been agreed and will commence Summer 2024.

Due to the pressures on side rooms and often the demand outweighing the supply, IPC worked with the informatics team to develop a ‘live’ side room view to enable quick clinical decision making with the support of IPC.

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 is UKAS accredited, confirming it operates an effective and quality-controlled system.

Throughout 2023/24 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 2024/25 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.

The department has been challenged at times due to the lack of staff but there have been no incidents reported relating to performance due to staffing levels.

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 2023-24 we made some progress on revision of outstanding policies. There are currently 3 policies out for review and once completed will be 100% compliant with reviews.

We monitor adherence to a number of our *Fundamentals of Infection Prevention and Control* 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 TIPCC, supporting detailed review of good practice

Our *Fundamentals of Infection Prevention and Control*

Infection Prevention Fundamentals of Care: Very High-Risk Area

Area: **Month:**

NHS Worcestershire Acute Hospitals NHS Trust

Link Practitioners Names:

Clinical Practice	Score	Cleanliness	Score
1. Hand hygiene audit: 100% of required audits completed All staff bare below the elbows in clinical areas		6. **Domestic cleanliness**: national cleaning standard score: high risk area: 98% minimum.	
2. Peripheral cannula care bundle audit: 100% completed: insertion and ongoing care		7. **Nursing cleanliness**: national cleaning standard score: high risk area: 98% minimum.	
3. Urinary catheter care bundle audit: 100% completed: insertion and ongoing care.		8. **Estates**: national cleaning standard score: high risk area: 98% minimum.	
4. Infection Prevention & Control Issues stated during huddles: To ensure all staff are fully briefed on specific precautions required.		9. **Commode and raised toilet seat cleanliness audit:** 100% achieved.	
		10. **Bed and bed-space cleaning standards:** All cleaned bed spaces to have a bed space check list completed	
5. Mandatory Level 2 Infection Prevention & Control Training: minimum 90% of all staff employed by the specialty team/department have completed their training.		11. **Daily clinical cleans**: Achieve twice daily clinical cleans. Clinical equipment is cleaned after each use. I am clean stickers are applied to key re-usable equipment.	

Hand hygiene is audited monthly, and all clinical areas are expected to participate. There has been a high level of compliance, achieving 98%. However, there has been a variable compliance with completion. After review it was decided to drop the number of observations for some areas as they were areas that did not have high activity.

Safe	●	Hand Hygiene Compliance to Practice	Strategic	Trust	99.71	99.45	99.27	99.57	99.52	99.67	99.33	99.45	99.71	99.37	99.83
Safe	●	Hand Hygiene Audit Participation	Strategic	Trust	84.07	84.96	87.61	87.61	85.71	89.29	90.18	91.96	95.58	92.11	88.29

During the past year the audit program and response to alert organisms have shifted and a cleanliness and standard infection control interventions are measured. Work is in progress to move the IPC audits to GAP to ensure that all clinical areas can audit at any time and contribute to the ward accreditation process.

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 winter vaccination programme was promoted for 23/24 and involved co-administration of flu and Covid boosters, delivered in partnership with the Health and Care Trust. Improving uptake proved to be a challenge but this was comparable nationally across other Trusts.

FLU VACCINATION DATA WAHT	Flu Vaccines as at 31.12.22				Flu Vaccines as at 31.12.23		
	Yes	Grand Total	%		Yes	Grand Total	%
Corporate	333	640	52		278	683	41
Digital	45	93	48		53	106	50
Estates and Facilities	166	372	45		128	390	33
Specialised Clinical Services Division	1038	2105	49		753	2186	34
Speciality Medicine	666	1446	46		461	1510	31
Surgery	393	967	41		266	1024	26
Urgent Care	229	607	38		202	660	31
Women and Children	348	816	43		208	858	24
Grand Total	**3218**	**7046**	**46%**		**2349**	**7417**	**32%**

COVID VACCINATION DATA WAHT	COVID Vaccines as at 31.12.22				COVID Vaccines as at 31.12.23		
	Yes	Grand Total	%		Yes	Grand Total	%
Corporate	298	640	47		215	683	31
Digital	44	93	47		35	1106	33
Estates and Facilities	134	372	36		101	390	26
Specialised Clinical Services Division	909	2105	43		523	2186	24
Speciality Medicine	567	1446	39		338	1510	22
Surgery	350	967	36		188	1024	18
Urgent Care	180	607	30		57	660	9
Women and Children	314	816	38		161	858	19
Grand Total	**2796**	**7046**	**40%**		**1618**	**7417**	**22%**

There has been an increase in measles outbreaks across the region and OH have done a lookback exercise on MMR Vaccination compliance amongst staff. In January 2024, **92.3%** of clinical staff were known to be 'Immune', rising to **93.7%** as of March 2024. There is a need to focus on high-risk areas and to focus on PPE compliance in those areas.

The Occupational Health Service also provides follow up and support when there is an inoculation injury. Compliance audit is undertaken monthly, to ensure that all inoculation injuries are followed up and cross checked against Datix information. Hotspot areas include Delivery suite, A&E and Theatres. Doctors have the most inoculation injuries compared to other job roles. Awareness has been raised through a campaign to all Trust staff this year around best practice regarding prevention and advice following inoculation injuries.

Our Plan for 2024-25

In the coming year we will continue to strive for clean safe care for our patients. We will continue to focus on protecting patients and staff from all infections, reacting and risk assessing the Trusts requirements against the national guidance to ensure we follow recommended good practice.

Our overall aim remains to achieve excellent infection prevention standards and very low rates of infection. Although we have not met any of the Trajectories, we have worked to increase the engagement with teams and increase their understanding of IPC and improve standards.

We will continue our focus on hand hygiene, cleanliness, antimicrobial prescribing, and the care of invasive devices.

With the introduction of Patient Safety Incident Response Framework (PSIRF) the IPC team have worked with the clinical and governance teams to align the reviews to the new way of working. There will be a strong focus on actions and learning from infection incidents. There is work underway to have the DATIX form as the assessment tool for the incident to enable an auditable process and to track completion of actions. There will be shared learning disseminated across the Trust.

Top three priorities will be:

1. Optimisation of Cdiff management – focus on AMS, cleaning, and patient assessment
2. Promotion of the fundamentals of infection prevention and control, to include cleaning both environmentally and equipment. This will cover all responsible groups.
3. Education and training to ensure that we have a skilled workforce that have good knowledge of IPC to deliver safe clean care. In line with the Infection Prevention and control education framework.

To deliver these improvements and continue responding to the Quality Priorities we are implementing a comprehensive annual infection prevention improvement plan for 2023-24. This continues our focus on our '*Fundamentals of Infection Prevention and Control'* along with the other core actions we must take to achieve our aim.

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 2023. https://view.officeapps.live.com/op/view.aspx?src=https%3A%2F%2Fwww.england.nhs.uk%2Fwp-content%2Fuploads%2F2022%2F04%2Fnipc-board-assurance-framework.xlsx&wdOrigin=BROWSELINK

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

4. Infection prevention and control education framework 2023. https://www.england.nhs.uk/long-read/infection-prevention-and-control-education-framework/

5. UK 5-year action plan for antimicrobial resistance 2024 to 2029 https://www.gov.uk/government/publications/uk-5-year-action-plan-for-antimicrobial-resistance-2024-to-2029

Appendix 1: Outbreaks and Incidents

During 2023-24 we identified the following infection outbreaks and incidents which were not related to COVID-19:

Organism	Summary	Learning and Key Actions
CDiff	**4 X Cases** **Avon 4 – 3 cases** **Ward 12 – 2 cases** **Ward 12 – 2 cases** **PDU – 2 Cases**	Robust cleaning is in place as per policy. Improvement required in D&V risk assessment and stool chart completion. This is now in the ERP system and compliance will be monitored for 23/24.
CPE	**Aconbury 3** **5 Cases** **Avon 3** **5 Cases**	Rolling HPV clean and surveillance screening implemented in both areas, screening remains in place
Influenza	**18**	Ward closure and cleaning in larger outbreaks and rolling HPV completed. Less outbreaks for this year compared to 2023/24, r
Norovirus	**5**	Extended outbreak on Aconbury 0 – ward closure and deep clean required.

Appendix 2: WAHT Infection Prevention Improvement Plan 2024-25

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 2024-25. 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 4ward Improvement System. 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 2024-25

Top three priorities will be:

1. Optimisation of Cdiff management – focus on AMS, cleaning, and patient assessment
2. Promotion of the fundamentals of infection prevention and control, to include cleaning both environmentally and equipment. This will cover all responsible groups.
3. Education and training to ensure that we have a skilled workforce that have good knowledge of IPC to deliver safe clean care

How will we do this:

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 '*NHSE Infection Prevention & Control Board Assurance Framework 2023*.
2. Achieve national improvement targets for healthcare-associated infections, in particular a reduction of CDiff numbers. To monitor actions and ensure completion of actions and dissemination of shared learning.
3. Deliver safe, effective care whilst ensuring the prevention and management of infection is promoted, to strengthen education and training.
4. Development and delivery of a robust audit program that clearly demonstrates improvement.

Key Issues and Elements for Focus

Focus: Infections

- *Clostridioides difficile* infection
- *Staphylococcus aureus* bacteraemia, including MRSA
- E coli and other gram-negative bacteraemia
- Respiratory Viruses
- Multi-Drug Resistant Organisms, including Vancomycin Resistant Enterococci and Carbapenemase Producing Enterobacteriaceae
- 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

- *Fundamentals of IPC – embed standards*
- 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 practices
- Sharps safety & waste management
- MRSA, CPE and other MDRO screening and MRSA decolonisation, respiratory swabbing
- Update and 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 local practices and knowledge

Drivers: Guidance, Standards, Reports

- Priorities and Operational Planning Guidance (NHSE)
- National Infection Prevention & Control Manual
- Patient feedback
- Learning from incidents and outbreaks
- CQC Standards, and the Hygiene Code (2015)
- National infection Control Board Assurance Framework
- 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
- National Standards for Cleaning (2021)
- Safer Sharps legislation, H&SaW Act
- 4ward Improvement System

	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 the contractual set trajectories.	Via TIPCC and monthly performance reporting
2.	***Staphylococcus aureus* bacteraemia** • There will be no Trust-attributable cases of MRSA bacteraemia. (zero tolerance) • 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 cases per annum	Via TIPCC and monthly performance reporting
3.	**E coli bacteraemia** • The number of E coli bacteraemia will reduce, to no more than the contractual set trajectories	Via TIPCC and monthly performance reporting
4.	**Klebsiella species bacteraemia** • The number of Klebsiella sp bacteraemia will reduce, than the contractual set trajectories	Via TIPCC and monthly performance reporting
5.	**Pseudomonas aeruginosa bacteraemia** • The number of Pseudomonas aeruginosa bacteraemia will reduce, to no more than the contractual set trajectories	Via TIPCC and monthly performance reporting
6.	**Respiratory Viruses** • Patients, staff and visitors will be protected from nosocomial respiratory infection • The number of HCAI infections will be minimised; aiming to benchmark at or better than the Midlands rate.	Via TIPCC
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 T
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 TIPCC Report to ICB AMS group
9.	**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 TIPCC, with link into Emergency Planning & Resilience Response Meeting
10.	**Fundamentals of IPC** • Fundamentals to be promoted and embed • 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 TIPCC and Divisional governance meetings

	Objective	Reporting
11.	**Cleanliness & Care Environments** • All areas across WAHT will consistently meet or be above the national minimum standards for cleanliness, as set out in the *Fundamentals of IPC* . • 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 TIPCC, PEOG and Divisional governance meetings
12.	**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 TIPCC and Divisional governance meetings
13.	**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 TIPCC and Divisional Governance Groups
14.	**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. • Involvement in the development of information • Engagement with cleanliness reviews	Annual review by TIPCC
15.	**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 TIPCC

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 Trust Infection Prevention and Control Committee (TIPCC), 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: TIPCC **Date: 23/05/24**

National Infection Prevention and Control Board Assurance Framework

Version 1.0 March 2023

Publication approval reference:

Introduction

The National Infection Prevention and Control board assurance framework ('the framework') is issued by NHS England for use by organisations to enable them to respond using an evidence-based approach to maintain the safety of patients, services users, staff and others. The framework is for use by all those involved in care provision in England and can be used to provide assurance in NHS settings or settings where NHS services are delivered. This framework is not compulsory but should be used by organisations to ensure compliance with infection prevention and control (IPC) standards (unless alternative internal assurance mechanisms are in place).

The purpose of the framework is to provide an assurance structure for boards against which the system can effectively self-assess compliance with the measures set out in the National Infection Prevention and Control Manual (NIPCM), the Health and Social Care Act 2008: code of practice on the prevention and control of infections, and other related disease-specific infection prevention and control guidance issued by UK Health Security Agency (UKHSA).

The aim of this document is to identify risks associated with infectious agents and outline a corresponding systematic framework of mitigation measures.

The framework should be used to assure the executive board or equivalent, directors of infection prevention and control, medical directors, and directors of nursing of the assessment of the measures taken in line with the evidence based recommendations of the NIPCM (or whilst the NIPCM is being implemented) including the relevant criterion outlined in the Health and Social Care Act 2008: code of practice on the prevention and control of infections. The outcomes can be used to provide evidence to support improvement and patient safety. The adoption and implementation of this framework remains the responsibility of the **organisation and all registered care providers** must demonstrate compliance with the Health and Social Care Act 2008. This requires demonstration of compliance with the ten criteria outlined.

If the criterion is not applicable within an organisation or setting for example, ambulance services then select not applicable option.

Links

NHS England » National infection prevention and control manual (NIPCM) for England

Health and Social Care Act 2008: code of practice on the prevention and control of infections - GOV.UK (www.gov.uk)

Legislative framework

The legislative framework required to protect patients, service users, staff and others from avoidable harm in a healthcare setting is detailed in the Health and Social Care Act 2008: code of practice on the prevention and control of infections, the duty of care and responsibilities are set out in the Health and Safety at Work Act 1974, and associated regulations for employers and employees.

Local risk assessment processes are central to protecting the health, safety and welfare of patients, service users, staff and others under relevant legislation. This risk assessment process (primary care, community care and outpatient settings, acute inpatient areas, and primary and community care dental settings) has been designed to support services in identifying hazards and risks, and includes guidance on measures that should be maintained to improve and provide safer ways of working by balancing risks appropriately. Where it is not possible to eliminate risk, organisations must assess and mitigate risk and provide safe systems of work using the risk assessment process and the organisation's governance processes.

Links

Health and Social Care Act 2008: code of practice on the prevention

Health and Safety at Work etc. Act 1974

Primary care, community care and outpatient settings

Acute Inpatient areas

Primary and community care dental settings

Instructions for use

The adoption and implementation of the National Infection Prevention and Control Board Assurance Framework remains **the responsibility of the organisation and all registered care providers** must demonstrate compliance with the Health and Social Care Act 2008. This requires demonstration of compliance with the ten criteria outlined in the Act.

The Board Assurance Framework worksheet is ordered by the ten criteria of the Act and allows for evidence of compliance, gaps in compliance, mitigations, and comments to be recorded in a text format.

The compliance rating column allows for the selection of a RAG rating for each criteria using a drop down list. Specifically: not applicable, non-compliant, partially compliant, compliant.

Once options have been selected a summary plot for each criteria is generated automatically, which are displayed in the corresponding worksheet. The overall RAG status for an organisation/provider across all ten criteria is shown in plots under the summary worksheet.

N.B. Use of the framework **is not compulsory** but should be used by organisations to ensure compliance with infection prevention and control (IPC) standards (unless alternative internal assurance mechanisms are in place). In addition, not all of the criteria outlined in the framework will be relevant or applicable to all organisations or settings.

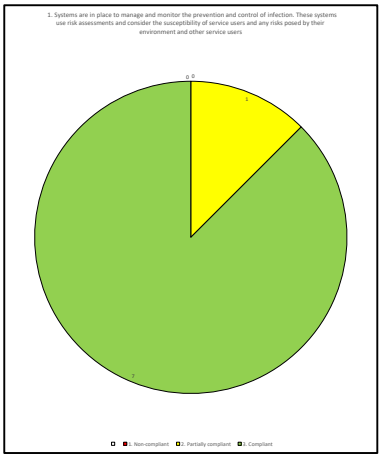
Please note: Specific URL's referred to in the document can be accessed via the ' Hyperlinks included in the BAF' tab. Or alternatively, can be accessed by

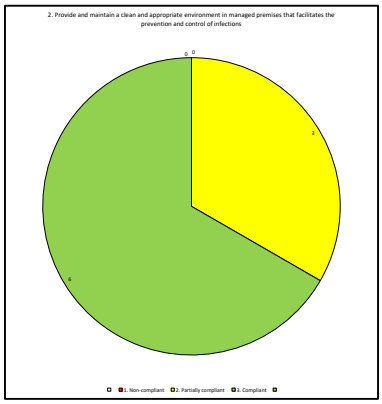
Links

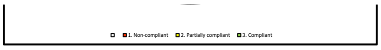
Section 1	
1.4	NIPCM
1.6	NICPM
	Primary care, community care and outpatient settings,
1.8	Acute inpatient areas
	Primary and community care dental settings
Section 2	
2.1	National cleanliness standards
2.2	Patient-Led Assessments of the Care Environment (PLACE)
2.4.1	HTM:03-01.
2.4.2	HTM:04-01
2.5	HBN:00-09
2.6	HTM:01-04
	NIPCM
2.7	HTM:07:01
	HTM:01-01
2.8	HTM:01-05
	HTM:01-06
Section 3	
3.2	UK AMR National Action Plan
3.3	UK AMR National Action Plan.
	NICE Guideline NG15
3.4	TARGET
	Start Smart, Then Focus
Section 5	
5	NIPCM
Section 6	
6.2	Roles and responsibilities
Section 7	
7	NIPCM
Section 9	
	UKHSA
9	A to Z Pathogen
	NIPCM

Infection Prevention and Control board assurance framework v0.1

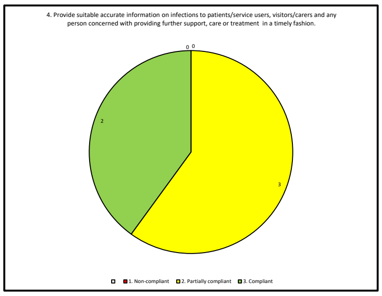
	Key Lines of Enquiry	Evidence	Gaps in Assurance	Mitigating Actions	Comments	Compliance rating
1. Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks their environment and other users may pose to them						
Organisational or board systems and process should be in place to ensure that:						
1.1	There is a governance structure, which as a minimum should include an IPC committee or equivalent, including a Director of Infection Prevention and Control (DIPC) and an IPC lead, ensuring roles and responsibilities are clearly defined with clear lines of accountability to the IPC team.	TIPCC meeting in place - minutes Chief Nurse - DIPC in JD TOR for TIPC TIPCC Terms of Reference -v5				3. Compliant
1.2	There is monitoring and reporting of infections with appropriate governance structures to mitigate the risk of infection transmission.	Reports to TIPCC timely sign off of the HCAI data capture system at executive level Scrunity and learning for Cdiff TOR and meeting notes				3. Compliant
1.3	That there is a culture that promotes incident reporting, including near misses, while focusing on improving systemic failures and encouraging safe working practices, that is, that any workplace risk(s) are mitigated maximally for everyone.	DATIX system in use and all IPC incidents are reported via this system Scrunity and Learning for alert organisms is in place overview and scrunity by ICB partners Move to the new PSIRF processes. This will be live by the end of May 2024 this is an example of the the reporting template 1. Urgent Care IPC SBL April.pptx				3. Compliant
1.4	They implement, monitor, and report adherence to the NIPCM.	Policies in place but not the National IPC manual now availble on line and referenced itn all policy reviews		Current policies in place and up to date there is a reduction of outsanding polices but there is an associated action plan		3. Compliant
1.5	They undertake surveillance (mandatory infectious agents as a minimum) to ensure identification, monitoring, and reporting of incidents/outbreaks with an associated action plan agreed at or with oversight at board level.	HCAI data capture system up to datea and sign off completed by Chief Executive. Reporting: TIPCC is a sub committee of board, papers go to CGG, QGC and TME				3. Compliant
1.6	Systems and resources are available to implement and monitor compliance with infection prevention and control as outlined in the responsibilities section of the NIPCM.	Self assessment completed against the Hygiene Code - compliant Robust audit programme in place. IPC audit tracker in place, broken down by division. File too big to embed. Audit High impact intervention Self assessment v1 May 2024.xlsx	EPR systems requires development to ensure the correct reporting mechanisms are in place for assurance - under development	High impact interventions and audit and review of cases		2. Partially compliant
1.7	All staff receive the required training commensurate with their duties to minimise the risks of infection transmission.	Monthly monitoring of level 1 and level 2 training in place and escalation via the divisional teams. HEE training is mandatory for all staff, link nurse days quarterly link practitioner study days				3. Compliant
1.8	There is support in clinical areas to undertake a local dynamic risk assessment based on the hierarchy of controls to prevent/reduce or control infection transmission and provide mitigations. (primary care, community care, and outpatient settings, acute inpatient areas, and primary and community care dental settings)	there are systems and process in place to support the risk assessment for patient placement to reduce or control infection transmission, this is often carried out with the support of the IPC team and the clinical site teams. EPR system supports IPC safe patient placement Daily symptom checker for COVID in place. Process for EPR alerts to assisst with patient placement Safer patient boarding risk assessement in place				3. Compliant
2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections						
System and process are in place to ensure that:						
2.1	There is evidence of compliance with National cleanliness standards, including monitoring and mitigations (**excludes some settings e.g. ambulance, primary care/dental unless part of the NHS standard contract** these setting will have locally agreed processes in place).	Audit reports Efficacy audit program and results available 3 star and below monitoring group Draft notes Cleanliness scrutiny meeting management for PFI partners	Systems and processes are in place however PFI partners need to provide greater levels of assurance with regards to the output contract.	PFI partners conduct and report audit compliance and there is further overview by the Trusts monitoring officers. Any areas that are 3 Stars or below an accountability meeting is held and action plan generated		2. Partially compliant
2.2	There is an annual programme of Patient-Led Assessments of the Care Environment (PLACE) visits and completion of action plans monitored by the board.	Timetable for PLACE PLACE reports	Pending completion in October.			3. Compliant
2.3	There are clear guidelines to identify roles and responsibilities for maintaining a clean environment (including patient care equipment) in line with the national cleanliness standards.	Cleaning rotas clinical and facilities are in place Roles and responsibilities chart is in place. Policies and protocols for cleaning equipment are in place. Audits carried out by IPC, facilities are in place and reporting to TIPCC Cleaning Responsibility Framework v2				3. Compliant
2.4	There is monitoring and reporting of water and ventilation safety, this must include a water and ventilation safety group and plan. **2.4.1** Ventilation systems are appropriate and evidence of regular ventilation assessments in compliance with the regulations set out in HTM-03-01. **2.4.2** Water safety plans are in place for addressing all actions highlighted from water safety risk assessments in compliance with the regulations set out in HTM-04-01.	Water Safety Committee in place Critical Ventilation Committee in Place TOR in place for all meetings and report into the TIPCC Water safety plan in place and reviewed at the Trust Water Safety Committee			operational Water safety group needs to be set up o review PPM - this is currently reviewed in the strategic group	3. Compliant
2.5	There is evidence of a programme of planned preventative maintenance for buildings and care environments and IPC involvement in the development new builds or refurbishments to ensure the estate is fit for purpose in compliance with the recommendations set out in HBN 00-09	Reports from retained estate and PFI partners to TIPCC meeting. PEOG meetings Capital planning - twice monthly meetings. Minutes/notes regarding UEC. Capital planning updates given at TIPCC	PFI contract management Age of buildings impacts on PPM	Oversight and scrunity by IPC for Capital builds in place Escalation via DIPC regarding contract management to Board.		2. Partially compliant
2.6	The storage, supply and provision of linen and laundry are appropriate for the level and type of care delivered and compliant with the recommendations set out in HTM-01-04 and the NIPCM.	Audit reports Efficacy audit program and results available 3 star and below monitoring group Output contract management for PFI partners				3. Compliant
2.7	The classification, segregation, storage etc of healthcare waste is consistent with HTM-07-01 which contains the regulatory waste management guidance for all health and care settings (NHS and non-NHS) in England and Wales including waste classification, segregation, storage, packaging, transport, treatment, and disposal.	waste policy external waste audit - compliance to regulation Waste management policy:				3. Compliant
2.8	There is evidence of compliance and monitoring of decontamination processes for reusable devices/surgical instruments as set out in HTM-01-01, HTM-01-05, and HTM-01-06.	Decontamination AE audit and action plan Minutes of decontamination meeting Draft Decontamination Committee notes ner review	semi- critical probes and use in the departments, need to have greater oversight	Decontamination audit conducted	Issues with Trophon to explore UV as a solution	2. Partially compliant
2.9	Food hygiene training is commensurate with the duties of staff **as per food hygiene regulations**. If food is brought into the care setting by a patient/service user, family/carer or staff this must be stored in line with food hygiene regulations.	Food hygiene policy Training records can be provided on request.				3. Compliant
3. Ensure appropriate antimicrobial stewardship to optimise service user outcomes and to reduce the risk of adverse events and antimicrobial resistance						
Systems and process are in place to ensure that:						
3.1	If antimicrobial prescribing is indicated, arrangements for antimicrobial stewardship (AMS) are maintained and where appropriate a formal lead for AMS is nominated.	AMS Committee TOR :	AMS pharmacy appointed in April but there is a need to review stewardship across the Trust	Oversight and scrunity by AMS committee, escalation into division and via TIPCC		2. Partially compliant
3.2	The board receives a formal report on antimicrobial stewardship activities annually which includes the organisation's progress with actions in the UK AMR National Action Plan(s).	Reporting in place - need report example Reports go to CGG, QGC and TIPCC 11. AMS Report TIPCC July 25.docx				3. Compliant
3.3	There is an executive on the board with responsibility for antimicrobial stewardship (AMS), as set out in the UK AMR National Action Plan.	Chief medical officer				3. Compliant
3.4	NICE Guideline NG15 "Antimicrobial Stewardship: systems and processes for effective antimicrobial medicine use" Treat Antibiotics Responsibly, Guidance, Education, Tools (TARGET) are implemented and adherence to the use of antimicrobials is managed and monitored: •To optimise patient outcomes. •To minimise inappropriate prescribing. •To ensure the principles of Start Smart, Then Focus are followed.	Point prevelance surveys Cdiff reviews WREN antimicrobial audits	Variability in compliance with point prevalence surveys. Need to have real time feedback to the prescribes and engagement with clinical teams need to review the new 24/29 AMS national reduction plan and align stewardship agensa	All non compliance are addressed via clinical governance groups with action plans put in place.		2. Partially compliant

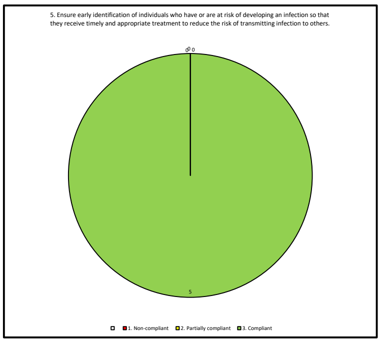


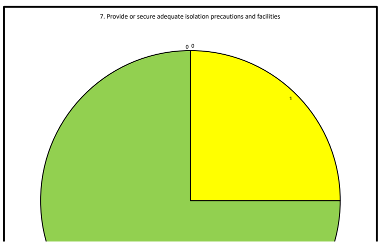




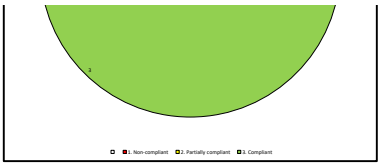
3.5	Contractual reporting requirements are adhered to, progress with incentive and performance improvement schemes relating to AMR are reported to the board where relevant, and boards continue to maintain oversight of key performance indicators for prescribing, including: • Total antimicrobial prescribing. • Broad-spectrum prescribing. • Intravenous route prescribing. • Treatment course length.	CQUIN information				3. Compliant
3.6	Resources are in place to support and measure adherence to good practice and quality improvement in AMS. This must include all care areas and staff (permanent, flexible, agency, and external contractors)	Point prevelance audit and AMS audit process in place Divsional assurance reports Example report from AMS meeting for Speciality Medicine:	Actions need to be strengthened re areas of none compliance, intially this was to improve engagement, now need to move to action and learning	point prevelance surveys and quarterly review by pharmacy		2. Partially compliant
4. Provide suitable accurate information on infections to patients/service users, visitors/carers and any person concerned with providing further support, care or treatment nursing/medical in a timely fashion						
Systems and processes are in place to ensure that:						
4.1	Information is developed with local service-user representative organisations, which should recognise and reflect local population demographics, diversity, inclusion, and health and care needs.	Patient information leaflets accessilble to staff via the intranet	Availability of information in different formats	Utilisation of information that is avialable on te UKSHA website	this will be adhoc requests for information in different formats	2. Partially compliant
4.2	Information is appropriate to the target audience, remains accurate and up to date, is provided in a timely manner and is easily accessible in a range of formats (eg digital and paper) and platforms, taking account of the communication needs of the patient/service user/care giver/visitor/advocate.	Accessible in different formats Published via a variety of social media formats as well as via the internet page - links to NHS website to ensure that the information remains up to date				3. Compliant
4.3	The provision of information includes and supports general principles on the prevention and control of infection and antimicrobial resistance, setting out expectations and key aspects of the registered provider's policies on IPC and AMR.	Information is available on the intranet Patient information leaflet re general IPC practice and how to stay safe in hospital	Requires review intranet and internet site needs updating	Access to up to date information by NHS website and UKSHA is available	IPC team to review patient information and decision made to update in line with UKSHA/NHS website to be confirmed	2. Partially compliant
4.4	Roles and responsibilities of specific individuals, carers, visitors, and advocates when attending with or visiting patients/service users in care settings, are clearly outlined to support good standards of IPC and AMR and include: • Hand hygiene, respiratory hygiene, PPE (mask use if applicable) • Supporting patients/service users' awareness and involvement in the safe provision of care in relation to IPC (eg cleanliness) • Explanations of infections such as incident/outbreak management and action taken to prevent recurrence. • Provide published materials from national/local public health campaigns (eg AMR awareness/vaccination programmes/seasonal and respiratory infections) should be utilised to inform and improve the knowledge of patients/service users, care givers, visitors and advocates to minimise the risk of transmission of infections.	Set out in Job descriptions and at the point of job application to the organisation. IPC standards are set out in policy with clear roles and responsibiltie set out. Multiple policies available via intranet page.				3. Compliant
4.5	Relevant information, including infectious status, invasive device passports/care plans, is provided across organisation boundaries to support safe and appropriate management of patients/service users.	Electronic patient record is in place Shared ICNET system with the Health and Care Trust	The EPR system is not yet embedded and there further updates required to ensure IPC risk is clearly indicated in the patient record	IPC review of all alert organisms via the ICNET system Calls to update ward areas for at risk patients and advice given and documented	EPR is a staggered roll out and the system updates are being managed at a strategic level. The project is over the next couple of years Some sections in EPR system have been updated regarding IPC to promote recording of PVD management and stool chart completion.	2. Partially compliant
5. Ensure early identification of individuals 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 others.						
Systems and processes are in place to ensure that patient placement decisions are in line with the NIPCM:						
5.1	All patients/individuals are promptly assessed for infection and/or colonisation risk on arrival/transfer at the care area. Those who have, or are at risk of developing, an infection receive timely and appropriate treatment to reduce the risk of infection transmission.	IPC risk assessment carried out on admission Daily COVID symptom checker is in place in clinical areas MRSA screening policy in place CPE screening policy D&V risk assessment on EPR system Alerting via ICNET that links to PAS			All policies going forward will make refereence to the NIPCM, it should be noted that all policies currently make reference to the requirement to standard infection control and transmission based precautions	3. Compliant
5.2	Patients' infectious status should be continuously reviewed throughout their **stay/period of care**. This assessment should influence placement decisions in accordance with clinical/care need(s). If required, the patient is placed /isolated or cohorted accordingly whilst awaiting test results and documented in the patient's notes.	COVID daily symptom checker Sepsis six compliance Patient daily assessment and review Alerting via the lab, PAS and ICNET system			EPR system has been updated to include respiratroy risk assessement, diarrhoea risk assessment, cdiff care plan	3. Compliant
5.3	The infection status of the patient is communicated prior to transfer to the receiving organisation, department, or transferring services ensuring correct management/placement.	Discharge information recorded on the EDS document Shared ICNET system with health and care trust this means there is access to all alerts				3. Compliant
5.4	Signage is displayed prior to and on entry to all health and care settings instructing patients with respiratory symptoms to inform receiving reception staff, immediately on their arrival.	Observation during audits.				3. Compliant
5.5	Two or more infection cases (or a single case of serious infection) linked by time, place, and person triggers an incident/outbreak investigation and this must be reported via governance reporting structures.	Outbreak Management Policy Reports to the insight dashboard Daily outbreak report				3. Compliant
6. Systems are in place to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection						
Systems and processes are in place to ensure:						
6.1	Induction and mandatory training on IPC includes the key criteria (SICPs/TBPs) for preventing and controlling infection within the context of the care setting.	Induction - powerpoint Policy IPC presentation for HCA inductions: Trust Induction Infection Prevention v7				3. Compliant
6.2	The workforce is competent in IPC commensurate with roles and responsibilities.	HEE level 1 and 2 IPC training in place.	ANTT for medics	moving to role specific mandatory training requirement	for education boards to approve	2. Partially compliant
6.3	Monitoring compliance and update IPC training programs as required.	Monthly updates via governance teams into TIPCC, and during monitoring of outbreaks, and C diff and MSSA proformas at S&L meetings.				3. Compliant
6.4	All identified staff are trained in the selection and use of personal protective equipment / respiratory protective equipment (PPE/RPE) appropriate for their place of work including how to safely put on and remove (donning and doffing) PPE and RPE.	Role specific requirement to complete donning and doffing training. Designated fit testing service.	fit testing service ATR pending for appointment of 1.5 WTE	NHS P sessions and in house fit testers	with DMT for approval	2. Partially compliant
6.5	That all identified staff are fit-tested as per Health and Safety Executive requirements and that a record is kept.	Fit tested via portacount and self booking system and records kept via Fusion.	Total numbers of staff that are fit tested fall below the expected level.	Promotion of fit testing and visiting ward areas for fit testing.	can now book through fusion	2. Partially compliant
6.6	If clinical staff undertake procedures that require additional clinical skills, for example, medical device insertion, there is evidence staff are trained to an agreed standard and the staff member has completed a competency assessment which is recorded in their records before being allowed to undertake the procedures independently.	ANTT - is a a prerequisite for staff to be able to continue on to do venepuncture and cannulation training. Infection Prevention Procedure and Practice Guidelines for Intravenous Access Devices:				3. Compliant
7. Provide or secure adequate isolation precautions and facilities						
Systems and processes are in place in line with the NIPCM to ensure that:						
7.1	Patients that are known or suspected to be infectious as per criterion 5 are individually clinically risk assessed for infectious status when entering a care facility. The result of individual clinical assessments should determine patient placement decisions and the required IPC precautions. Clinical care should not be delayed based on infectious status.	ICNet tagging system. Alerts via Patient First to indicate patient risk factors Weekly IPC/Microbiology meetings to scrutinise patients with infections and determine best plan.				3. Compliant
7.2	Isolation facilities are prioritised, depending on the known or suspected infectious agent and all decisions made are clearly documented in the patient's notes. Patients can be cohorted together if: • Single rooms are in short supply and if there are two or more patients with the same confirmed infection. • There are situations of service pressure, for example, winter, and patients may have different or multiple infections. In these situations, a preparedness plan must be in place ensuring that organisation/board level assurance on IPC systems and processes are in place to mitigate risk.	Trigger tool for escalation with regards to respiratory virus. This is a risk based approach in order to maintain the presenting conditions model.	Volume of patients that present with infection that we are unable to isolate due to lack of side rooms and the inability to cohort because of capacity pressures.	Daily attendance at capacity meetings. Active side room management to ensure optimum patients are alloacted to isolation rooms.		2. Partially compliant

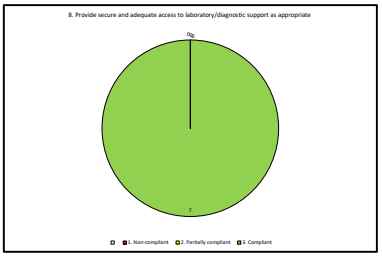


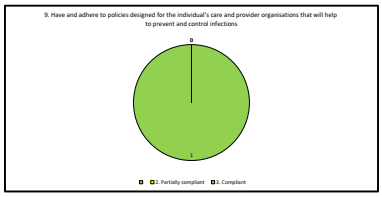


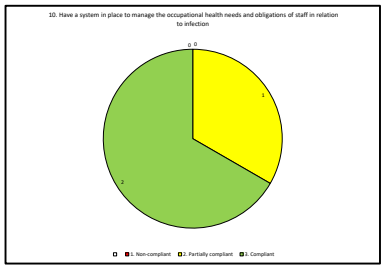


7.3	Transmission based precautions (TBPs) in conjunction with SICPs are applied and monitored and there is clear signage where isolation is in progress, outlining the precautions required.	Isolation posters: Contact Precautions Poster FINAL 05.07.21.pub Droplet Precautions Poster FINAL 05.07.21.pub Standard Precautions Poster FINAL 05.07.21.pub Protective Isolation Precautions Poster FINAL120721.pub				3. Compliant
7.4	Infectious patients should only be transferred if clinically necessary. The receiving area (ward, hospital, care home etc.) must be made aware of the required precautions.	Shared ICNet with Health and Care Trust. Admission and discharge summary. Hand over requirements from ward to ward.				3. Compliant
8.Provide secure and adequate access to laboratory/diagnostic support as appropriate						
Systems and processes to ensure that pathogen-specific guidance and testing in line with UKHSA are in place:						
8.1	Patient/service user testing for infectious agents is undertaken by competent and trained individuals and meet the standards required within a nationally recognised accreditation system.	UKAS accredited laboratory. Consultant Microbiologists and Biomedical scientists support IPC service.				3. Compliant
8.2	Early identification and reporting of the infectious agent using the relevant test is required with reporting structures in place to escalate the result if necessary.	Imports on ICNet Verbal updates from Microbiologists if urgent action required. Results managed via ICE and Winpath, and then onto Sunrise system.				3. Compliant
8.3	Protocols/service contracts for testing and reporting laboratory/pathology results, including turnaround times, should be in place. These should be agreed and monitored with relevant service users as part of contract monitoring and laboratory accreditation systems.	Managed by Pathology lab manager and stakeholder opinions sought when required.				3. Compliant
8.4	Patient/service user testing on admission, transfer, and discharge should be in line with national guidance, local protocols and results should be communicated to the relevant oreanisation.	ICNet EDS for notifying relevant organisations. IPC risk assessment will drive the testing protocols. Sepsis screening monitoring is in place.				3. Compliant
8.5	Patients/service users who develops symptoms of infection are tested / retested at the point symptoms arise and in line with national guidance and local protocols.	Post infection reviews completed by governance teams. This includes complete time line, and outcomes recorded on lockdown log along with admission dates, sample dates etc.				3. Compliant
8.6	There should be protocols agreed between laboratory services and the service user organisations for laboratory support during outbreak investigation and management of known/ emerging/novel and high-risk pathoens.	Laboratory Manager has confirmed compliance.				3. Compliant
8.7	There should be protocols agreed between laboratory services and service user organisations for the transportation of specimens including routine/ novel/ emerging/high risk pathogens. This protocol should be regularly tested to ensure compliance.	Laboratory Manager has confirmed compliance. Assessment via				3. Compliant
9. Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections						
9.1	Systems and processes are in place to ensure that guidance for the management of specific infectious agents is followed (as per UKHSA A to Z pathogen resource, and the NIPCM). Policies and procedures are in place for the identification of and management of outbreaks/incidence of infection. This includes monitoring, recording, escalation and reporting of an outbreak/incident by the registered provider.	Policies accessible via intranet.				3. Compliant
10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection						
Systems and processes are in place to ensure that any workplace risk(s) are mitigated maximally for everyone. This includes access to an occupational health or an equivalent service to ensure:						
10.1	Staff who may be at high risk of complications from infection (including pregnancy) have an individual risk assessment.	Occupational Health reports to TIPCC. Access to policies via intranet.				3. Compliant
10.2	Staff who have had an occupational exposure are referred promptly to the relevant agency, for example, GP, occupational health, or accident and emergency, and understand immediate actions, for example, first aid, following an occupational exposure including process for reporting.	Datix for recording incidents with prompt to report to OH. Safer Sharps meetings to review themes and trends of any incidents. OH also attends. Full risk assessment in place	there are gaps in relation to prescribing, this was highlighted following exposure to a staff member and Pertussius	to contact GP and consultant to support		2. Partially compliant
10.3	Staff have had the required health checks, immunisations and clearance undertaken by a competent advisor (including those undertaking exposure prone procedures (EPPs).	Not able to commence employment until Occupational Health have provided confirmation.				3. Compliant

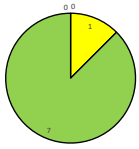








1. Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks posed by their environment and other service users



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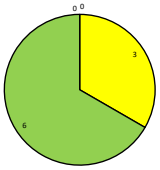
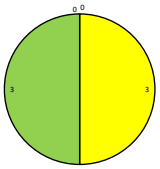
2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections



1. Non-compliant 2. Partially compliant 3. Compliant

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



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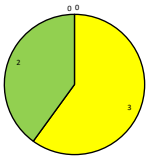
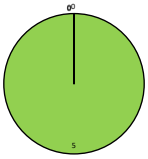
4. Provide suitable accurate information on infections to patients/service users, visitors/carers and any person concerned with providing further support, care or treatment in a timely fashion.



1. Non-compliant 2. Partially compliant 3. Compliant

5. Ensure early identification of individuals 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 others.



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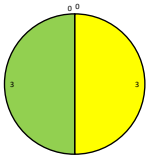
6. Systems are in place to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection



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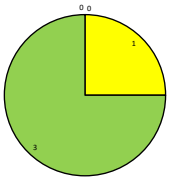
7. Provide or secure adequate isolation precautions and facilities



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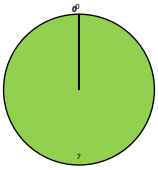
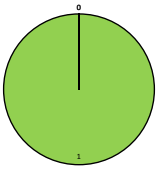
8. Provide secure and adequate access to laboratory/diagnostic support as appropriate



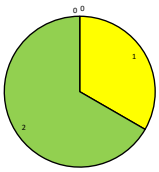
1. Non-compliant 2. Partially compliant 3. Compliant

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



2. Partially compliant 3. Compliant

10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection



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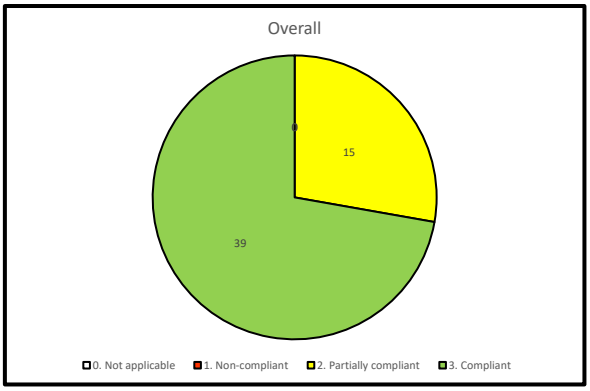

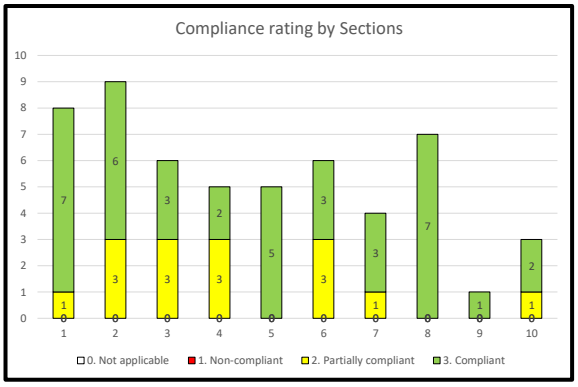

NHS
Worcestershire
Acute Hospitals
NHS Trust

WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST COVERING REPORT 2024-2025

Report to:	**Public Board**
Date of Meeting:	**11/06/2024**
Title of Report:	Integrated Safeguarding Team Annual Report 2023/24
Status of report:	☐**Approval** ☐**Position statement** ☐**Information** ☐**Discussion**
Report Approval Route:	Quality Governance Ctte
If Other, provide details:	Integrated Safeguarding Committee 28.05.2024
Lead Chief Officer/Director:	**Chief Nursing Officer**
Author:	Deborah Narburgh, Head of Safeguarding
Documents covered by this report:	Integrated Safeguarding Team Annual Report 2023/24

1. Purpose of the report

The Safeguarding Annual Report highlights the work undertaken over 2023/24 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 2023/24 and forward plan for 2024/25.

2. Recommendation(s)

Safeguarding activity continues to grow year on year and it is therefore vital that agencies, and the public (contextual safeguarding) work together to protect the most vulnerable within society.
In order to protect those most at risk, the Trust has:

- Worked with safeguarding partners locally, regionally and nationally to share key safeguarding information
- Met its statutory obligations as a partner agency of the Worcestershire Safeguarding Children Partnership and Worcestershire Safeguarding Adult Board and associated sub groups
- Met its obligations in accordance with the PREVENT Duty and statutory reporting requirements
- Continued to look for quality improvements pertaining to safeguarding activity to ensure people accessing our services get the best possible care by staff trained to recognise abuse and take appropriate action – reflected in the latest 2 CQC inspection reports
- Lucy Letby murders – asked ourselves, could this happen here?
- Shared learning from adult and child safeguarding practice reviews in order to continuously improve both the organisational and system response to those at risk of or experiencing abuse and neglect
- Areas for continued focus remain: mandatory training compliance – industrial action having impacted during 2023/24
- Mental Health Act detentions continue to exceed the Service Level Agreement.

This paper PROPOSED a level 6 Assurance overall to the Quality Governance Committee.

3. Chief Officer/Executive Director Opinion[1]

A comprehensive annual report from the Safeguarding Team providing detailed assurance to the Board of the Trust's compliance with its statutory obligations as a safeguarding partner agency for both Adults and Children, and in accordance with our PREVENT duty.

4. Please tick box to identify which of the Trust's 10 Point Plan the report relates to:

[1] Chief Officer opinion must be included and approved by the Chief Officer concerned prior to issue, except when the Chief Officer has given their consent for the report to be released.

☐ *Focus on Flow*	☒ *Think/Act as a Lead Provider*
☒ *Governance*	☒ *Improve Staff Experience*
☐ *Home First Mindset*	☐ *Tertiary Partnerships*
☒ *4ward Improvement System*	☒ *Leadership and Structures*
☐ *Elective Care: No Delays*	☐ *Strategic 'Big Moves'*

NHS
Worcestershire
Acute Hospitals
NHS Trust

Safeguarding Adults, Children & Young People Annual Report April 2023 – March 2024	
Recommendations	The Safeguarding Annual Report highlights the work undertaken over 2023/24 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 2023/24 and forward plan for 2024/25.

Executive summary

Safeguarding activity continues to grow year on year and it is therefore vital that agencies, and the public (contextual safeguarding) work together to protect the most vulnerable within society.
In order to protect those most at risk, the Trust has:

- Worked with safeguarding partners locally, regionally and nationally to share key safeguarding information
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- Areas for continued focus remain: mandatory training compliance – industrial action having impacted during 2023/24
- Mental Health Act detentions continue to exceed the Service Level Agreement.

This paper PROPOSES a level 6 Assurance overall to the Integrated Safeguarding Committee who will need to approve before onward consideration by the Improving Safety Action Group (ISAG), 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 2023/24
Regulation – mandatory training compliance	5 ↑
PREVENT & WRAP statutory requirements	7
Female Genital Mutilation	7
Homelessness Reduction Act 2017	7
Modern Slavery /Human Trafficking	7
Serious Violence Duty	N/A
Mental Health Act	6

Safeguarding Supervision	7
Safeguarding Alerts	6
Domestic Violence –multi agency	7
Partnership Working - adults & children -statutory	7
National Safeguarding Agenda	7
Audit /Quality Assurance	6
Managing Allegations	7
Policy revision	5

1.0 Introduction/Background

Safeguarding activity has continued to increase in both volume and complexity during 2023/24. There has been a significant increase in the safeguarding adult workload as a result of a change in the way the Local Authority now triage safeguarding referrals.
Working Together to Safeguard Children was revised in December 2023 and the partnership is currently working through what this means for individual agencies and the wider safeguarding system.
The global situation remains under constant review in respect of emerging terror threats and the response to the Prevent, Pursue, Protect & Prepare agenda.
The early recognition and detection of abuse and /or neglect are key in ensuring agencies continue to do all they can to protect the most vulnerable within our society when they touch/access our services.

2.0 Issues and options

2.1 Leadership Arrangements

Listen, Learn, Lead:

The Chief Nursing Officer (CNO) is the Executive Lead for safeguarding adults, children, young people and PREVENT. The Deputy Chief Nurse leads the safeguarding portfolio 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), subsequently replaced by the Improving Safety Action Group 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 Integrated Care Board (ICB) provides a level of oversight and scrutiny as part of the safeguarding assurance process.

Terms of reference are updated annually.

2.3 Safeguarding Risk Register

Do what we say we will do:

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 Corporate Risk Management Group.
Safeguarding is currently linked to the following open risks:

2.3.1 Current high risks:

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

Current high risks (12- 14) are:

ID2873 – Safeguarding training compliance
ID5361 – Integrated Safeguarding Team capacity

2.3.2 Moderate risks:

ID1748 CAMHS service out of hours –monitoring Committee Women & Children
ID5076 Paediatric attendances Alexandra Hospital – monitoring Committee Emergency Medicine

2.3.3 Closed risks

ID3511 – Liberty Protection Safeguards implementation – closed as LPS delayed beyond the life of this parliament.

3.0 Care Quality Commission(CQC) Regulatory Activity Mandatory Training

The Care Quality Commission inspections of urgent and emergency and medical care during November 2022 (published 6th April 2023) and Maternity services during October 2023 (Published 29th November 2023) cited mandatory training compliance as an area of ongoing concern:

Nov 2022: Should do:

- The trust should ensure that medical staff stay up to date with mandatory training including, but not limited to, safeguarding training and training on the Mental Capacity Act and Deprivation of Liberty Safeguards (Regulation 12).

Nov 2023: Must do:

- The service must ensure staff are up to date with safeguarding training. Regulation 12(1)(2) (c)

Despite the training position, during both inspections the regulator referenced that staff were able to recognise and protect patients from abuse, working well with other agencies to do so.

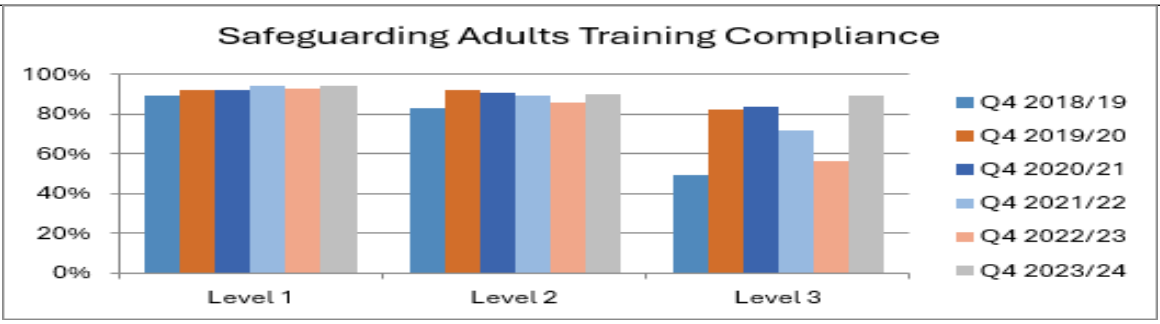
3.1 Outturn Position as at 31st March 2024:

3.1.1 Safeguarding Adults

	Q4 2022/23	Q4 2023/24	Compliance required 90%
SGA L1	93%	94%	Compliant
SGA L2	86%	90%	Compliant
SGA L3	56% (108/192 completed)	89% (159/179 completed)	Partial compliance

Trend since 2018/19 CQC Inspection

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

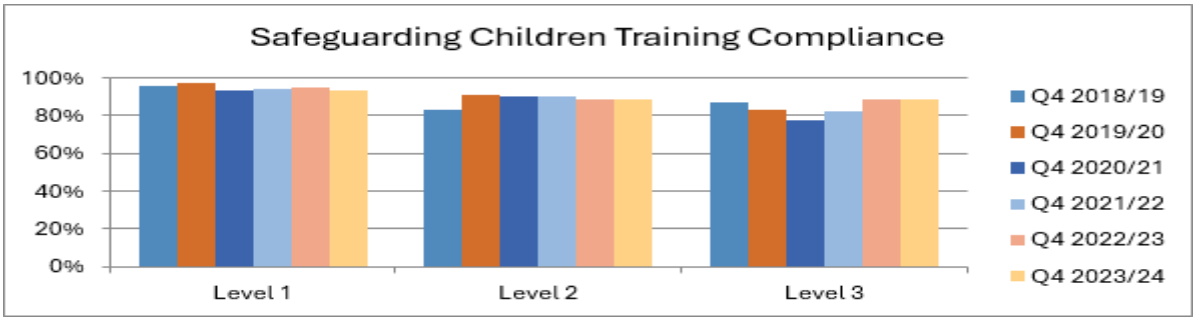


Do what we say we will do:
The Trustwide position as at 31st March has improved over 2023/24 with almost all levels now fully compliant with the 90% Trustwide requirement. The above graphs indicate that the levels of training compliance have been either sustained or improved.
Action taken: The Integrated Safeguarding Team focus upon L3 training has moved the position from 56% as at outturn last year to 89% this year.

3.1.2 Safeguarding Children

	Q4 2022/23	Q4 2023/24	Compliance required 90%
SGC L1	95%	93%	Compliant
SGC L2	89%	89%	Partial compliance
SGC L3	89%	89%	Partial compliance

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

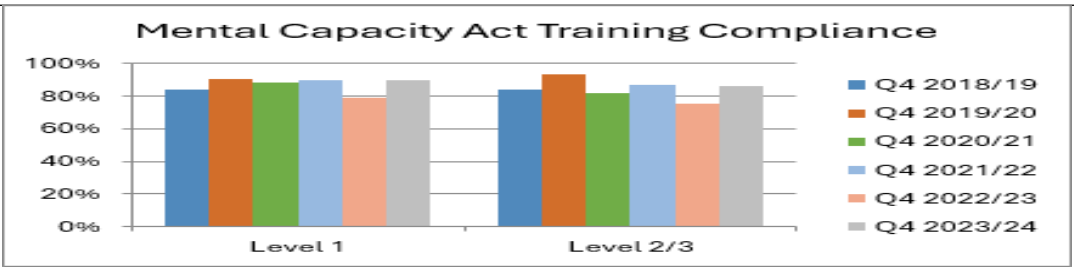


Do what we say we will do:
The Trust has sustained compliance above the 90% requirement for L1 training with L2 and L3 at 89% Trustwide as at year end. This remains consistent with the previous years outturn position.

3.1.3 MCA & DoLS

	Q4 2022/23	Q4 2023/24	Compliance required 90%
MCA & DoLS L1	79%	90%	Compliant
MCA & DoLS L2/3	75%	86%	Partial compliance

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



Trust compliance with MCA & DoLS (all levels) has improved significantly over the last year with Level 1 compliance now at 90% Trustwide requirement.

Do what we say we will do:

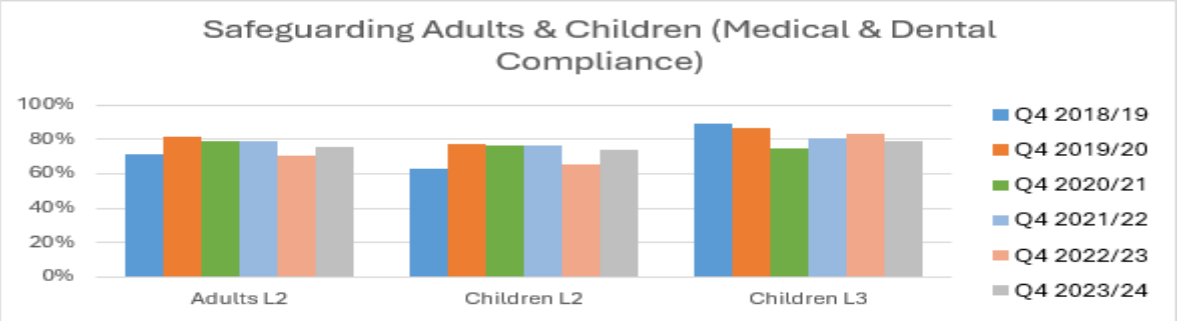
The team continue to offer a range of training opportunities for staff to access, including bespoke sessions.

3.1.4 Medical & Dental Staff Training Compliance: Safeguarding Adults and Children:

Staff Group	Competency	Sum of % completed 31st Mar 2022	Sum of % completed 31st Mar 2023	Sum of % completed 31st Mar 2024	Trend	Compliance required 90%
Medical & Dental	SGA L2	78.93%	70.37%	76%	↑	Partial compliance
	SGC L2	76.41%	65.55%	74%	↑	Partial compliance
	SGC L3	80.71%	83.23%	79%	↓	Partial compliance
	MCA & DoLS L2			50% (234/467 completed)		Partial compliance
	MCA & DoLS L3			86% (313/363 completed)		Partial compliance
	Combined L2/3 – Higher level			66%		Partial compliance

Trend since 2018/19 CQC Inspection

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



2023/24 has seen an improvement in medical and dental safeguarding adult and children L2 compliance. L3 has shown a decrease.

Do what we say we will do:

Medical and dental staff remain outliers when compared with other staff groups safeguarding training compliance. This continues to be escalated via Safeguarding reporting structures and governance forums. Industrial action during 2023/24 and the need to maintain safe clinical services will have impacted upon mandatory training compliance for this group of staff.

Level of Assurance: Level 5 ↑
What needs to happen: CQC 'Should do': Mandatory training compliance of 90% across all levels of safeguarding training, MCA & DoLS

4.0 PREVENT/WRAP

4.1 Training compliance

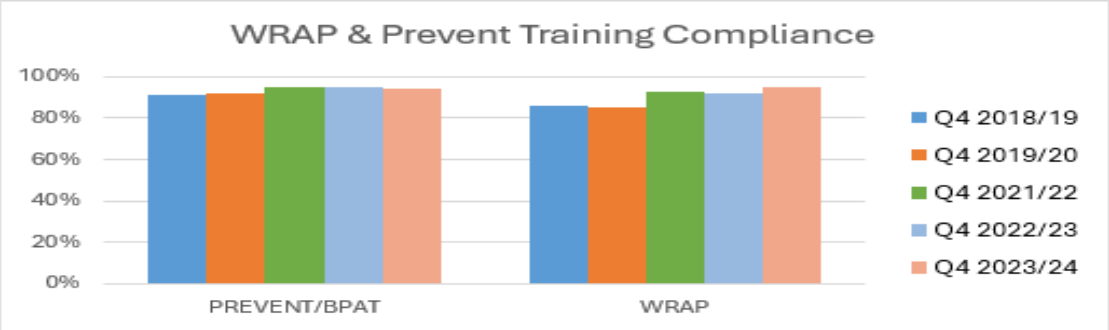
Section 26 of the Counter-Terrorism and Security Act 2015 (the Act) places a duty on certain bodies ("specified authorities" listed in Schedule 6 to the Act), in the exercise of their functions, to have "due regard to the need to prevent people from being drawn into terrorism". The Act states that the 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 2023/24	
94% (1813/1926 staff completed)	Compliant

Workshop to Raise Awareness of Prevent (WRAP)	Compliance 85%
Q4 2023/24	
95% (5318/5588 staff completed)	Compliant

Trend since 2018/19 CQC Inspection

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



Do what we say we will do:

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

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, and the PREVENT Lead for the Integrated Care Board:

- 3 cases with PREVENT concerns have been reviewed by the Head of Safeguarding during 2023/24 identified during routine safeguarding activity

- The Trust has made no direct referrals to PREVENT during 2023/24.

4.2.1 Ideologies
Ideologies of concern remain Islamist extremism and extreme right wing. Reported concerns remain predominantly male in origin; under the age of 18yrs, and linked to online activity. Online activity remains a challenge, however work is underway to promote child safety online and also to enable children and young people to be able to challenge what they are being told. This has been further strengthened by the introduction of the Online Safety Act during 2023.

4.2.2 PREVENT data upload to Strategic Data Collection Service (SDCS)
The Trust has met all of its statutory reporting deadlines for PREVENT.

4.3 PREVENT Partnership working

4.3.1 Current National Threat Level - Joint Terrorism Analysis Centre(JTAC)
The current threat level remains **SUBSTANTIAL** – this means an attack is likely. Given the current global situation, this remains under constant review by JTAC.

4.3.2 PREVENT Strategy Group
Do what we say we will do:
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 work streams. Outcomes are shared via the Integrated Safeguarding Committee. The Trust received the CTLP briefing in February 2024.

4.4 CONTEST Strategy updated July 2023
New guidance was issued during July 2023 due to the evolving terror threat. The aim of the revised guidance being aiming to transform our counter-terrorism response to ensure that it is:

- Agile in the face of evolving threat
- Integrated, bringing the right interventions to bear at the right time to reduce risk
- Aligned with our international allies to ensure that we continue to deliver together against a common threat
- Learning from incidents, exercises and external scrutiny – including the lessons from the Manchester Arena Inquiry
- Implementation of all the recommendations from the Independent Review of Prevent.

4.5 Updated Prevent Duty Guidance October 2023 – effective as of 1st January 2024
The Prevent duty does not confer new functions on any specified authority.
The term 'due regard' as used in the Counter-Terrorism and Security Act, 2015 means that the authorities should place an appropriate amount of weight on the need to prevent people from becoming terrorists or supporting terrorism when they consider all the other factors relevant to how they carry out their usual functions.
Do what we say we will do:
A full gap analysis was undertaken with the statutory guidance for specified authorities and Level 7 assurance presented to the Worcestershire PREVENT Strategy Group.

4.6 Worcestershire PREVENT Strategy Group – Prevent Assurance Statement – August 2023
An assurance exercise was undertaken during August to demonstrate the internal governance and oversight mechanisms in place, as well as providing appropriate assurance to the Prevent

Strategic Group regarding the delivery of Prevent by partner agencies. The Trust was able to offer a high level of assurance in this regard.
This will be an ongoing assurance exercise monitored via the Worcestershire Strategic PREVENT group with oversight by the Prevent Regional Home Office Advisor.

4.7 Annual PREVENT Newsletter 2023
Published during April 2023 and circulated via Weekly Brief.

4.8 Supplementary activity

- Newsletters and briefings continue to be circulated to professionals to keep them appraised of PREVENT activity.

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.
Do what we say we will do:
5.1 FGM National Dataset reporting
There have been 10 reported cases of FGM during 2023/24. This continues the trend of increasing numbers being identified (previous year n7).
Country of origin: Nigeria, Gambia, Iraq, Israel.
Identification remains predominantly via obstetric services.

5.2 Amina Noor – conviction and sentence for assisting FGM
This refers to a case where a woman was found guilty of handing over a 3-year-old British girl for female genital mutilation (FGM) during a trip to Kenya, being jailed for 7 years. The crime came to light years later when the girl was 16 and confided in her English teacher at school. The conviction was the first of its kind for assisting in such harm under the Female Genital Mutilation Act 2003.
Do what we say we will do:
The Named Midwife reminded staff groups that all areas should remain alert to FGM.

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' - Homelessness Reduction Act 2017

6.1 Homelessness Pathway Project
The Worcestershire Homeless Pathway Project provides specialist support to inpatients within acute and community hospitals across the county as well as offering training to staff and students. The role currently sits within Worcester City Council and is funded via ICB NHS funding.

6.2 Referral Data
179 referrals were made to the service during 2023/24:

Acute Hospitals	149
Community Hospitals	30

Of these:

- 149 cases (83%) were referrals from the Acute Trust. This has continued to increase year on year, based upon previous activity
- 126 referrals were male
- 52 referrals were females
- 1 referral non binary

6.3 Safeguarding Concerns

35 of the total referrals (20%) had safeguarding concerns.

Quarter 1 2023	9
Quarter 2 2023	9
Quarter 3 2023	8
Quarter 4 2024	9

6.4 Discharging people at risk of or experiencing homelessness –published 26th January 2024 (DHSC/DLHC)

This guidance is for staff involved in planning discharge of patients (including NHS, local authority, housing and other partners). It includes examples of best practice, including step by step guides and example pathways, which can be adapted to suit local practices, for discharging patients:

- at risk of or experiencing homelessness
- with safeguarding concerns
- with no recourse to public funds (NRPF)

Do what we say we will do:

The implications of the guidance are currently being worked through by the Homeless Liaison Pathway Officer.

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 Modern Slavery / Human Trafficking

The Integrated Safeguarding Team continue to provide advice and support to staff when concerns are identified on a case by case basis. 2 cases have been identified and directly referred to the Integrated Safeguarding Team during 2023/24.

Signposting to:

- Modern Slavery Helpline and National Referral Mechanism
- Police and safeguarding partners.

7.1 Home Office – Modern Slavery Statement

The Trust annual Modern Slavery statement was uploaded to the Home Office during June 2023.

7.2 Human Trafficking Foundation

Modern Slavery Newsletters and key messages are shared via the Integrated Safeguarding Committee(ISC).

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

8.0 Serious Violence Duty – commenced 31st January 2023

The Serious Violence Duty, which is encompassed in the Police Crime, Sentencing and Courts Act 2022 is part of the Government's broad approach to prevent and reduce serious violence. The key strands being a multi-agency public health approach to understanding the drivers and impacts of serious violence, and a focus on prevention and that of early intervention. The Duty is being introduced in the context of an increase in violence over the last decade and the impacts this has on victims and their families.

Work together, celebrate together:

The Duty is currently being worked through by the Community Safety Partnerships & Integrated Care Board (ICB). At this time, implications for the Trust would appear to be in relation to data collection.

Level of Assurance: N/A

9.0 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. The legislation supporting the Mental Health Act 1983 and the Mental Capacity Act 2005 (MCA), and Deprivation of Liberty Safeguards (DoLS) was intended to be updated, but the implementation of this has been delayed beyond the life of this parliament.

9.1 Types of Detention

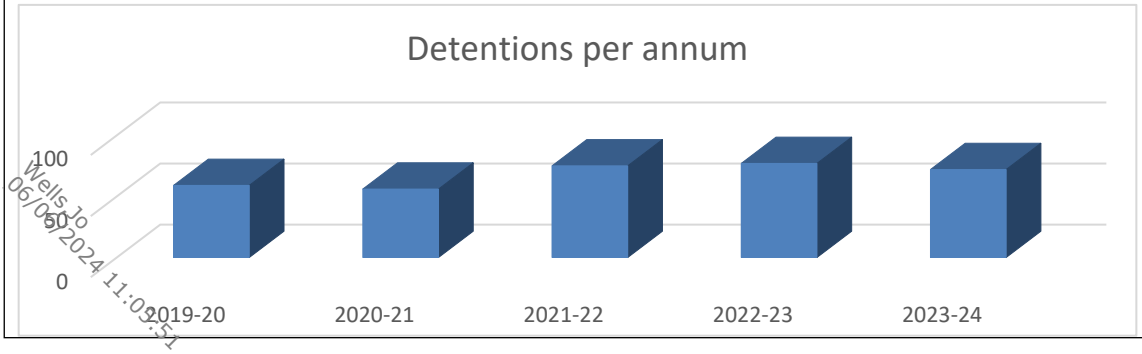
Section 2	detention in hospital for up to 28 days for assessment and/or treatment
Section 3	renewable treatment section which lasts for up to 6 months initially. Once renewed twice, the section duration becomes one year
Section 4	Admission for assessment in cases of emergency where only one doctor is 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

9.2 Uses of Section

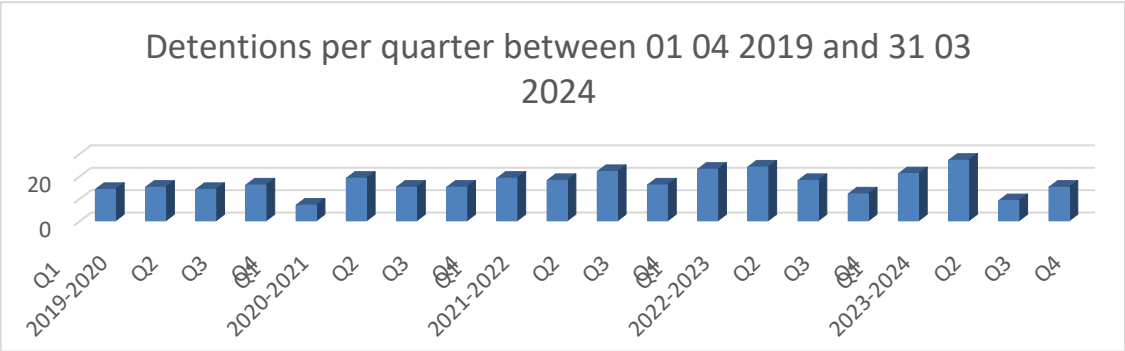
For the third year in succession, the Trust were Hospital Managers to over 70 sections, with 72 within 2023/2024.

The detentions involved 47 individuals.

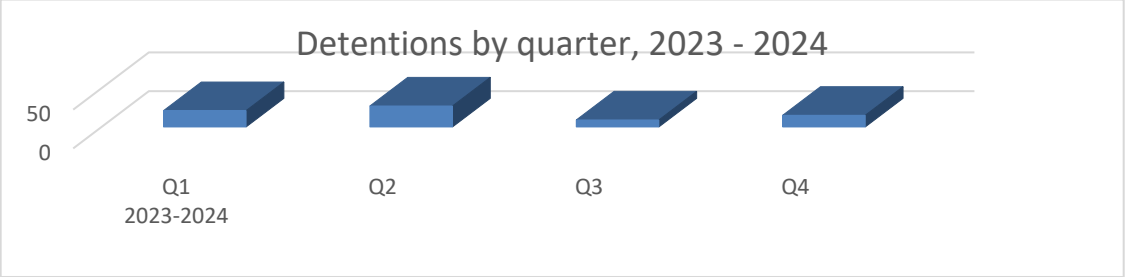
There were no open sections held within the trust as at year-end.



The graph below shows the number of sections held within the Trust, quarter by quarter since the contract began in 2019.
Fluctuation is normal and there are no patterns or trends which are particularly evident, although Q2 regularly appears to be the period in which most detentions take place (in 3/5 years).



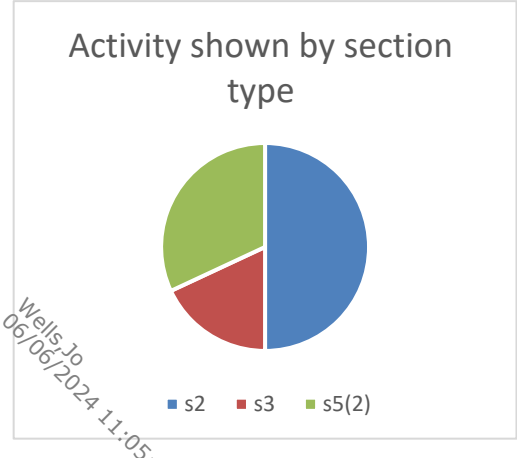
Section activity by quarter 2023/24



Quarter 2 in this year had the highest number of detentions recorded within the contract.

Breakdown of Section Activity
By type:

- Section 2 36
- Section 3 13
- Section 5(2) 23

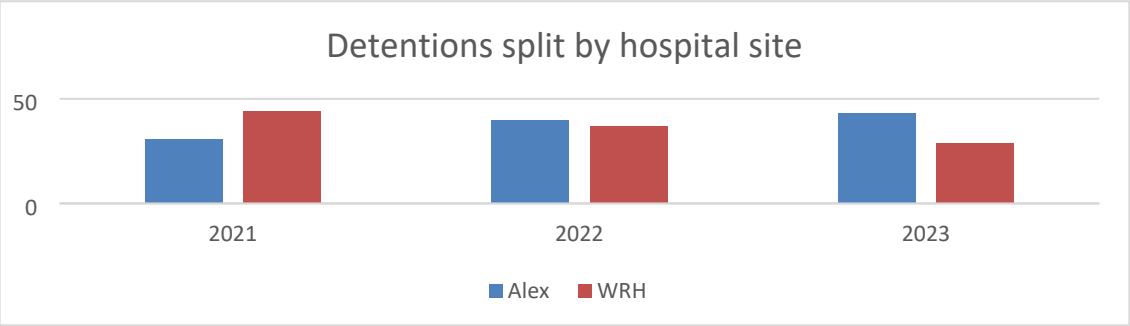


Of the 23 s5(2)'s recorded during 2023/24, 4 were declared invalid by MHA Admin due to errors on the documentation or insufficient reasons recorded.

Section Activity by Hospital

- 43 detentions took place in the Alexandra Hospital (Alex)
- 29 detentions took place in Worcester Royal Hospital (WRH)

	2021	2022	2023
Alex	31	40	43
WRH	44	37	29



From this, it appears that detentions in WRH are becoming less common, with the Alex having more activity. This may be influenced in part by the proximity of New Haven, an older adult mental health unit based at Bromsgrove, which accounted for 7/9 transfers into the Alex for care in 2023/2024.

Location of Detention Activity

The wards with the most detention activity are as follows:

Alex

- AMU - 20
- MSSU - 6

WRH

- AMU - 7
- Avon 2 - 6

These 4 wards accounted for 54% of the total.

Breakdown of Sections

There are a variety of ways in which sections can start:

Direct Admission (where the admission under section takes place directly to the Hospital Managers of the Trust)
Regrade (where a section changes type whilst under the care of the Hospital Managers of the Trust)
Regrade from Informal (this is where a section is started after a person has been admitted voluntarily. Usually – but not always – a holding power)
Transfer (where the section was started whilst the patient was under the care of another provider and subsequently moved to WAHT)

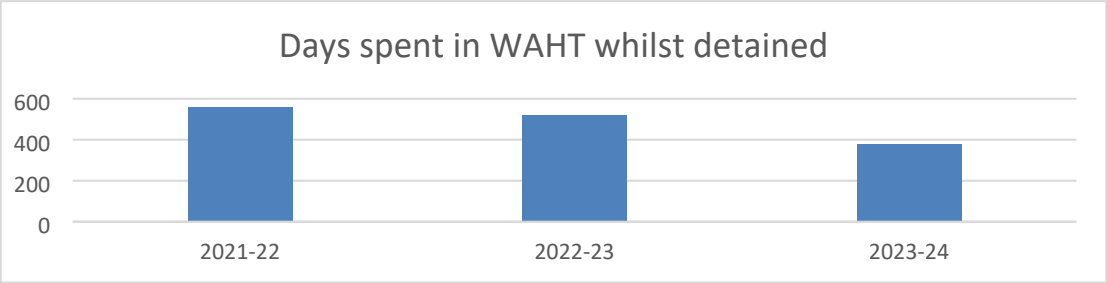
The most common way for sections to start in WAHT within this year was a regrade from informal (47). This is the same as in previous years.

- 10 sections were regraded while the patient was receiving care at WAHT; and
- 15 sections were transferred into the care of WAHT

Of the sections transferred into WAHT, 14 were from HWHCT.

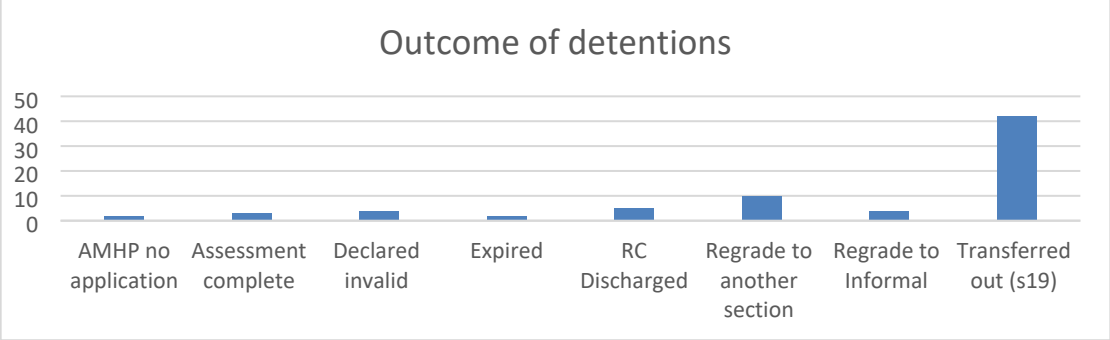
9.3 Time Spent on Section

In total, patients spent 377 days on section within the year. This is a decrease on previous years (557 in 2021/22 and 521 in 2022/23).



As would be anticipated, the majority of patients who were sectioned were transferred out to mental health care providers once their physical health was stabilised.

Outcome of detentions 2023/24



9.4 Gender and Ethnic Breakdown of Detained Patients

Of the 47 individuals detained:

- 26 were female
- 21 were male.
- 'White British' accounted for 94% of individuals

9.5 Age

- 16 were over 65yrs
- 28 were 18-65yrs
- 3 were under 18yrs

9.6 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.

9.6.1 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 were no FTT applications during 2023/24.

9.6.2 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 2023/24.

9.7 Sections Declared Invalid
4 sections were declared invalid within the year; all were documentation errors within the statutory forms used for Doctors' holding powers. In each case, MHA Liaison were advised and via them, the wards. The person and their Nearest Relative will have been notified in writing that an error had occurred.

9.8 Care Quality Commission Notifications
There were no notifications to the CQC required within the year.

9.9 Independent Mental Health Advocate (IMHA) Services Children & Young People
IMHA services for Children & Young People (18yrs and below) detained under the Mental Health Act are now fully commissioned from Onside Advocacy as of January 2024.
Once a child /young person is detained under the MHA, the Mental Health Act Administration team will automatically refer to the service – it will be an opt out process rather than an opt in. Patient information will be provided to the child /young person via CAMHS / Liaison in order to comply with the requirements of the Act.

9.10 WMAS Transportation Policy Update – Feb 2024
In October 2022, WMAS commenced a consultation on the West Midlands Ambulance Service University NHS Foundation Trust Mental Health Act Transportation Policy. In October 2023, following a period of internal review and governance, the final version of the Policy was circulated to partners via local multi-agency mental health forums. The aims of the Policy review were to address risks identified by:

- Ensuring statutory compliance with the Mental Health Act 1983 and its Code of Practice
- Ensuring processes described by the policy align with current WMAS triage and dispatch processes.
- Embedding learning from serious incidents and coronial inquiries.
- Ensuring the delivery of a consistent, equitable and just service to patients with mental health needs aligned to the WMAS commissioned position.

Do what we say we will do:
Updated version circulated and uploaded to Trust Intranet.

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.

Medical staff focus on the correct completion of S5(2) Dr Holding Power documentation to ensure detention is lawful.

10.0 Safeguarding Supervision

Safeguarding supervision continues to be delivered across the Trust via a number of mediums.

Do what we say we will do:

- Supervision Newsletters have been circulated via the weekly Brief in relation to homelessness liaison, MCA, domestic abuse, armed forces veterans and links to suicide, neglect (with a focus on medical neglect).
- Specialist teams continue to receive regular supervision from the Named Professionals due to the increasing complexities of their caseloads
- Richard Swann Safeguarding Supervision training promoted March and April 2024 offering free places to Trust staff.

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

11.0 Safeguarding Alerts

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

11.1 Police Log alert – commenced July 2023

New alert developed to differentiate between Police Log notifications and high risk domestic abuse (MARAC). It was agreed with the Caldicott Guardian that these would be reviewed every 2 years.

11.2 Strategy Meetings – sharing health information: forthcoming OPD attendance

The Trust is notified by H&WHCT 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. An alert is added to clinical systems to appraise practitioners that concerns have been raised that have met the threshold for a strategy discussion. 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.

- Strategy notifications 2023/24 received – 1181
- Children discussed – 2475
- 126 (approx. 5%) of these children had forthcoming OPD with the Trust

11.3 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.

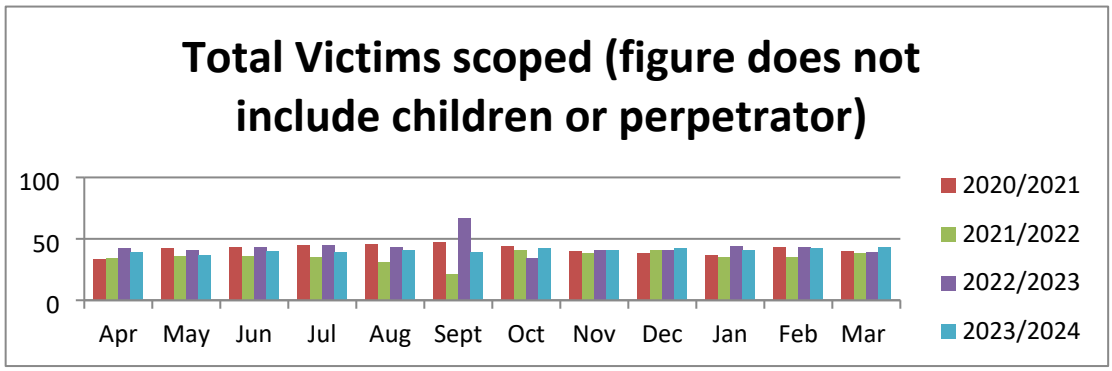
During 2023/24 the Integrated Safeguarding Team were notified of 10 out of hours' strategy discussions. Of these, 4 were attended by clinical staff.

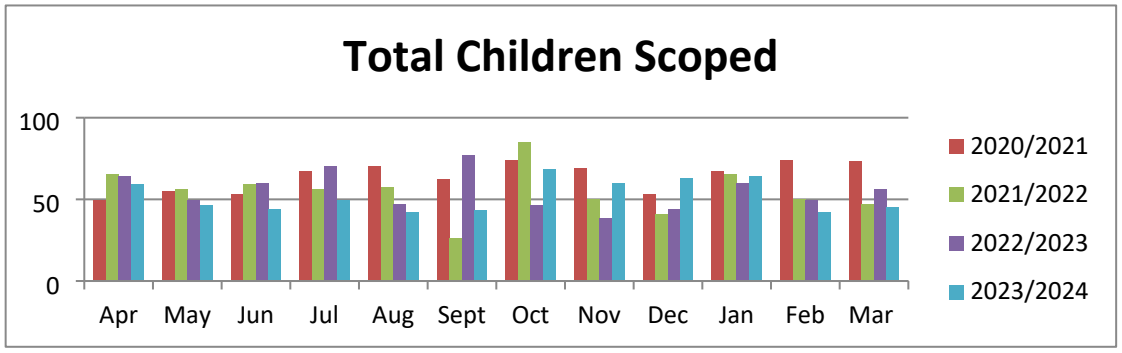
Level of Assurance: Level 6
Named Doctor currently exploring alternatives to WAHT as 'health' representative out of hours for strategy discussions as due to workload and pressures on the system Consultant Paediatricians are not always able to contribute out of hours.

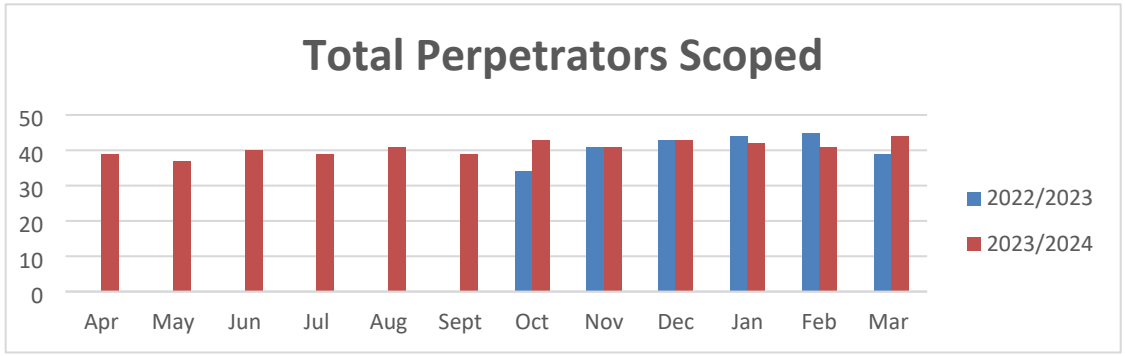
12.0 Domestic Abuse /Domestic Violence

12.1 Multi-Agency Risk Assessment Conference (MARAC)

The Trust has undertaken 1600 (2022/23 n1429) individual scoping's for *high risk* domestic abuse during 2023/24. 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. This continues to show a year on year increase in the total numbers being scoped for MARAC.

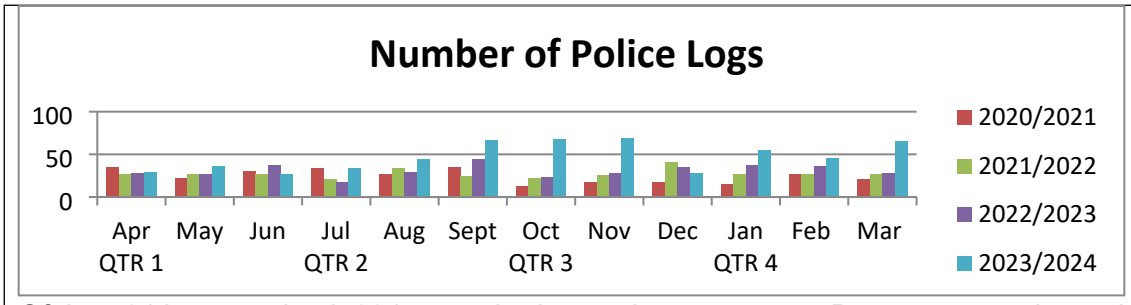




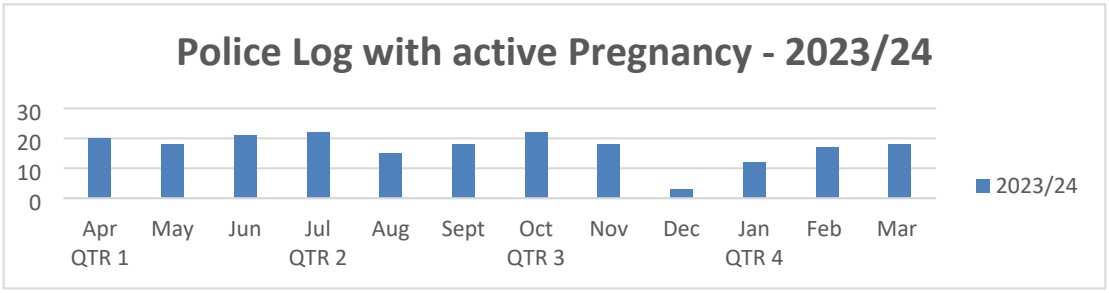


12.2 Police Logs flagged:

Police Logs are received by WAHT Integrated Safeguarding Team. All victims and their children are "flagged" on Trust Information Systems. Police Logs are received when the victim or perpetrator is pregnant or have recently delivered. 564 Police Logs have been reviewed and flags added to clinical systems during 2023/24. Police log activity has doubled when compared with 2020/21 activity.



Of the 564 logs received, 204 cases had an active pregnancy. Pregnancy can be a trigger for domestic abuse, and existing abuse may get worse during pregnancy or after giving birth.



12.3 Hospital Independent Domestic Violence Advisor (HIDVA)

The below details referrals during 2023/24. In total, 81 referrals were made to the HIDVA service across the Trust. This is an increase on the previous years' activity (n70). Activity on the Alexandra Hospital site has doubled when compared to 2022/23 activity:

Referrals 2023/24 by site:

Source of Referral	Q1	Q2	Q3	Q4	Total
Redditch Alexandra Hospital	11	3	1	11	**26**
Worcester Royal Hospital	16	14	13	12	**55**
Engagement by Referrer (Appropriate Referrals)	**Q1**	**Q2**	**Q3**	**Q4**	**Total**
Redditch Alexandra Hospital	6	3	1	9	**19**
Worcester Royal Hospital	11	11	8	11	**41**

Referrals 2022/23 by site:

	Q1 22/23	Q2 22/23	Q3 22/23	Q4 22/23	Total
Redditch Alexandra Hospital	4	2	1	6	**13**
Worcester Royal Hospital	17	17	9	14	**57**

12.4 NHSE Non-Fatal Strangulation Rapid Read

Strangulation is common in interpersonal violence. In domestic abuse, up to 44% of victims report having been strangled. In sexual violence, 1 in 11 adults reporting rape also describe strangulation as part of the assault.

Do what we say we will do:

Circulated to key areas Trustwide to raise staff awareness and inform clinical practice.

12.5 Supplementary activity:
Further communications have been circulated to practitioners in respect of:

- Referral for domestic abuse housing support – Wyre Forest
- New MARAC referral form including information sharing without consent

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).

13.0 Safeguarding Children

13.1 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. During 2023/24, Trust staff submitted 23 GetSafe referrals.

13.1.2 GetSafe Portal and Weekly Triage Meetings
The Trust has provided information for 1728 children/young people during 2023/24. This number has continued to increase year on year (n1095 2021/22, n1466 2022/23). Of these:

- 408 new referrals
- 1320 reviews

13.2 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 increase in the work associated with MACE over the last year, 390 MACE reports have been scoped / flagged during 2023/24. Previous year activity n352.

13.3 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.
Do what we say we will do:

- During 2023/24, 3528 children/young people attendances were reviewed via this process –a slight increase on previous years' activity.
- Of the 537 referrals recorded into the Family Front Door, 298 were made by Trust staff or the Integrated Safeguarding Team (55%).

13.4 National Child Exploitation Day – 18th March 2024
Key messages promoted Trustwide including spotting the signs, anyone can be at risk.

13.5 NHSE Virginity Testing – Honour Based Abuse
Virginity testing and hymenoplasty are forms of 'honour based' abuse and violence against women and girls. It can be a precursor to child or forced marriage and other forms of family and/or community coercive behaviours, including physical, emotional and financial abuse. Such practice became illegal as of 1st July 2022.
Do what we say we will do:

The briefing was circulated trustwide, to key practitioners and uploaded to the Safeguarding Pathway to raise staff awareness.

13.6 Home Office – Child sexual Abuse Consultation –closed November 2023
The Independent Inquiry into Child Sexual Abuse(IICSA) recommended that the government make it a legal requirement for certain people to report child sexual abuse when:

- they're told about it by a child or perpetrator
- they witness it happening
- they observe recognised indicators of child sexual abuse

Staff were encouraged to contribute to the consultation. Outcome awaited.

14.0 Statutory Partnership Working - Children

14.1 Working Together to Safeguard Children – revised December 2023
The statutory guidance replaces Working Together to Safeguard Children (2018). Safeguarding partners are under a duty to make arrangements to work together, and with other partners locally including education providers and childcare settings, to safeguard and promote the welfare of all children in their area.
The partnership has recently met to look at the implications of the new guidance across the system. Internal Policies and Procedures will be updated to reflect the new guidance over the coming months.

14.2 Information Sharing
14.2.1 Information Sharing for Safeguarding Practitioners - Consultation
Consultation ran for 11 weeks. Closed 6th September. New guidance awaited.

14.2.2 Information Commissioners Office – 10 Step Guide to Sharing Information to Safeguard Children
Circulated Trustwide to inform practitioners working with children & young people.

14.3 Neglect Toolkit – updated March 2024
As defined by Working Together 2023, Neglect is complex and is not always easily identifiable. The updated toolkit is designed to support practitioners and managers across the safeguarding partnership to identify neglect, understand children's experiences and support a plan of what to do next for children & families.
The tools can be used throughout the child's journey and at different levels of need.
Do what we say we will do:
The revised toolkit has been circulated Trustwide and will be promoted to staff groups via safeguarding supervision.

14.4 Worcestershire Children First - Guidance for Agencies attending Child Protection (CP) Conference
As professionals attending Conference, staff will be asked to provide a view about whether or not a child is at continued risk of suffering, or is likely to suffer, significant harm. This decision is an important one and must be evidence based, as it justifies compulsory intervention in family life (Working Together 2023).
Do what we say we will do:
Circulated to key staff groups March 2024.

14.5 Case Escalations
The Trust has made 28 escalations for complex cases during 2023/24. Themes:

- Case closure

- Exploitation
- Moving between Local Authorities

14.6 WSCP Newsletters
Circulated Trustwide to keep staff appraised of learning and work of the Worcestershire Safeguarding Children Partnership.

14.7 Audit activity - Quality of referrals to Family Front Door
55 Trust referrals were reviewed during 2023/24. Of these:

- 6 rated as outstanding
- 40 rated as good
- 9 rated as requires improvement – feedback given to respective practitioners

14.8 Multi-Agency Safeguarding Hub (MASH)
The Trust has shared information for 11 MASH requests for children during 2023/24.
Themes:

- Perplexing presentation
- Emotional harm
- Parents moving around a number of local authorities, not coping
- Alcohol abuse

14.9 Worcestershire Safeguarding Children Partnership
14.9.1 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.

14.9.2 Sudden Unexplained Death in Childhood (SUDIC)
The Named Professionals have scoped and submitted reports/attended on behalf of the Trust for 9 SUDIC cases during 2023/24.
Themes:

- Road traffic accident
- Cardiac arrest
- Found unresponsive
- Underlying health conditions

14.10 Rapid Review / Child Safeguarding Practice Review (CSPR)
The Trust has undertaken scoping for 8 rapid reviews during 2023/24.

14.10.1 Child Safeguarding Practice Review (CSPR) status:
Alfie Steele - Child Safeguarding Practice Review
On Friday 26th January 2024, the findings of the multi-agency review following the murder of Alfie Steele were published. Alfie was a nine-year-old boy who died in Droitwich on 18th February 2021. His death was as a result of abuse and cruelty inflicted over a period of time by his mother, Carla Scott and her partner, Dirk Howell. Both have been charged following a court case in 2023. Dirk Howell was convicted of murder and child cruelty and received a lengthy custodial sentence. Carla Scott was convicted of manslaughter and child cruelty and has also received a significant custodial sentence. The multi-agency review (Child Safeguarding Practice Review) highlighted learning points, practice considerations and recommendations, many of which have already been introduced into best practice by the Safeguarding Partnership and its partner agencies.

Do what we say we will do:
The review did not identify any single agency learning for WAHT.
A multi-agency action plan has been developed and will be progressed with oversight and input from the Quality Assurance Procedures & Practice sub-group (QAPP) of the Worcestershire Safeguarding Children Partnership. This will be fed into business as usual for children's safeguarding.

14.10.2 CSPR Hereford –child HN
Child HN was diagnosed with type 1 diabetes in June 2020, when he was 11 years old. This Local Child Safeguarding Practice Review (LCSPR) looked at how professionals work with adolescent children and their families to ensure the effective management of a long-term health condition. The trigger for this review was as a result of Child HN being taken to hospital in an ambulance due to concerns of Diabetic Ketoacidosis (DKA). Fortunately, Child HN recovered from this critical episode. Health professionals described it as a "*near miss*" and, whilst in hospital, his condition became critical with death a real possibility.
Single Agency Learning WAHT
The review highlighted the delay in transfer of diabetic care when HN moved from Worcestershire to Herefordshire. The practitioners involved with the child were involved with the review, have received supervision regarding the learning from the case, and have an agreed process in place going forward should a child move out of area.

14.10.3 SCR 6 – CSPR commissioned, defined areas for review. Audit activity complete. Currently on hold.

14.10.4 CSPR 59 (joint CSPR and DHR)
This case involved the death of a mother and significant injury to a young child as a result of a house fire. In progress.

14.10.5 CSPR 78 (joint CSPR and DHR)
This case involved a murder and attempted murder observed by children in the household. In progress.

14.10.6 Local Child Safeguarding Practice Review (LCSPR): Leicester
This case involved domestic abuse and non-accidental injury. In progress.

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

15.0 Multi agency working

15.1 HM Coroner Prevention of Future Deaths Reports
The ICB provide a summary report of cases with potential learning in order for partner agencies within Worcestershire to ask themselves 'could this happen here?'
Do what we say we will do:
LB Dog bite fatality
On 28th March 2022, LB, a 2 ½ year-old boy, was attacked and mauled by an adult Rottweiler at his home in Worcestershire. The Rottweiler was in a field at the address, to which L had gained access from his garden by climbing a gate and unhitching a security chain. He was taken to Worcestershire Royal Hospital, and then to Birmingham Children's Hospital, where he died from his injuries on the morning of 30th March 2023. The Integrated Safeguarding Team circulated a briefing for staff and developed a Dog Bite Policy on the back of this case when it was initially raised:

- Staff are encouraged to use professional curiosity in regards to dog bite injuries, any animal has the potential to cause harm, not just banned breeds
- Although the death concerns a small child, learning across the 'think family' spectrum needs to be considered. The coroner's concerns were related to unlicensed breeders and the limited alerts if no concerns are raised about the dogs or the breeding.
- Professionals' understanding of the exposure of vulnerable adults and children to potentially dangerous dog related situations needs to be considered in any assessment undertaken. The Trust Integrated Safeguarding Team reviews all dog bites in children & young people as part of the daily WREN report review process.

15.2 Worcestershire Suicide Audit Group

Commenced during 2022/23 the group was set up to look at a real time surveillance system(RTSS). The aim of the RTSS is to seek to reduce deaths by suicide in Worcestershire. The process will help to provide bereavement support to residents of Worcestershire affected by suspected suicides in a timely fashion.

Data and information gathered during this process will be used to identify patterns and trends so that suicide prevention strategies can be adopted and inform public health interventions and strategies. The Head of Safeguarding represents the Trust on this group.

Do what we say we will do:

- Suicide prevention training – leading well for staff health & wellbeing in the NHS promoted Trustwide
- Suicide Prevention – National Strategy 2023-2028 published 11th September 2023 – focus on what more can be done to help stop people contemplating death by suicide, making suicide prevention *'everyone's business'*
- Suicide prevention resources, further training opportunities circulated Trustwide
- Relevant information fed into the Trust health & wellbeing agenda

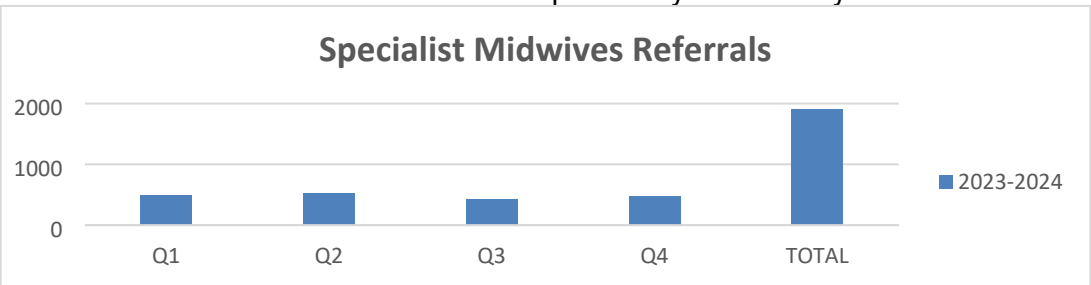
16.0 Midwifery & Maternity

16.1 Multi Agency Safeguarding Hub (MASH)

The Trust has shared information /attended MASH for 38 unborns during 2023/24.

16.2 Specialist Midwifery Referrals:

There have been 1903 referrals to the Specialist Midwives during 2023/24. Numbers of referrals has remained consistent with the previous year's activity.



16.3 Urine Toxicology Screening

On average, in the region of 90 tests per quarter are undertaken. Of these, approximately 1/3 come back with a positive result for illicit substances.

16.4 DASH risk assessment – high risk domestic abuse

The SafeLives Dash risk checklist aim is to help front line practitioners identify high risk cases of domestic abuse, stalking and 'honour'-based violence. The Specialist Midwives on average complete 4-5 of these per quarter to inform decision making /next steps.

16.5 Hospital Independent Domestic Violence Advisor (HIDVA) referrals.
The Specialist Midwives have referred in excess of 30 cases to the HIDVA service during 2023/24. As of 1st April 2024, the referral form will be accessible within Badger Net which will enable midwives to refer directly to HIDVA from Badger Net.

16.6 Perinatal Mental Health Team Referrals
Perinatal mental health (PMH) problems are those which occur during pregnancy or in the first year following the birth of a child. Perinatal mental illness affects up to 27% of new and expectant mums and covers a wide range of conditions. If left untreated, mental health issues can have significant and long-lasting effects on the woman, the child, and the wider family. As of Q4, the dataset includes referrals to perinatal mental health. During Q4, the Specialist Midwives made 83 referrals. Work is underway to review the outcome of referrals to ensure appropriate referrals are being made for those requiring this specialist service.

16.7 Supplementary activity
- Review of the Perinatal Mental Health Report – Strengthening Perinatal Mental Health – a roadmap to the right support at the right time: The Trust has had no maternal deaths due to death by suicide in the last 5 years, a maternal mental health midwife sits within the team and delivers trauma informed care. Further work will be led by Midwifery & Maternity.
- NHSE 3yr Delivery Plan –Maternity & Neonatal services – the plan has been reviewed by the Integrated Safeguarding Committee and Named Midwife who will work with the Division to develop the key concepts of making services safer, equitable, supporting the workforce, developing a culture of safety and contributing to the national ambition in this regard.

16.8 Quality Assurance Visit (QAV) -18th August 2023
A team of 14 reviewers undertook a QAV to antenatal / triage, Delivery suite, Meadow Birth Centre and Postnatal ward. Staff spoken to by the Named Midwife had a good level of safeguarding knowledge in response to the questions posed. Areas for improvement identified were in relation to:
- Baby abduction drills
- Awareness of the Levels of Need Guidance
- Antenatal clinic - leadership and oversight re safeguarding training, referral etc

16.9 CQC Inspection Midwifery & Maternity – 11th October 2023 (Published 29th November 2023)
The CQC undertook a short notice announced inspection of the maternity service at Worcestershire Royal Hospital looking at safe and well led, as part of their national maternity inspection programme. As a result of this inspection, the overall rating improved to being rated as 'good'.
Mandatory training compliance remained an area of concern and therefore a *'must do'*: ***The service must ensure staff are up to date with safeguarding training. Regulation 12(1)(2)(c)***.
In respect to safeguarding practice, the regulator noted:
'Not all staff had completed training on how to recognise and report abuse. However, staff understood how to protect women and birthing people from abuse and the service worked well with other agencies to do so'.

16.10 Child Safeguarding Practice Review Panel – Bruising in non-mobile babies – risks, concerns, serious harm

The above seminar was promoted across key staff groups to raise awareness. Links to previous work undertaken in this regard.

16.11 ICON (Babies cry; you can cope) – Worcestershire 'Keep me Safe' Strategy
Two touch points for Trust staff are now linked to the Badger Net maternity system:

- Postnatal handover on discharge from post-natal ward to community
- From community to Public Health / Health Visitor.

Ongoing training and work associated with ICON will be led by the 2 Public Health Midwives who are also looking to identify ICON champions across the organisation.

17.0 Safeguarding Adults

17.1 Multi-Agency Safeguarding Hub(MASH)
The Trust has shared information /attended as required 472 adult MASH requests during 2023/24. This is a significant rise on 2022/23 activity (n202):
Q1 – 46 requests
Q2 – 60 requests ↑
Q3 – 123 requests ↑
Q4 – 243 requests ↑
This significant increase during Q3 and Q4 is as a direct result of the new safeguarding model detailed below as of October 2023.

17.2 Adult Social Care Safeguarding Model Changes as of October 2023
Adult Social Care implemented a new model of safeguarding on 9th October 2023, with phase 2 rolled out on 8th January 2024. The safeguarding team has been split into two teams with separate functions:

- The Safeguarding Early Response and Triage Team (SERTT) are responsible for gathering information to determine whether the S42(1) critieria are met or whether alternative actions, including an 'other' enquiry regarding risk to others is required. SERTT assess the level of risk involved in the enquiry and will undertake low level enquiries.
- The Safeguarding Enquiry Team (SET) will manage the modertate, high and extreme level enquiries. They will identify an Enquiry Officer with the appropriate skills and knowledge, lead on enquiry planning, quality assure the completed enquiry and lead on the development of the safeguarding plan. The Enquiry Officer for moderate, high and extreme will be allocated to the professional with the most appropriate skills and knowledge.

17.3 Cases progressing to S42 Enquiry
Themes in relation to:

- Self-neglect
- Care omissions
- Tissue Viability
- Discharge planning

17.4 Advice and support logs - Adults
The Integrated Safeguarding team have provided advice & support for 84 cases during Q4. This will become a standard reporting item due to the volume being received.

17.5 Worcestershire Safeguarding Adult Board (WSAB)
17.5.1 Rapid Review (RR) and Safeguarding Adult Reviews(SAR)
As can be seen from the below, there has continued to be a significant amount of work in relation to the rapid review and safeguarding adult review process during 2023/24.

The Trust contributes to this work as a partner agency of the Worcestershire Safeguarding Adults Board and associated sub groups.

	Type Title of review	Status	Outcome	Single agency actions identified
SAR 53	SAR	Complete	**Published July 2023 "Ruth"**	N/A
RR SAR 66	RR SAR	Report out for comment		
RR SAR 67	RR SAR	Complete	**Published Jan 2024 "Joseph"**	Assurance submitted re availability of shared care record
Extended SAR 68	Extended SAR	Report out for comment		
Extended SAR 70	Extended SAR	Report in progress		
Case 61		Rapid review	Not for SAR	
Case 69		Rapid review	Not for SAR – learning to be fed back to Taunton	
Case 79		Rapid review	Not for SAR –single agency actions	N/A
Case 71			**L Brief published Nov 2023 "Adult M"**	N/A
Case 74		Rapid review	Not for SAR	N/A
Discretionary SAR Case 76	Discretionary SAR	Rapid review	In progress	
SAR Case 72	SAR	Rapid review	In progress	
Case 81		Rapid review	Not for SAR – single agency actions	
Case 77		Rapid review	Not for SAR – single agency actions	

17.5.2 SAR Learning

Learning from SAR and rapid review is a standing agenda item on the Integrated Safeguarding Committee agenda. Published cases /learning presented during 2023/24 included: Dorothy, BS, Ruth, Joseph, Peter, John, Adult M and Dee.

17.5.3 Single Agency Action Plans /Assurance

The Trust provided single agency assurance to the WSAB in relation to SAR 'Peter':

Recommendation: Worcestershire Acute Hospitals NHS Trust should ensure that staff exercise appropriate professional curiosity when persons present with self-harm injuries and that consideration is given to raising a safeguarding concern.

Do what we say we will do:

A Trustwide briefing was circulated via the Trust Worcestershire Weekly on 27th February 2024, to ensure all staff are appraised of the key learning from this SAR. In addition, the learning was also shared via the Urgent and Emergency Care Governance meeting held on the 6th March 2024 to ensure the key messages are shared with frontline /front door practitioners.

17.6 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 Awaiting final approval from WSAB

17.7 Domestic Homicide Reviews
The Trust has undertaken scoping and contributed to 5 DHR during 2023/24:

- 2 cases were for out of area DHR (Herefordshire & Windsor)
- 2 cases did not meet threshold for DHR
- 1 case is a joint DHR and CSPR currently in progress.

17.8 Worcestershire Safeguarding Adult Board(WSAB) - Statutory Stakeholders Annual Objectives
The Trust provided its annual assurance / contribution to the WSAB annual objectives for 2023/24:

- Further development of the SAR and Rapid review process
- Further development and embedding of the Complex Adult Risk Management (CARM) framework
- Implementation of the Exploitation strategy

17.9 WSAB Assurance – Management of Waiting Lists
At the WSAB held September 2023, organisations were asked to provide the Board with an update on waiting times and actions being taken to address the backlog. An assurance report was provided in regards to Elective and Cancer recovery plans and WSAB were advised that performance in these top priority areas is overseen internally via the Integrated Performance Report.

17.10 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

Campaign materials in relation to the following have been promoted during 2023/24:

- National Knife Crime Awareness week – 15-21 May 2023
- Stop Loan Sharks week – 24-31 October 2023
- Suicide Prevention resources and training availability
- Safeguarding Adults week – 21-27th November
- White Ribbon Campaign – November 2023
- Illegal Money Lending Newsletter –winter 2023
- ICON week – 25th-29th September 2023

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

19.0 Further 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 Regional Safeguarding Assurance Tool – Adults and Children (previously S11)
The Trust completed its return to the regional audit tool during late December 2023. A number of elements were rated good with some areas identified for further improvement:

- Internal audit and use of Policies & Procedures
- Clearly Communicated L&D plan – links to training compliance
- Supervision – all staff and volunteers

An action plan is currently in development.
The current plan is for the audit to be repeated bi annually. Assurance will be sought by the Adult Board and Worcestershire Safeguarding Children Partnership via deep dive into agency responses for specific themes.

19.2 Quality Assurance Visits - Alexandra Hospital
The Integrated Safeguarding Team have supported QAV visits to MSSU and ward 17 as part of the assurance process during 2023/24.

19.3 Safeguarding children, young people and adults at risk in the NHS - Safeguarding Accountability & Assurance Framework (SAAF)
Reviewed and updated August 2023 in respect of the HR DBS referral and oversight process.

19.4 Child Protection Information Sharing(CP-IS) Dip Sample
A dip sample was undertaken to review the weekly report from Worcestershire Children First with the alert for child protection plan (CPP) held in CP-IS. The findings from this dip sample provided reassurance that Trust staff are checking CP-IS as part of their lateral checks.

19.5 Multi agency audit – Child Protection Plans
Following the National Review Panel report 'Child Protection in England' following the deaths of Arthur Labinjo-Hughes and Star Hobson, 6 cases within Worcestershire were reviewed. The Named Doctor contributed to the audit and disseminated audit findings to peers. Key learning:

- Strategy discussions should take place before any request for a CP medical.

19.6 Multi-agency audit – Closing the Learning Loop – Domestic abuse
Undertaken during August and assurance provided to QAPP sub group.
Key learning:

- The CP-IS system will contain Child in Need information (currently only has child protection and looked after children)

19.7 GetSafe Operational Audits
Deep dive cases were reviewed in June, October and March. All were rated as 'good'.

19.8 CSPR Group - Strategy Discussions not attended by 'Health'
Joint audit undertaken with H&WHCT during October. Key learning:

- Not all GP practices in receipt of strategy notification
- All agencies to follow up minutes if not received

Level of Assurance: Level 6
What needs to happen: audit schedule completion in accordance with Audit Schedule – delays due to workload and capacity due to long term sickness.

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.
Themes in relation to:

- Sexual abuse –current / historical
- Violence & aggression, including domestic abuse
- Substance misuse

- Alcohol misuse
- Non engagement with statutory safeguarding procedures

20.1 Managing Allegations –People in a Position of Trust – ICB Annual Assurance Exercise – October 2023
An annual assurance exercise was undertaken with the Deputy Designated Safeguarding Nurse, Herefordshire & Worcestershire NHS on 13th October into 5 cases. A high level of assurance was offered in respect of our systems and processes. Level 7 assurance agreed.

20.2 Managing Allegations Policy & Procedure
Approved May 2023. Now published.

20.3 Volunteer Action Plan – Saville & Lampard – DBS Checks & attendance at Trust Induction – Annual Assurance
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.
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.
Do what we say we will do:
Annual assurance update was provided to the Integrated Safeguarding Committee on the 30th May 2023. The Head of Patient Experience offered assurance that the necessary standards have been maintained. The Head of Patient, Carer and Public Engagement continues to develop the work undertaken in order to sustain the level of assurance in regard to the safeguarding of children, young people and adults who access services from the Trust. A substantive staffing team to deliver volunteering at the Trust will ensure that capacity is available to maintain robust systems with an up to date database to support an increase in volunteer numbers post COVID.

20.4 Chaperone Training
Chaperone training continues to be offered to staff via ESR.

20.4.1 Chaperone Audit – Children & Young People
Undertaken by Women & Children Division. Review of 35 patients notes from specialities seen within the Children's Clinic at KTC, WRH, Alex.
2 intimate examinations carried out were chaperoned and documented. The name and designation of the chaperone was documented.

20.5 Local Authority Designated Officer (LADO) Managing Allegation Training
Training availability promoted internally.

20.6 Lucy Letby – Murder Conviction – could this happen here?
Lucy Letby is a former neonatal nurse who murdered 7 infants and attempted to murder 6 others between June 2015 and June 2016. Letby was the focus of suspicion following a high number of deaths at the Countess of Chester Hospital neonatal intensive care unit.
She was charged in November 2020 and on 21 August 2023, Letby was sentenced to life imprisonment, with a whole life order. On the 18th August 2023, NHSE wrote to all Integrated Care Boards, NHS Trusts and Primary Care Networks and requested that all must urgently ensure:

- All staff have easy access to information on how to speak up.

- Relevant departments, such as Human Resources, and Freedom to Speak Up Guardians are aware of the national Speaking Up Support Scheme and actively refer individuals to the scheme.
- Approaches or mechanisms are put in place to support those members of staff who may have cultural barriers to speaking up or who are in lower paid roles and may be less confident to do so, and also those who work unsociable hours and may not always be aware of or have access to the policy or processes supporting speaking up. Methods for communicating with staff to build healthy and supporting cultures where everyone feels safe to speak up should also be put in place.
- Boards seek assurance that staff can speak up with confidence and whistle-blowers are treated well.
- Boards are regularly reporting, reviewing and acting upon available data

Do what we say we will do:

The Trust asked itself the question – could this happen here?
A paper was submitted to respective Governance Committees presented by the Chief Nursing Officer outlining the assurance in place. This report was presented to QGC August 2023. The paper outlined the good governance, implementation and oversight at Trust Board level and the assurance that the five points outlined in the letter from NHSE had been urgently reviewed.

Next Steps: Thirlwall Enquiry – launched 22nd November 2023

As a result of the Letby case, a public enquiry is now underway. Any implications /actions required, will be reviewed in light of any findings. A preliminary hearing is scheduled for May 2024.

20.7 DBS Workshops

Circulated to key professionals to support HR and recruitment practice.

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 2023/24 includes:

- Deprivation of Liberty Safeguards – reviewed and updated, awaiting approval at ISAG
- Self-Harm - reviewed and updated, awaiting approval at ISAG
- Managing Allegations – approved and published May 2023.
- Sexual Safety Charter – Trust Leads identified and work undertaken with HR to progress implementation – will be linked to the Trust Behavioural Charter.
- Restrictive Interventions – updated and approved, published.
- Teenage Pregnancy Guideline – updated and approved June 2023
- Alcohol abuse in Pregnancy - new guideline May 2023 –led by Public Health Midwife

Level of Assurance: Level 5

What needs to happen: All Policies reviewed in accordance with Policy revision schedule.

22.0 Priorities / Forward Plan 2024/25

- Regulatory - Safeguarding mandatory training compliance -90% Trust requirement –all levels adults & children
- 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
- Embed system changes as a result of revised guidance / legislation e.g. Working Together to Safeguard Children updated 2023

Conclusion

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

The Trust Board is asked to receive, for assurance, the Safeguarding Annual Report 2023/24 and the forward plan for 2024/25.

Appendices

RAG rating	ACTIONS	OUTCOMES
Level 7	Comprehensive actions identified and agreed upon to address specific performance concerns AND recognition of systemic causes/reasons for performance variation.	Evidence of delivery of the majority or all of the agreed actions, with clear evidence of the achievement of desired outcomes over a defined period of time ie 3 months.
Level 6	Comprehensive actions identified and agreed upon to address specific performance concerns AND recognition of systemic causes/reasons for performance variation.	Evidence of delivery of the majority or all of the agreed actions, with clear evidence of the achievement of desired outcomes.
Level 5	Comprehensive actions identified and agreed upon to address specific performance concerns AND recognition of systemic causes/reasons for performance variation.	Evidence of delivery of the majority or all of the agreed actions, with little or no evidence of the achievement of desired outcomes.
Level 4	Comprehensive actions identified and agreed upon to address specific performance concerns AND recognition of systemic causes/reasons for performance variation.	Evidence of a number of agreed actions being delivered, with little or no evidence of the achievement of desired outcomes.
Level 3	Comprehensive actions identified and agreed upon to address specific performance concerns AND recognition of systemic causes/reasons for performance variation.	Some measurable impact evident from actions initially taken AND an emerging clarity of outcomes sought to determine sustainability, with agreed measures to evidence improvement.
Level 2	Comprehensive actions identified and agreed upon to address specific performance concerns.	Some measurable impact evident from actions initially taken.
Level 1	Initial actions agreed upon, these focused upon directly addressing specific performance concerns.	Outcomes sought being defined. No improvements yet evident.
Level 0	Emerging actions not yet agreed with all relevant parties.	No improvements evident.

Gillian Hooper (2019)

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Worcestershire Acute Hospitals NHS Trust

Minutes for Quality Governance Committee

Thursday 25th April 2024 at 10.00 am – 1.00 pm
Via MS Teams

			Attendance Status
Chair	Julie Moore	Non-Executive Director	**Apols**
Required Attendees	Sarah Shingler	Chief Nursing Officer	√
	Julie Booth	Deputy Director IPC	√
	Rachel Dunne	Deputy Chief Nursing Officer - ICB	√
	Justine Jeffery	Director of Midwifery	√
	Baylon Kamalarajan	Consultant Paediatrician and POSCU Lead	**Apols**
	Helen Lancaster	Chief Operating Officer	
	Simon Murphy	Non-Executive Director	√
	Vikki Lewis	Chief Digital officer	√
	Michelle Lynch	Associate Non-Executive Director	√
	Edwin Mitchell	Associate Divisional Director - SCSD	**Apols**
	Richard Oosterom	Associate Non-Executive Director	√
	Nicholas Purser	Surgery Governance Lead	√
	Stephen Collman	Managing Director	
	Alison Robinson	Deputy Chief Nursing Officer	√
	Rosemary Smart	Public Patient Forum	√
	Susan Smith	Deputy Chief Nursing Officer	
	Sue Sinclair	Associate Non-Executive Director (Chair)	√
	Jules Walton	Acting CMO – Quality, Governance & Professional Standards	√
	Julian Berlet	Acting CMO	**Apols**
	Chris Byrne	Healthwatch	√
	Erica Hermon	Company Secretary	√
Attending	Stuart Cooper	EPR Programme Director	√
	Gerry Bolger	Clinical Safety Officer	√
	Dr Claire Sutherland	Consultant Radiologist/Breast Screening Lead	√

Item	Title
QGC/24/1	**Welcome and Apologies for Absence**
	Dame Julie welcomed all present at the meeting.
QGC/24/2	**Declarations of Interest**
	There were no new declarations of interest raised.
QGC/24/3	**Minutes of the last meeting**

	The minutes of the meeting held on the 28th March 2024 were confirmed as a factual representation of the meeting and approved.
QGC/24/4	**Action Schedule**
	Progress on the outstanding actions were reviewed and updates received.
QGC/24/5	**Escalations from Chief Medical Officer and Nursing Officer for items outside of standard report / not on the agenda**
	Ms Shingler informed that an issue with drafts from the windows within the delivery suite was discovered during a Patient Safety visit. EQUANS have replaced the handles on the windows but this has not solved the issue. A number of issues with the windows had been discovered with Estates and urgent actions escalated to EQUANS regarding window seals. Ms Walton advised that following a Coroner's inquest yesterday, the Trust have received a verdict that contained neglect. The patent received no nutrition whilst in our care for 11 days. The incident occurred in August last year. A regulation 28 had been prevented due to the work that has already been ongoing and a robust action plan is in place. Nutrition has been listed as a quality priority for 2024/25. **Sepsis** A lot of work has been ongoing in relation to sepsis. There was currently no live module but testing was underway for imminent launch. The third round of testing was underway with clinicians. Paper audits were continuing. Ms Walton had oversight on a monthly basis and the process is adequate. **High-Risk Breast Screening** Following escalation at the last meeting, a report was included with an updated position. Ms Sutherland provided a background of the Breast Screening department. There was a plan in place to see all patients by the 5th June deadline. Harm reviews will be conducted to be completed by the beginning of July. Guidance will be provided at the beginning of May. Ms Sinclair queried the numbers. Ms Sunderland replied that 29 women in total required screening. Ms Sinclair queried whether the team were satisfied that they would be able to contact all of the patients. Ms Sunderland replied that there were 6 none responders. The Trust had been given set instructions to contact the patients. 3 letters have been sent out. Patients who have not responded will not be removed from the register and will be contacted again next year. There was confidence that the contact details are correct. Mr Oosterom asked how this had happened and how it could be prevented in future. Ms Sunderland replied that there was uncertainty around how it occurred, but it is a national issue. The issue had been identified by an audit in Manchester who hold the database for high dose radiotherapy. A robust system was implemented in 2015 but prior to that was individualised by Trusts. These are historic patients and this is a very small number. Mr Purser added that the process is now formalised and properly funded with a good process now in place.
QGC/24/6	**Best Services for Local People**
QGC/24/6.1	**Perinatal Safety Report**
	Ms Jeffery presented the report and highlighted the following key points: • Booking by 12+6 has decreased slightly, due to some variations in teams. • Perinatal mortality remains lower than the national average.

	• 1 stillbirth was reported in March. • No new cases have been reported to MNSI. • Training requirements expected to be met in Year 6 scheme. • Medical staffing in obstetrics middle grades and juniors is challenged. Mitigations are in place. • Neonatal nurse metrics are improving. • LMNS visited the Alex site and reported inconsistencies of information on boards, quiet room facilities and additional bereavement training. • Complaints had seen a theme around delays in induction and information. • A reduction in induction of labour pathway had been reported and was likely to halve this month. • Various actions and documents are required to report against COSMOS. Focus was on the single delivery plan. A quarterly report will be embedded within this report going forward. Mr Oosterom queried the vacancy rate on MCAs. Ms Jeffrey replied that the Trust have recruited 11.5wte but not had yet started. The number of vacancies would reduce again in April. *Ms Lewis left the meeting.*
	Resolved that: The report was noted for assurance.
	Perinatal Incident Report
QGC/24/6.2	Ms Jeffery advised that 3 moderate harm incidents had been reported. Consultant oversight of C section lists required more work. 1 stillbirth had been reported. Additional appointments or movement of appointments was being discussed. The Trust is an outlier in completing actions. There is weekly focus on actions and teams were working to close down open actions.
	Resolved that: The report was noted for assurance.
QGC/24/6.3	**Midwifery Safe Staffing Report**
	Ms Jeffery updated that turnover, sickness and vacancies had reduced. A retention midwife was in post and doing great work with the team. A slight turnover increase was shown due to retire and return. HR were providing support with sickness. Safe staffing was achieved but there were 30 occasions to redeploy staff to meet acuity. Continuity staff had been used 6 times. Specialist ward manager midwives had been required on 5 occasions. Vacancies were being advertised. 14 posts were required and there was confidence that they will be filled. 2 specialist midwife posts to be advertised.
	Resolved that: The report was noted for assurance.
QGC/24/6.4	**Nurse Staffing Report**
Wells Jo 06/06/2024 11:05:51	Ms Shingler reported that the vacancy rate for RN is down to 3.19% and further improvements expected in April. Healthcare Support Worker vacancies were improving month on month. Retention is improving. 89 RNs and 33 HSWs are on maternity leave. This does place pressure on services to maintain safety. As we don't currently over recruit to cover maternity, a paper was being drafted for FPE to review as agency were being used. Thornberry had been used throughout March to manage and support 2 Tier 4 children awaiting mental health admission. No harms associated with staffing incidents had been reported across the Trust.

	Safer Nursing Tool and establishment review is underway. Mr Oosterom supported the proposal to over recruit. Ms Shingler advised that sickness and maternity overheads were to be planned into recruitment. Ms Jeffrey cautioned comparisons with model hospitals benchmarking data as they are often not consistent.
	Resolved that: The report was noted for assurance.
QGC/24/7	**Best Experience of care and best outcomes for patients**
	Experience
QGC/24/7.1	**Integrated Performance Report**
	Ms Shingler presented the report which was taken as read. Mr Oosterom observed that the 65 week target was not being met and would liaise with Ms Lancaster directly. Ms Smart referred to complaints and asked what measures were in place to monitor similar issues reoccurring. Ms Shingler replied that a quarterly report is presented to the Committee. Teams are focusing more on the learning and key themes, which remain to be communications and attitude of staff, overcrowding in ED and boarding on wards. Ms Walton advised that work was underway with divisional teams. Ms Booth advised that there needs to be a stronger focus on c.diff. There was a significant number of patients with c.diff based on antimicrobial prescribing. There had been a national rise in cases of MSSA. Management of PVD's are under review along with practice. Ms Shingler advised that there were issues reported with cleaning and high dust. It remains a significant problem and there was little traction on nurse responsibilities. Mr Purser stated that boarding is an issue as the protections aren't in place. Mr Byrne referred to feedback from patients and asked how it linked to the Big Quality Conversation and getting feedback in a meaningful way. Ms Robinson replied that more responses from the Friends & Family Test would've been preferable. A new inpatient survey had been introduced and teams were trying to obtain 50 surveys per ward per month to get a real time picture. Responses would be triangulated and reviewed at the Fundamentals of Care Committee. There had been a decrease in F&FT compliance since introducing the Inpatient survey. Ms Sinclair noted improvement in falls and queried Neck of Femur progress. Ms Walton replied that meetings are in place to review. Ms Sinclair referred to patients that were not medically fit for theatre and advised that she would expect the number to be fewer than what it is. Ms Walton replied that the lead is attending a meeting next week and reviewing what factually happens with patients and what needs to be done to make improvements. Ms Sinclair encouraged linking to appraisals and job plan data.
	Resolved that: The report was noted for assurance.
QGC/24/7.2	**MRSA**
	Ms Booth updated that there was an extraordinary number of MRSA cases. 4 are contaminants. Aseptic touch was highlighted as an issue. Positive testing equal to or greater than 3 days is linked to hospital acquired infection.

	Managing discharge to nursing home elements are under review. There was no theme in relation to blood culture contaminants. Dust issues have been escalated to Estates and are addressing through ISS. The Trust is compliant from a cleaning standard perspective but not from what is being seen.
	Resolved that: The report was noted for assurance.
QGC/24/7.3	**Big Quality Conversation**
	Ms Shingler informed that the Big Quality Conversation is a local initiative and is an annual survey designed for patients and carers. The latest results showed there was positive experience around privacy, appointment changes, feeling safe and cleanliness. Patients feel welcomed and staff are friendly. These findings, however, don't correlate with complaints coming in and the significant increase in complaints. Ms Shingler advised that there is some learning to take through the Fundamentals of Care Committee but there is general positivity. Mr Oosterom stated that he was unable to judge if the results were good as there was little to compare it to and questioned the scope of the patients who took part. Ms Robinson replied that a report was attached which provided further information in relation to diversity and monitoring. Over 900 patients responded. The majority of responses were from older patients but steps had been made to reach out to more vulnerable patients. Mr Murphy encouraged engagement with the voluntary community sector and REACH - Research, Engagement and Community Health run by Worcestershire VCSE Alliance. Ms Shingler advised that more work was required in relation to inequalities. Each ward area would be undertaking 50 inpatient surveys per month and there was particular focus in areas where more work was required previously. Over 1000 surveys were completed across the wards in March.
	Resolved that: The report was noted for assurance.
QGC/24/7.4	**Learning Disabilities**
	Ms Shingler informed that improving the Learning Disability service was a quality priority for 2023/24 and is being carried over into 2024/25. An LD Steering Group had been set up, met for the first time recently and was now getting established. An action plan is in place to focus on specific areas. There had been good engagement from divisions. A number of issues were being seen around patient safety incidents. It is suggested that the Trust does not have enough LD liaison support for its size. The steering group will be looking at reviewing what workforce is required to deliver the LD improvement plan. Quarterly updates would be provided to the Committee moving forward. Ms Smart was pleased to see the report but noted that there wasn't enough liaison nurses and expressed concerns about weekends and how patients are looked after. Ms Shingler replied that there is a gap. Critical incidents currently have occurred on bank holidays or weekends. Gaps are being reviewed which would come at a cost but they are required in order to provide adequate support.
	Resolved that: The report was noted for assurance.

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QGC/24/7.5	**EPR Deployment & Implementation**
	Mr Cooper and Mr Bolger joined the meeting. Slides were shared relating to the EPR clinical safety approach and optimisations. The process of continuous improvement is system design, human factors etc. Ms Sinclair was pleased to hear of the safety progress being made. Mr Murphy applauded the use of #callme.
	Resolved that: The updated was noted.
QGC/24/7.6	**Medical Devices**
	Ms Walton advised that the paper could be taken as read. The following key points were highlighted: The Committee was cancelled on one occasion. Training in the use of medical devices could not be assured. There are some vacancies and single point of failure within services. Ms Smart observed that there was only one member of staff at point of care and asked what the process would be if they were off sick. Ms Walton replied that such issues required a resolve. A further report would be provided in 3/4 months time. *Ms Lancaster joined the meeting.*
	Resolved that: The report was noted for assurance.
QGC/24/7.7	**GIRFT**
	Ms Lancaster presented the report to note the progress being made within the programme. The alignment of opportunities to meet ambitions across the organisation should be a huge focus for this year. Ms Sinclair queried whether theatre utilisation is measured. Ms Lancaster replied that it was an area of focus moving forward. Mr Oosterom observed overall good adoption of GIRFT and queried whether Ophthalmology was an exception. Ms Lancaster informed that the biggest challenge is uncertainty given the amount of other providers in the system. There are some challenges across the system around the future of the service and whether it will be provided in the volumes that it is within an acute setting. Ms Walton added that the clinical elements of GIRFT are reviewed at the Clinical Effectiveness meeting.
	Resolved that: The report was noted for assurance.
QGC/24/7.8	**CQUIN**
	Ms Walton presented the report, informing that of the 8 CQUINS assigned to the Acute for 2023/24, 4 have been achieved. It was anticipated that 6 may be achieved. Frailty and documentation of pressure ulcers risk had not achieved. Teams were sighted on the reasoning as to why they have not achieved.

	5 of the CQUINS were agreed to be incentivised and the Trust will have achieved 3 of the 5. It remains unclear whether there will a financial penalty of all 5 incentivised targets are not met. Ms Dunne clarified that it was unlikely that front loaded funding would be sought repayment. Ms Walton advised that the 2024/25 national programme had been paused but it was likely that local measures will be put in place.
	Resolved that: The report was noted for assurance.
QGC/24/7.9	**Health & Safety Report**
	Ms Lancaster presented the report which provided a summary of the information presented and discussed at the H&S Committee, which was taken as read. Ms Sinclair welcomed the expanded report and noted the common theme of aggression faced by staff. Ms Lancaster stated that cards are more of a symbol as patients still need to be seen in an emergency. Mr Oosterom advised that fire safety has been a long standing concern and asked if any external audits were undertaken. If they were not, he recommended that this should be explored. Ms Lancaster agreed, from a fire safety point of view. Mr Purser informed that there is an external company who attend to compete fire safety reviews.
	Resolved that: The report was noted for assurance.
QGC/24/7.10	**Clinical Effectiveness Group Update**
	Ms Walton informed that the Clinical Effectiveness Group had met for first time 2 weeks ago. Its purpose is to bring together the clinical body MDT to discuss the effectiveness programme.
	Resolved that: The report was noted.
QGC/24/7.10.1	**Clinical Effectiveness Group ToR**
	The incorrect Terms of Reference were shared. The ToR would be shared outside of the meeting.
	Resolved that: The ToRs would be shared outside of the meeting.
QGC/24/7.10.2	**Clinical Audit Forward Plan**
	Ms Walton reported that there had been difficulties with compliance. Steps had been taken to try to simplify the expectations in regard to audits. Mandatory audits had been split into 2 tiers. Learning would be taken from them and the results of the national and mandated audits will be reviewed by the group.
	Resolved that: The report was noted for assurance.
QGC/24/8	**Governance**
QGC/24/8.1	**Risks**
	Ms Hermon informed that risks should be presented for monitoring by the Committee. Given the new risk policy and TOR, Risk should be a standing agenda item for oversight and monitoring.
QGC/24/9	**Committee Escalations**
	Trust Board
	Escalations: Ongoing issues with EPMA & Project Board and making decisions. Labour ward windows.

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QGC/24/9.1	**Other Committees**
	No further items for discussion.
QGC/24/10	**Any Other business**
QGC/24/11	**Reflections on the meeting**
	Ms Sinclair noted the progress of good work being made. Thanks were extended the teams for their efforts. The LD initiative was fantastic. Ms Sinclair was pleased to her of the positive reporting in relation to staffing and retention. There had been an increase in development of divisional ownership.
QGC/24/12	**Close**
	The meeting closed at 12.30.

Enc A

AUDIT AND ASSURANCE COMMITTEE

Minutes of the Meeting held on Thursday 14 March 2024 at 9.00am held via MS Teams

PRESENT:

CHAIR:	Colin Horwath	Non-Executive Director
MEMBERS:	Simon Murphy	Non-Executive Director
	Karen Martin	Non-Executive Director
	Tony Bramley	Non-Executive Director

IN ATTENDANCE:

Erica Hermon	Company Secretary
Neil Cook	Chief Finance Officer
Lynne Walden	Associate Director of Finance (Financial Services & Coding)
Emma Masters	Internal Audit
Paul Westwood	Counter Fraud
Zoe Thomas	External Audit
Kristina Woodward	Internal Audit
Andrew Smith	External Audit
Liz Faulkner	Deputy Chief People Officer (for item 123/23)
Sanjeev Narwal	Director of Procurement (for item 125/23)
Tania Carruthers	Director of Pharmacy (for item 126/23)

APOLOGIES:

113/23 **WELCOME AND APOLOGIES FOR ABSENCE** **ACTION**

Mr Horwath welcomed all to the meeting. There were no further items of business identified.

114/23 **DECLARATIONS OF INTEREST**

There were no new declarations of interest. Declarations are available on the Trust's website.

115/23 **MINUTES OF MEETING HELD ON 13 FEBRUARY 2024**

The minutes of the meeting held on 13th February 2024 were approved.

RESOLVED THAT: The minutes of the meeting held on 13 February 2024 were approved.

116/23 **Matters Arising and Action Schedule**

The action schedule was reviewed and updates were noted.

Internal Audit

117/23 **Internal Audit Progress Update**

Ms Masters updated that the Theatre Governance action plan had been shared and 2 draft reports had been issued; High Earners and Financial Controls & Payroll.

Mr Horwath was assured that the Theatre Governance report was being taken seriously. Ms Masters added that there was good evidence of actions which was a positive step going forward.

In regard to next year's plan, the team had met with Executives and had received input from Non-Executive Directors. The list had been prioritised and returned, including the mandated reviews.

Mr Murphy asked when the high earners locum response was expected. Ms Masters replied that it was expected by May. Work had been shared and discussed with the Chief Medical Officers. There had been a slight delay due to the change of CMO and job planning. The level of assurance given was agreed and a new action plan would be created.

Mr Horwath asked when a draft plan would be available. Ms Masters replied that it would be shared in May but could be shared beforehand if required.

There were no overdue recommendations in relation to action tracking.

Mr Horwath observed good progress being made but queried whether the requirements would be met for next year. Ms Masters replied that items have been closing down when due. Response performance did improve during the second part of the year so there was reasonable confidence.

Ms Masters added that the appendices outline progress and KPIs.

Mr Bramley referred to the appendices and noted that there were some low rates. Ms Masters replied that they were lower than expected but there had been some issues around the complexities which were taking longer to work through, in addition, the change in CMO.

Head of Internal Audit Opinion Stage 2
The main areas of concern were the out of date Risk Management Strategy and the BAF not being presented at Board. These elements had now been actioned. Areas such as the Corporate Risk Register will now be actioned.
3 out of 4 will be closed.

Mr Murphy encouraging highlighting PFI as an issue to be aware of. Ms Masters informed that it is a top priority and will be on next year's plan.

Ms Hermon informed that a corporate risk division was being created.

RESOLVED THAT: The reports were noted.

Counter Fraud

118/23 **Counter Fraud Progress Report**
Mr Westwood presented the report and updated that there had been no new incidents reported. 2 long standing cases were ongoing. One case was being presented at the Crown Court today for the first hearing.

Counter Fraud had a slot on Trust Induction starting in April. A training and awareness package had been created and available on the website.

Payroll matches on the National Fraud Initiative was underway along with working with finance on duplicate payments.

Ms Hermon informed that fraud risks will be hosted on Datix to form part of the risk register. The Declaration of Interest process had started and will be published online including those who have not completed declarations.

Mr Bramley queried whether it is a concern that there had been no new reports and questioned whether anti-fraud was being promoted sufficiently. Mr Westwood replied that there had been a number of referrals received over the year but there had not been any since the last Committee, last month. Mr Westwood was satisfied with the number of referrals that were being received.
Ms Walden suggested linking counter fraud to Standing Orders.

Counter Fraud Workplan
The risk assessment had been reviewed and updated. Areas of proactive work were outlined. Exercises will ensure that the standards are met for 24/25.

Ms Hermon observed that outside employment is a specific question on the Declarations of Interest and would link in with Mr Westwood on that element. **Action.**

Mr Horwath queried if there were any gaps or resource limitations. Mr Westwood replied that if more resource was available, he would spend more time raising awareness and walking the site.

RESOLVED THAT:

- **The report was noted for assurance.**
- **The Counter Fraud Workplan was approved.**

External Audit

119/23 **Audit Plan**

Mr Smith introduced the plan, advising that the main headlines were detailed on page 7. Significant risks were outlined as:

- Management override of controls
- Valuation of property, plant and equipment
- Revenue.

Materiality was determined as £8.5m.
Weakness with Value for Money was identified last year. Progress will be followed up in those areas.
It was noted that there had been a code change which required VFM to be complete by the time the accounts opinion is issued. A report would be presented in June.

Planning work is well progressed and interim testing work had commenced.
The draft accounts were due to arrive by the end of April.

Fees for this year are £124k. They were £126k last year.

Mr Cook advised that the challenge has always been VFM opinion and inequity when looking at end results and significantly challenged systems. Mr Cook asked if anything had changed in terms of the approach for this year. Mr Smith replied that the issue has been discussed. There is a process around moderation and the team were satisfied that they are consistent. Judgements are based upon evidence and consistency issues have been raised.

Mr Bramley referred to the risk identified in terms of controls and efficiency and observed that the management response sounded weak. Mr Cook informed that more training development had been put in place. Steps were being taken seeking to constantly improve the quality of working papers and year end audit. Ms Walden updated that there had been significant training undertaken with the finance team, which included creating a guide on working papers. There is more assurance this year regarding accuracy.

Mr Horwath asked if there were any significant risks that the Trust needed to be concerned about. Mr Smith replied that the Trust was similar to most provider Trusts and that there was nothing specific to this Trust of concern.

Committee approved the fees of the audit for the coming year.

Risk Assessment
Mr Smith updated that enquiries had been sent to management for responses to inform the planning work. Responses had been received and were presented for information.

Mr Bramley referred to page 90 of the report and related parties, querying whether Charles Hastings transactions were recorded anywhere. Mr Smith replied that they should be referenced and would be presented at a later meeting. **Action NC/AS**.

Responses were consistent with the Committee understanding.

RESOLVED THAT:

- **The report was noted for assurance.**
- **Committee approved the fees for the audit of the coming year.**

120/23 **Breaches to SFI's and SOD**

Ms Walden presented the new report, advising that she had liaised with the Foundation Group and others don't collate this information.

Ms Walden highlighted that the team had reviewed the capital purchase of scopes which was a breach and retrospective approval sought.
Invoices had been received with no PO. There is a 'No PO no Pay Policy. This was costed at £2.3m as at 16th February and is a moving target. The team do work with directorates to rectify.
The appendix outlined a breakdown of departments.

SFIs were being updated and the team were trying to engage with directorates to advise of the right process to follow.

Ms Martin stated that it was a useful report to have sight of which helped to understand the cultural issues and cross check.

Ms Hermon agreed that it was useful and would suggest the same at Wye Valley Trust. Ms Hermon cautioned that breaches of SFIs and SOs are a disciplinary action and encouraged steps to be taken to rectify the position and suggested recording names of those who were responsible for breaches. Ms Walden replied that there is a template issued to ascertain why a breach has occurred and lessons are taken from the responses. Usually, the breach is discovered after the event.

Mr Bramley referred to section 7 and suggested a review to make it easier to understand how the breach occurred. Ms Walden replied that payments are being stopped and the team were asking divisions to complete an order so payments can be made.

Mr Cook informed that the policy is clear, but the controls needed to be strict. Strengthening controls have been shared with Executives and reports would be presented to the Trust Management Board. Engagement will continue but there does need to be consequences and enacting the policy appropriately.

Mr Horwath agreed with taking appropriate action. Mr Horwath asked if the Committee could provide any support. Mr Cook welcomed action when required.

RESOLVED THAT: The report was noted.

121/23 **SFI's and SOD**

Ms Walden presented the reports, advising that the updated had been slightly delayed in order to complete a comparison with the Foundation Group.
Substantial changes are outlined in the report. The reports will be presented to TMB prior to Trust Board.

It was anticipated that they would start to be published by the end of March in readiness for people to start using them in the new financial year.

There had been poor response rates received previously and any suggestions to ensure people have read and understand the breaches were welcomed. LW to discuss with EH. **Action.**

Mr Bramley queried if there was a guide available for people to follow. Ms Walden replied that there was which could re reviewed and republished.

RESOLVED THAT: Committee recommended Trust Board approval.

122/23 **Standing Orders**

Ms Hermon updated that the Standing Orders had been reviewed and aligned with Foundation Group colleagues with the exception of SWFT.

Mr Horwath asked if there was sufficient training in place. Ms Hermon replied that there was not but would discuss with Ms Walden and would feed back arrangements back to Committee. **Action.**

RESOLVED THAT: Committee recommended Standing Orders to Trust Board for approval.

123/23 **International Nurse Staffing Salary Overpayments**

Ms Faulkner joined the meeting and provided a background to the report. The Trust was potentially discriminatory as the policy wasn't applied consistently across divisions. There was no Standard Operating Procedure of criteria in place. An approval process had been agreed with TMB.

Following a review, some staff members had received back pay beyond 2 years which was a total of £28k total across 20 nurses. Approval was sought for not proceeding with obtaining money back due to the lack of clarity of processes and the unfair process.

Ms Martin asked for clarification of the biggest sum for any individual. Ms Faulkner replied that none were excessive, and they were fairly split. Ms Walden confirmed that the largest payment to an individual was £1700 down to £175 for the lowest.
Ms Martin observed that people at the time thought it was the understood process.

Mr Murphy asked if repayments had been requested from individuals. Ms Faulkner replied that they had not.

Mr Horwath was satisfied with the rationale and that a sufficient process was now in place.

RESOLVED THAT: The International Nurse Staffing Salary Overpayments were approved.

124/23 **Understanding Off Payroll Working (IR35)**

Ms Walden advised that a report was presented to the Financial Recovery Board for assurance that checks are completed. Contracts had been reviewed under IR35. Any breaches will appear on the breach report.

There was a caveat in that the process is only as good as long as the breaches are located. Directorates have to provide support.

RESOLVED THAT: The report was noted.

125/23 **Waiver Report**

Mr Narwal joined the meeting to present the report. There had been a reduction in the value of waivers and volume but there was still more work to do in this area.

A system had been introduced alongside the Foundation Group which was put in place 2 months ago.
A lack of alternatives had been reported.
Corporate was the biggest culprit, there are very little frameworks or other ways of contracting for some elements.
Digital and estates have decreased expenditure.

Ms Hermon suggested including the reason against each individual line entry to provide more narrative.

Mr Bramley gave thanks to the team for the progress made as it was a big step forward and asked for clarity on the inventory management deployment. Mr Narwal replied that there was a small team so they were trying to balance standardisation across all 3 sites.

Mr Horwath gave thanks for the helpful report and queried whether there would be consequences. Mr Narwal replied that the team are starting to challenge more.

Mr Cook provided assurance that waivers are signed off by himself and he did push back.

RESOLVED THAT: The report was noted for assurance.

126/23 **Head of Pharmacy – Losses**

Ms Carruthers joined the meeting and presented the report. Overall, good progress had been made with reducing loss and waste. There was one exception.
Total loss of 0.68% was reported against the target. Without an incident that occurred, it would've achieved 0.3%. Actions have been put in place which are an addition to the last report.

There had been a new recruitment to the OPAT team.

Flu vaccine figures were not included but it was expected waste to be reduced due to a reduced order.

A cold room incident summary was included. An internal critical incident was held in conjunction with Estates for learning. The Trust should be able to claim some of the losses back.

Mr Horwath welcomed the report and continued progress.

RESOLVED THAT: The report was noted for assurance.

127/23 **Draft AGS and Annual Report**

Ms Hermon informed that the Annual Report was not yet available as the reporting was up to end of March. Adjustments were starting to be made and adding in this year's text. The Committee were assured that we are following the requirement template produced by NHSE.
Last year didn't meet fully the requirements due to requests made for changing the content. A draft will be shared when available.
There is a prescribed template to use and Committee were asked that we adopt the principles and Grant Thronton will provide a checklist.

Mr Horwath welcomed early draft reviews.

Ms Hermon advised that in order to obtain final approval and meet timescales, there may be a requirement for Trust Board to delegate to Committee for final approval. An Extraordinary Committee would be arranged.

RESOLVED THAT: The report was noted.

128/23 **Seal Register**

Ms Hermon advised that a review of the Trust Seal was not a requirement of the Terms of Reference and the use of seal is approved at Trust Board.

The benefit of the report was queried with Committee. Mr Horwath agreed that it was a Board matter. Mr Bramley agreed.

RESOLVED THAT: The Seal Register was noted. No further reports would be provided to the Committee.

For Information

129/23 **Any Other Business**
There was no other business.

130/23 **Committee Escalations**
SFI & SOD recommended for approval by Trust Board

131/23 **Reflections**

Worcestershire Acute Hospitals NHS Trust

WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST

PEOPLE & CULTURE COMMITTEE

Minutes of the meeting
Tuesday 2nd April 2024 at 10:00
Boardroom, Alexandra Hospital

Present		
Chair	Karen Martin	Non-Executive Director
Members	Alison Koeltgen	Chief People Officer
	Simon Murphy	Vice Chair
	Justine Jeffery	Director of Midwifery
	Colin Horwath	Non-Executive Director
Attendees	Stephen Collman	Managing Director
	Bianca Edwards	Assistant Director of People
	Rich Luckman	Assistant Director of Culture
	Ella Jackson	EA to Chief People Officer & Director of Communications (Minutes)
	Melanie Stinton	Freedom to Speak Up Guardian/Lead 4ward Advocate
	Louise Pearson	Associate Director of Nursing Workforce & Education
	David Southall	Chaplaincy Team Leader
	Bec Harris	Vice Chair LGBTQ+ Network
	Sue Sinclair	Associate Non-Executive Director
	Rachael Hayter	Interim Director of AHPs
Apologies	Julie Moore	Non-Executive Director
	Jules Walton	Interim Chief Medical Officer
	Sarah Shingler	Chief Nursing Officer
	Liz Faulkner	Assistant Director HR Corporate Services

Ref		Action
021/24	**Chairs Welcome and Apologies for Absence**	
	Ms Martin welcomed all to the meeting and the apologies received were acknowledged.	
022/24	**Quorum and Declarations of Interests**	
	There were no additional Declarations of Interest pertinent to the agenda. Declarations of Interest are available on the Trust's website. Ms Martin confirmed that: a) A Quorum of the P&C was present. b) There were no declarations of interest.	
023/24	**Minutes of the previous meeting**	
	The minutes of the last meeting held on the 5th December 2023 were reviewed and agreed as a true and accurate record. **RESOLVED – that the minutes of the meeting held on 6th February 2024 approved.**	
024/24	**Matters Arising and Review of ongoing Action Log**	
	The ongoing action log was reviewed and updated accordingly.	

025/24	**Staff Story – Chaplains**	
	Revd Dr Southall explained the role of Chaplaincy in supporting patients, relatives, and staff of all faiths and of no faith. Staff can drop in to the office when they need to, book a time that is convenient, or stop them in the corridor if they need someone to talk to. Volunteers are an invaluable resource to the Chaplaincy service, and Revd Dr Southall highlighted Sue Perry, who has supported emergency staff for 8 years. The number of volunteers in the Trust has decreased in recent years and with the majority being Christian by background, more volunteers of different faiths are needed to ensure a multi faith provision of the service. Where a Muslim patient requests religious end of life support, the Chaplaincy team try to find an individual of this faith to meet with them. This service is 24/7 on-call and the team consists of 3 WTE staff who can be called upon in the middle of the night to meet spiritual needs. It was noted that volunteers give their time freely, with no financial remuneration for travel or parking and can be called upon day or night. A proposal has been submitted to Charitable Funds to provide the volunteers with an honorarium, to show the Trust's appreciation for the service they provide. Revd Dr Southall also suggested further improvements could be made in the Hospital to improve the experience for deaf and hard of hearing patients and staff. Ms Martin suggested that having the profile of the organisation's workforce based on Faith and Spirituality would be helpful. MS shared workforce figures from ESR that were taken at the start of the year: 12.6% Atheism, 36.58% Christianity, 3.56% Islam, 2.31% Hinduism, 0.07% Jainism, 0.04% Judaism, 4.33% other, 7.08% did not wish to disclose. Mr Horwath shared his disappointment with the feedback regarding provisions for deaf and hard of hearing people and asked if the Trust is addressing this. Mr Haynes advised that the partnership working the Trust has been doing with HealthWatch at the ICB has been shortlisted for a national award. Mr Murphy noted that the ICB has launched a network for deaf and hard of hearing staff and agreed that improvements can be made. It was noted that this could be addressed within the Diverse Abilities Network, and the Committee agreed that an update from the Network Chair at the next meeting would be beneficial. **ACTION – Donna Scarrott (DAWN Network Chair) to provide an update on deaf and hard of hearing provisions within the Trust.**	
026/24	**Chief People Officer Report**	
	Ms Koeltgen informed the Committee of key headlines that could affect the Trust in coming months. There is a renewed mandate for Junior Doctors to continue with Industrial Action from 3rd April to 19th September 2024, with no	

	confirmation of a date for strike action yet. A new pay offer is currently the subject of a referendum for consultants, with voting open until 3rd April 2024. Conversations are ongoing regarding a separate nursing pay spine. There has been a significant amount of feedback and concern from other groups. Ms Koeltgen shared that Ms Edwards has volunteered to be part of the National Terms & Conditions group. There have been changes to the Immigration policy which will affect health and care visa holders and skilled worker via holders. There have also been legislative changes regarding statutory paternity leave and pay taking effect from the 8th March 2024. Ms Koeltgen noted that most policies in the NHS already cover this.	
027/24	**Best Services for Local People**	
	Freedom to Speak Up Report (Quarterly) Ms Stinton presented the report and advised that Freedom to Speak Up (FTSU) Champion scoping has now taken place; all existing Champions have been contacted and those wishing to continue have done so. A further 13 Champions have been trained however there are gaps in Surgery and Urgent Care. There has been an increase in FTSU concerns raised since December and some are multiple concerns regarding one area, so Ms Stinton is working with Mr Collman closely on this. The FTSU training will soon be mandatory on ESR and Ms Stinton, Ms Koeltgen and Mr Collman have recently met with Chris Turner to discuss Civility and Respect training. Ms Stinton shared that two Trusts have shown interest in the portal, and the Health and Care Trust have also adopted it. Ms Martin asked whether staff in areas with no FTSU Champions can contact a Champion from another area to raise a concern and Ms Stinton confirmed this and added that the 4Ward Advocates can be approached too. Ms Martin asked for clarification regarding the mandatory training, and Ms Stinton confirmed that every member of staff will be required to complete Speak Up level 1 which takes roughly 20 minutes to complete. The training should be released in May and staff will need to recomplete it every 3 years. Dr Sinclair shared her concern particularly with Theatres at the Alex, and noted the very low engagement levels with the 4Ward programme across the Trust, so suggested that it shouldn't be viewed as a solution to some of these issues. Mr Collman explained that the 4Ward Improvement methodology is separate to the Trust's vision and values. Mr Collman shared his impression that the two have been confused as the same thing. Mr Collman agreed that where issues are identified in particular areas, the Trust needs to put specific actions to put in place to address it.	

	Mr Luckman agreed that FTSU, Improvement training and the 4Ward Advocates need to be clearly separated so they are easier for staff to understand. Ms Koeltgen shared that she will be looking to create a Culture Roadmap to outline the direction of travel with this work. Mr Horwath raised his concern that the number of anonymous referrals has increased and asked what further actions the Trust can take to reassure staff that there will be no detriment to speaking up. Ms Stinton replied that continuing to emphasise this message is essential to reassure staff. Medical staff in particular report fearing detriment of how it could affect their career progression if they were to speak up, and Ms Stinton has had feedback from International Nurses that they feared they may lose their visas. Ms Jeffery noted that reporting Midwives and Nurses together has been ceased and they should be reported separately. Ms Stinton advised that the data is received from the National Guardian's office, but that she can separate it locally.	
028/24	**Best Experience of Care & Outcomes for Our Patients**	
	No items.	
029/24	**Best Use of Resources**	
	Workforce Sexual Orientation Equality Standard Ms Harris presented the Standard for approval and explained that the Workforce Race Equality Standard (WRES) and the Disability Equality Standard (DES) are in place nationally and produced every year, however there is nothing like this for sexual orientation. There is evidence to show that there are groups of people who don't feel safe to come to work or don't feel they can be their whole selves at work. 23.5% of LGBTQ+ colleagues face bullying and harassment at work compared to 17.9% of heterosexual staff. Few staff declare their sexual orientation on ESR out of fear of it being used to their detriment. The LBGTQ+ Network has created this Standard, and the proposal is that the report is produced annually. Colleagues in Morecambe Bay have been running this standard for 8 years and have shared their best practice. Ms Harris shared that the Network has won the National LGBTQ+ Alliance award for services to health. Mr Luckman shared that it is one of the priorities of the Rainbow Badge that the Trust should have a formalised report on sexual orientation. Fewer staff declare their sexual orientation in ESR than on the staff survey, possibly because it is anonymous. Mr Luckman also added that the data already being collected, and that this provides a purpose for it. Mr Murphy shared that previous Board meetings ended with the IPR which included staff gender, and only male and female were listed. Mr Murphy agreed that the Trust needs to work further to create an enabling climate for colleagues to come forward.	

	Ms Koeltgen suggested that a deep dive into the data would be useful as there could be a generational impact with younger people possibly being more open to declaring their sexual orientation and any disabilities. Ms Martin asked how widely the Standard has been shared so far and Mr Luckman replied that it has been to Trust Management Board for approval, with the view to progressing to Trust Board next. Mr Luckman also suggested it would be beneficial if it was shared at an Exec Live meeting and would show colleagues why they are asked to declare their sexual orientation on ESR, and that the data is used to help make the organisation a better place to work for them. A communication and action plan will be produced to ensure the Standard is widely shared. **RESOLVED – that the Workforce Sexual Orientation Equality Standard is approved.**	
030/24	**AHP Workforce Development** Ms Hayter introduced the Committee to the different staff groups that are included within the "AHP" workforce. Ranging from Physiotherapists to Occupational Therapists, the AHP workforce is diverse with colleagues of different training and professional backgrounds, and spanning across Divisions, services, and pathways. There have been challenges recently with recruiting Occupational Therapists, Radiographers, and ODPs so there is a need to be more creative when reviewing career structures. Apprenticeships are being explored to counteract the dropping number of undergraduates. Generational changes are being observed, with younger people looking to swap careers and move to different areas and professions, whereas in other generations, staff possibly would have chosen one profession and committed to it. There is a high vacancy rate and turnover in Occupational Therapy and Radiography and Ms Hayter explained that this is partially due to culture. Ms Hayter commented that there seems to be an apathy regarding turnover in Therapies which is affecting the quality of care that patients receive, as well as staff wellbeing. Ms Hayter shared her observation that AHPs do not work together cohesively within the Trust and she would like to see better networking. A National Strategy is available which can be helpful to share resources and review career development, however many staff are unaware of its existence. The number of AHPs going through preceptorship is very low and the feedback is that this is due to resources and capacity. The number of AHPs receiving appraisals is high, however the quality requires improvement. Ms Hayter added that a worthwhile appraisal and good clinical supervision might mean working across specialties to learn from each other. Ms Martin thanked Ms Hayter for her attendance and explained she	

	is pleased that the Trust is looking at the work that AHPs do. Ms Martin shared that feedback from different AHP groups is variable, with some being very positive and others being extremely negative. Ms Martin asked how the role of AHPs assists with flow throughout the hospital and whether there are any quality metrics from AHP roles. Ms Hayter responded that it is difficult to find metrics that measure the impact of Physiotherapy or Occupational Therapy input on flow. There are many metrics to measure things that negatively impact on flow, for example awaiting Occupational Therapy or Physiotherapy review. However there seem to be few metrics that measure where AHP input has facilitated flow. A national Occupational Therapy workforce has been released that provides guidelines of how to utilise Occupational Therapists' help, not just within people's homes, but in ITU, stroke and children's services too. Mr Murphy asked whether the Trust has enough AHPs or if it should consider international recruitment. Ms Edwards advised that the Trust did recruit international Occupational Therapists in 2023. Ms Hayter advised that Radiographer training varies in different countries so the Trust would need to consider this if recruiting internationally for this staff group. Ms Hayter shared that she feels there are not enough AHPs in the Trust in general, but her initial concern is with the high vacancy rate and turnover of the workforce. Mr Murphy detailed an Occupational Therapists' experience of leaving WRH site in the morning to visit a patient at their home, and then not coming back to site in the afternoon due to being unable to find a parking space. Ms Hayter commented that the Trust are aiming to work more collaboratively with the Health and Care Trust moving forward to determine their responsibilities. Ms Koeltgen shared her concern that in the presentation it is noted that more than two thirds of AHP staff disagree that there are good career options in the Trust, or don't know what career development is available to them. Ms Koeltgen noted the impact this could have on the high turnover. Ms Stinton thanked Ms Hayter for her work so far, in particular regarding a trend of concerns that were raised from a group of AHPs. Ms Stinton shared that they have worked together and now feel there is an action plan in place to address the issues that have been raised. Mr Collman advised the Committee that the Trust is meeting with the University of Worcester this month regarding training more staff and that they are keen to partner with the Trust on this. Dr Sinclair praised the new Retention Midwife and suggested a similar role to focus solely on AHP retention. Ms Jeffery agreed that she has made a significant impact on staff already as she knows the area well, and staff will share things with her that they wouldn't share with management.	
031/24	**Education, Learning & Development Review** Ms Pearson presented the report and noted that no risks have been identified with the project. A Corporate Education Risk Register has	

	been created and features risks mostly regarding clinical supervision for learners. Ms Pearson shared her intention to create a Clinical Supervision Policy for apprentices and ACPs. The careers framework for Nursing and AHPs will be shared soon with the imminent launch of Intranet 2. Estates and Finance teams have also requested to have a careers framework on the intranet. A page on the Trust's external website will be created to encourage people to work in the Trust and will detail what the Trust can offer in terms of continuous professional development, and a link to the jobs currently being advertised on NHS Jobs. A generic email address will also be included for any queries. Ms Pearson shared that she is working with Ms Hayter on a Return to Practice Policy. Mr Murphy agreed it is important that staff know that opportunities for career development and progression are a priority for the Trust. Mr Haynes added that the Estates and Facilities workforce is in a competitive market where staff have highly transferable skills and NHS rates are not comparable to rates at supermarkets for example. Mr Haynes shared that they are reviewing how they can advertise Estates and Facilities jobs in more ways such as via Facebook however there can be technical difficulties with the links.	
032/24	**Best People**	
	Integrated People & Culture Report Ms Koeltgen presented the report and highlighted that the On-Call consultation and policy has received significant feedback from staff who are struggling with being on-call and sharing concerns about the structure of the policy in terms of compensatory rest. Therefore, the decision has been made to pause implementation to allow for further review. Ms Koeltgen shared her concern regarding the policy development process and updated the committee that HR and Staffside would be reviewing this. Ms Martin asked where people policies should be submitted to for approval. Ms Koeltgen agreed to bring the proposed governance framework back to this Committee. Ms Koeltgen noted that the majority of feedback has been about staff's experience of being on-call, rather than the body of the policy itself. Ms Koeltgen is working with Helen Lancaster to address the operational issues of being on-call. Additionally, Ms Koeltgen noted that the Job Planning Policy has also been approved and is starting to be implemented. A summary will be produced regarding medical recruitment against agency usage and job planning and will be submitted to the Committee for assurance in due course. Ms Koeltgen recognised that a proportion of agency usage is aligned to sickness absence, however there is built-in headroom to cover this. Ms Koeltgen and Ms Martin agreed it would be useful to have the data of what percentage of bank and agency usage is to cover sickness.	

	ACTION: Report to be submitted to the committee regarding medical recruitment against agency usage and job planning - To include the percentage of bank and agency usage that is sickness cover. Mr Luckman shared that a new Personal Development Review and career conversations process has been launched. 317 reviewers have undertaken training on the new process in the last 3 months. Mr Luckman added that the training is not mandatory, and that reviewers had volunteered and chosen to enrol, so the uptake is very positive. Several requests have been received to the Organisational Development (OD) inbox from staff requesting to have a career conversation with someone other than their line manager, and the team are working through these as best they can. The Leadership programme has had strong uptake with 792 places being delivered as of 2023/24, and by 62% of those staff groups who were highlighted as being underserved. The programme is also not mandatory. The timeline for work on the NHS People Standards has been delayed slightly to allow the OD team time to focus on work regarding Staff Survey response rates. Ms Edwards informed the committee that the vacancy rate has reduced from 11.63% to 7.13%. Ms Edwards agreed with Ms Hayter's earlier statements regarding AHP turnover and recruitment. Overall turnover has reduced to 11.12% which is reminiscent of pre-pandemic levels. Agency usage remains a concern; despite considerable recruitment and a decrease in vacancy rates, agency usage has not reduced. Ms Edwards commented that there may be reporting issues, in terms of the reason for booking on erostering. Specialty Medicine and Urgent Care Divisions are now led by one Divisional Director; however, they are still operating as two separate divisions. The Divisional Director has reached out to OD for assistance in merging the two teams. Sickness absence remains high at 5.93%. Ms Edwards shared that there are plans in place for staff on long term sick leave, so the focus now needs to be on short term sick leave, and sick leave due to stress and anxiety as this accounts for most. Ms Jeffery raised that the S10 code for stress and anxiety is also used for bereavement leave. Ms Koeltgen commended the OD team for their positive work in developing a stress and anxiety toolkit to help managers have conversations with staff and showcase the support that is available. Mr Haynes asked if the uptake of the leadership programme is being mapped against the heatmap. Mr Luckman responded that areas where there are leadership concerns and managers are not committed to staff development are coded in blue on the heatmap. The HR Business Partners will shortly be engaging these line managers to encourage their staff onto training. The areas coded in red are in the most distress and the Staff Psychology team are supporting them. Dr Sinclair raised her concern that medical staff can complete their appraisals without an approved job plan.	

033/24	**Safe Staffing Report – Nursing** The report was noted by the Committee.	
034/24	**Safe Staffing Report – Midwifery** Ms Jeffery presented the report and explained that sickness absence has reduced but is still above the Trust target. Turnover remains below Trust target in Midwives and is now reducing within the Maternity Support Staff group, with 11.5 WTE being offered during February and March. A further 14 Midwives are expected to join the Trust and so the vacancy rate should be roughly 5% by the end of March. Ms Jeffery added that students are interested in the posts currently being advertised and Ms Martin asked whether students need to apply or whether they are offered the post outright. Ms Jeffery advised that as the Trust now has more students than vacancies, they are asked to apply to ensure a fair process. There has been high reliance on community continuity teams where the Trust has invited them in during episodes of increased escalation. Ms Jeffery noted the impact this can have on the health and wellbeing of the teams being asked to come in at short notice and do extra hours, and these staff then not being available afterwards due to needing compensatory rest. There has been zero agency usage since October, and upon review of the data from May onwards, the Trust should be able to avoid the need for programmed activity.	
035/24	**Staff Survey Results** Mr Luckman provided a verbal update on the results of the Staff Survey. The free text data has been analysed and share with the Executive team and will shortly be shared with Divisions. Over 30% of those who completed the survey, provided a free text comment. The most common themes are car parking, catering and discrimination and poor behaviour. The comments are being taken onboard to influence the development of the Trust's values and behaviours. A "You said, we did" video was released recently to showcase the improvements that can take place through staff providing their thoughts and feedback. A roadmap is being developed to address the low response rate and conversations are taking place with the Chief Medical Officer's team regarding burnout and teamwork as these were raised as key issues for medical and dental staff.	
036/24	**Governance**	
	People & Culture Risk Register Ms Koeltgen shared that a formal review of the Risk Register needs to take place to review which risks are being escalated to the Committee. A proposal will be brought to the next Committee meeting and the suggestion will be that only risks that score over 12 will be escalated to this Committee. A full review will be undertaken to understand the impact, and this will be detailed in the proposal.	

	Dr Sinclair agreed that the Risk Register needs to be reviewed and noted that many of the risks have not changed since last reporting and have no open actions. Ms Koeltgen recognised some risks will remain static, but the Directorate needs to be able to provide assurance on actions being taken to mitigate the risk.	
037/24	**Any Other Business (AOB)**	
	Mr Haynes informed the Committee that a permanent memorial to commemorate lives lost and lives saved during the Covid Pandemic has been installed in the main entrance of the Alex site, with Kidderminster and Worcestershire Royal to follow soon. Additionally, the Wellbeing area is almost complete in the Library at the Alex site and the staff wellbeing support package has been shortlisted in the Herefordshire & Worcestershire Chamber of Commerce awards.	
038/24	Ms Martin advised that a review of the Committees has been undertaken with feedback being collated from Board members. The outcome of this review will be discussed during the April Board Workshop. Comments will be brought back to the group to explore how the Committee can be improved, for example by extending the membership to include operational colleagues.	
	Date of Next Meeting	
	The date of the next meeting is 3th June, via Microsoft Teams.	

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WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST COVERING REPORT 2024-2025

Report to:	**Public Board**
Date of Meeting:	**11/06/2024**
Title of Report:	Board Assurance Framework (BAF) and Divisional Extreme Risk Report
Status of report:	☐**Approval** ☐**Position statement** ☒**Information** ☐**Discussion**
Report Approval Route:	Executive Risk Management, Trust Board
If Other, provide details:	
Lead Chief Officer/Director:	**Chief Nursing Officer**
Author:	Erica Hermon, Company Secretary
Documents covered by this report:	1) BAF as at 5 June 2024 2) Extreme Risks 15+ as at 3 June 2024

1. Purpose of the report

To present the Board Assurance Framework (BAF), which identifies the risks to delivery of WAHT's strategic objectives for 2024/25 and a review of the current operational Extreme Risks (rated 15 and above).

2. Recommendation(s)

The WAHT Trust Board is invited to note:

- The risks to delivery of WAHT's strategic objectives 2024/25; and,
- The operational Extreme Risks (rated 15 and above) being carried by divisions within the Trust.

3. Chief Officer/Executive Director Opinion[1]

An internal audit in 2023/24 reported that the Trust had an out-of-date Risk Management Strategy and that there were gaps in the processes and reporting that would ensure effective risk management is in place and ensuring that the Board is sighted on and managing its key risks. Consequently, the Trust's risk management process has been reviewed in the latter part of 2023/24, seeing the new Risk Management Strategy approved by the Trust Board, to ensure that risks are identified, assessed, controlled, monitored and when necessary, escalated and is premised on managers knowing what the predictable risks are, ranking them in order of importance and taking action to control them.

The Trust continues to adopt the NHS standardised approach for calculating the level of risk by multiplying the Likelihood (probability or frequency) and Impact (severity) using a 5 x 5 risk matrix. The remedial action required and timeline for completion are recorded in the table below. The consequence will not reduce but, with mitigation and controls, the likelihood of the risk being realised can be.

The attached Board Assurance Framework (BAF) is a live document which currently details the risks of achieving the Trust's 2024/25 strategic objectives, utilising the Incident and Risk Management system, Datix. This document is continually updated to identify and capture those risks that impact on the delivery of the Trust's objectives. The BAF also reflects the direction of travel of each risk.

As part of the review process described above, the Trust Board are also required to have routine visibility of the Trust's Extreme Risks (ie those that score 15 and above). These risks are reviewed bi-monthly by the new Executive Risk Committee, with a deep dive of each divisions' risk registers planned to take place

[1] Chief Officer opinion must be included and approved by the Chief Officer concerned prior to issue, except when the Chief Officer has given their consent for the report to be released.

on a rotational basis. Work continues to improve the effective and uniform use of Datix to capture, document and escalate risk, and an understanding of the benefits therein.

4. Please tick box to identify which of the Trust's 10 Point Plan the report relates to:	
☐ ***Focus on Flow***	☐ ***Think/Act as a Lead Provider***
☒ ***Governance***	☐ ***Improve Staff Experience***
☐ ***Home First Mindset***	☐ ***Tertiary Partnerships***
☐ ***4ward Improvement System***	☐ ***Leadership and Structures***
☐ ***Elective Care: No Delays***	☐ ***Strategic 'Big Moves'***

ID	Opened	Title	Description	Consequence (current)	Likelihood (current)	Rating (current)	Risk level (current)	Hospital Director or Executive Lead	Controls	Assurance	Gaps in controls	Gaps in assurance	Rating (initial)	Risk level (initial)	Rating (Target)	Risk level (Target)
1782	23/10/2009	Potential risk for serious patient harm from ligature points in hospital environment	Patients have the potential to cause self-harm whilst in hospital due to some potential ligature points. The injury could lead to death or serious physical harm. The hospital is not a mental health provider and therefore has different regulations, risk assessments need to be carried out and vulnerable patients protected where possible. Some bathrooms have been fitted with some items of anti-ligature nature, but this has not been standardised throughout the trust as per the assessment written and agreed in 2019.	Catastrophic	Possible	15	Extreme	Chief Nursing Officer	• Clinical engagement • Clinical staff involved at facility/department design stage, and the requirement for collapsible rails is included in specifications as required • Identification of collapsible rails on asset list, management schedule, routine testing of pull-off force • Anti-ligature devices installed in toilets and showers • Mental health risk assessment tools • Staff experience and skill in assessing and managing patients at-risk • ED doctors conduct mental health assessment, access to Mental Health Liaison Service • At-risk patients are searched, potential ligatures removed and placed in high visibility bay • Specialing for at-risk patients • Two anti-ligature rooms set up at the Alexandra hospital and WRH	• Environmental risk assessments per ward to check for AL points and assess if any action required to maintain standards • Trust wide risk assessment based on ward risk assessments • Guidelines on strategies to reduce potential for harm by vulnerable patients staff awareness to report via Datix any inability to protect patient or provide safe environment	• Possibility that a high risk clinical area has been re-purposed or opened since the 2009/10 risk assessment that has not had collapsible rails installed • Staff making assumptions about which rails are collapsible and/or not be able to identify which rails are collapsible • Capacity pressures to balance risks and/or correct space & resources unavailable • Incorrect judgement or limited experience conducting MH risk assessment • Change in clinical condition • Lighting/emergency pull cords may be available that could be used as a ligature • Ligature cutters not yet available • incomplete installation of A-L devices in all bathrooms across the trust - means there are gaps in agreed plan this may impact staff understanding of which areas have a higher risk	• guidelines not renewed or updated in a timely fashion • Risk assessments not updated when changes to an environment occur	15	Extreme	5	Moderate

ID	Opened	Title	Description	Consequence (current)	Likelihood (current)	Rating (current)	Risk level (current)	Hospital Director or Executive Lead	Controls	Assurance	Gaps in controls	Gaps in assurance	Rating (initial)	Risk level (initial)	Rating (Target)	Risk level (Target)
4873	28/01/2022	Patients on a fractured neck of femur pathway whose access to theatre has exceeded 36 hours are at risk of harm	In January 2022 CGG meeting the deterioration in the #NOF 36 hour target (BPT)performance since the transfer of the service from the Alexandra Hospital to Worcester Royal was noted The best practice Target is 85% Dec 2021 61% of patients had surgery with the 36 hour BPT on the #neck of femur pathway The average wait time to theatre in Dec 2021 had increased to 42 hours (in October 2021 it was 28 hours) In Dec 2021 53.1% (17) of the breaches were due to capacity - both theatre provision as now only 1 set theatre v previously 1 on each site (2nd theatre requires negotiation and staffing arrangements daily. Compounded by bed capacity on the ward, On average there have been 10-15 patients across Trauma floor waiting for Onward Care and into the 20's on occasions This has an impact on the patients not being able to move from ED in a timely fashion to be in the 'right place at the right time' GIRFT	Moderate	Almost certain	15	Extreme		• Daily safety huddles with site lead to identify issues with beds / waiting patients in ED • Daily theatre huddle to identify issues with theatres / staffing / capacity / waiting patients • Theatres and surgical division working together to maximise theatre capacity • Use of golden patient / hip' initiative, to improve theatre efficiency • Daily senior ward rounds of all orthopaedic in-patients	• Every 36 hour breach is Datix'd and a harm review completed in the designated meeting • Each patient is recorded on the national database • If patient comes to harm as a direct result of delay this is managed by the governance process which is well embedded	• Demand can outstrip capacity for beds on the ward especially when number of patients awaiting discharge are high • Theatre staffing is problematic with vacancy and rely on agency, sickness/ absence etc. • Due to staffing and other complications it is not always possible for a consultant to review all patients daily • Proposal to increase T&O ward capacity for #NOF presented to COO and CMO	• There may be a delay in the harm review process due to ability for staff to attend meeting and due to number of patients to be reviewed	12	High	6	Moderate

ID	Opened	Title	Description	Consequence (current)	Likelihood (current)	Rating (current)	Risk level (current)	Hospital Director or Executive Lead	Controls	Assurance	Gaps in controls	Gaps in assurance	Rating (initial)	Risk level (initial)	Rating (Target)	Risk level (Target)
5007	01/09/2022	Due to a backlog of typing there is a risk of delaying patient care/pathways/treatment (Bluespier backlog)	Due to a secretarial vacancy and long term sickness we have a backlog of letters waiting to be typed and actioned across the division. This backlog will be affecting patients care as GP's are delayed in receiving any changes in medication and onward referrals will also be delayed. All of this is having a negative impact on patient care/pathways. In addition to this the delays will have a negative impact on RTT and the requirement to upload letters on Bluespier within 10 days cannot be met. This backlog is also having a negative impact on staff morale as the teams are struggling to make any inroads into the backlog, as well as an impact on PALS and complaints.	Moderate	Almost certain	15	Extreme		• Overtime regularly offered to staff members to support reducing the backlog • Additional staff supporting typing on a regular basis until the vacancy is filled • Close monitoring of the backlog	• Close monitoring ensuring oldest and urgent letters are typed 1st	• No guarantee of uptake of overtime - this is based on goodwill	• If letters are not marked as urgent they may be delayed by up to a month before typed and actioned	16	Extreme	4	Moderate
5269	17/07/2023	Risk of negative impact on patient experience, operational performance and staff satisfaction in dietetics weight management	There is a risk of increased patient dissatisfaction, poor operational performance, compliance with national obesity audit data collection, loss of staff morale and reputational damage as a result of decreased dietetic capacity in the Tier 3 Weight Management Service, leading to likely increased waiting lists, complaints, poor clinical outcome, staff stress and sickness and turnover of staff.	Moderate	Almost certain	15	Extreme		• The Dietetic Team are reviewing job plans to ensure that the team are working consistently and sustainably to reduce the risk of staff burnout and to ensure the caseload is being managed as efficiently as possible • The team are developing their external communication to patients on the waiting list to ensure that expectations of when people may be seen are realistic	• Reviewing job plans of all staff to ensure good use of capacity	• The controls we are able to implement do not reduce demand on the service at all, so this will remain at a level that greatly outstrips capacity.	• Staffing will be depleted in January 2024 as 1.0wte B6 dietitian leaves for a new role	12	High	4	Moderate

ID	Opened	Title	Description	Consequence (current)	Likelihood (current)	Rating (current)	Risk level (current)	Hospital Director or Executive Lead	Controls	Assurance	Gaps in controls	Gaps in assurance	Rating (initial)	Risk level (initial)	Rating (Target)	Risk level (Target)
5329	20/09/2023	Speciality expected and referred patients spending a long time in ED.	If patients who have been referred to specialities cannot be accommodated in the respective assessment area then they must wait in ED and are at risk of harm due to the long delays in assessments, investigations and treatments.	Moderate	Almost certain	15	Extreme	Chief Medical Officer	• Staff are repeatedly contacting specialities as soon as the patient arrives in ED. • The NIC/EPIC will escalate speciality delays to Bed/Site Managers. • The 'Speciality Dashboard' on display in ED to highlight long speciality waits.	• The risks will be discussed at RMG. • The Governance Team will continue link individual Datix Incidents & monitor Serious Incident Investigations which are linked to this risk.	• The 'Speciality Dashboard' is not specific enough to each assessment area and does not provide a breakdown of each speciality.	•	15	Extreme	9	High
5402	15/11/2023	Urology failures in follow up process	Patients may come to harm if their planned follow up and treatment plan is not enacted. New processes are required to prevent lost to follow up occurring. A short term process for the directorate to support tracking of these patients is required. A long term review between cancer services and the directorate is required to assign roles and responsibilities.	Catastrophic	Possible	15	Extreme	Chief Operating Officer	• Outcome form from MDT (paper based) • Recording on Somerset cancer database • Paper outcome form from outpatients	• Divisional reports being undertaken as per actions • Patients identified as lost to follow up are now being reviewed and treatment plans identified	• Suggested treatment plan is documented, but not followed through	•	20	Extreme	2	Low
5517	22/03/2024	Risk of Microbiology service failure due to insufficient staffing to match increased workload.	There is a risk to service provision and failure to meet turnaround times for testing due to an unsustainable work load at its current growth rate with current staffing establishment. This may result in inability to provide the repertoire of testing that we currently provide including a decrease in out of hours/ weekend services.	Moderate	Almost certain	15	Extreme		• Night shift uncovered - on call staff member to cover • If on call not covered - band 7's taken off roster in preparedness to cover shifts when necessary • Locums covering vacancies/maternity weekend working adjusted depending on staffing	• Directorate aware of current situation	• Unplanned sickness/annual leave may leave service unmanageable • Unprecedented increase in bacteriology work (up 30%)	• No workforce plan in place currently	12	High	3	Low

ID	Opened	Title	Description	Consequence (current)	Likelihood (current)	Rating (current)	Risk level (current)	Hospital Director or Executive Lead	Controls	Assurance	Gaps in controls	Gaps in assurance	Rating (initial)	Risk level (initial)	Rating (Target)	Risk level (Target)
5535	11/04/2024	Potential risk of patient harm due to functionality of EPR not meeting the required needs of the service	There are a number of patient safety incidents occurring where by key information was missed on EPR which impacted the patient outcomes i.e: • increasing news scores not easily identifiable/no escalation parameters noted • Fluid balance discrepancies due to lay out of EPR meaning paper has to be documented • ITU notes not crossing over onto the EPR system meaning historical news/fluid balance cannot be seen - Paper Notes being utilised due to EPR capability not meeting the requirement of the service and cross linking with other IT systems These are just examples but this risk exposes staff to missing deteriorating patients in a timely manner and increases the risk of harm to patients	Moderate	Almost certain	15	Extreme	Chief Medical Officer	• Divisional reports being undertaken which identify EPR insufficiencies • NEWS scores are input into EPR which populate a trend graph • Fluid balance values are input into EPR in most ward areas • Fluid Balance and News scores are documented on ITU online patient system • CLIP system is accessible within the EPR system • Prescriptions are currently documented on paper to enable staff to administer relevant medications in a given timeframe • Divisional incident reports are identifying evidence of copy and paste of doctor ward round notes from previous entries which are not consistent with the patients current clinical picture or relevant • Patient notes are documented on multiple systems including clip, bluespier, Sunrise and the ITU online system • There is a process of optimisation of EPR and the resources to improve the system through Digital Team	• Divisional reports being undertaken which highlight inefficiencies in EPR to support the service offering • NEWS scores and fluid balance information is input into EPR throughout the working shift which enable identification of the deteriorating patient • Divisional incident reports are identifying evidence of copy and paste of doctor ward round notes from previous entries which are not consistent with the patients current clinical picture or relevant • Patient notes are documented on multiple systems	• Clip access does not always work within EPR and users have to exit EPR to log onto clip • Paper prescriptions are exposing patients to risk of harm as staff are not completing them in a correct manner. If prescription chart were sat in EPR this would reduce the risk of errors being made as completion fields would be mandatory such as signature and would act as a reminder to complete the necessary medicine safety checks prior to prescribing and administration • Divisional incident reports are identifying evidence of copy and paste of doctor ward round notes which is not clinically relevant or current. This exposes doctors to errors in patient care/management and increases the risk of harm to patients through lack of assessment and correct management • Documenting patient notes on multiple systems does not make finding entries easy for the user. This cause discrepancies when writing investigation reports, coroners statements and complaint responses. It is time consuming having to search for the entries in a working population already under immense time constraints • Insufficiencies in EPR are not always notable until a	• Investigation reports highlight the inefficiencies of EPR but not until the point the patient clinical incident is identified • There are not enough handheld devices available on the wards, meaning some news scores/fluid balances are documented on paper, and not input onto a computer in a timely manner that would identify clinically deteriorating patients • Documenting patient notes on multiple systems does not make finding entries easy for the user.	15	Extreme	2	Low

ID	Opened	Title	Description	Consequence (current)	Likelihood (current)	Rating (current)	Risk level (current)	Hospital Director or Executive Lead	Controls	Assurance	Gaps in controls	Gaps in assurance	Rating (initial)	Risk level (initial)	Rating (Target)	Risk level (Target)
											patient safety incident report is written that highlights the issue • No Clinical response to the NEWS trigger thresholds identifiable on EPR. This increases the potential of harm to those patients who are deteriorating and may not be recognised as quickly • Fluid balance charts are not always input into EPR due to the lack of scope of the fluid balance chart. • ITU Online PAS does not link/cross over onto EPR for the main hospital. This means that ITU notes are not seen by ward staff and exposes patients to risk of deterioration not being acknowledged in a timely manner due to staff being unaware of historical NEWS scoring/Fluid balance					

ID	Opened	Title	Description	Consequence (current)	Likelihood (current)	Rating (current)	Risk level (current)	Hospital Director or Executive Lead	Controls	Assurance	Gaps in controls	Gaps in assurance	Rating (initial)	Risk level (initial)	Rating (Target)	Risk level (Target)
3341	08/11/2016	Risk of patient harm due to C.difficile	There is a risk of Cdiff acquisition if there is not a clean environment and if the correct level of clean in not carried out. There is a risk of cdiff acquisition if there is not robust antimicrobial stewardship.	Major	Likely	16	Extreme	Chief Nursing Officer	• PSIRF has been implemented to focus on learning and there is divisional action plans in place • IPC enteric precautions audit check if case identified • Policy and Protocol for management of C.difficile and prevention of spread • D&V rapid risk assessment tool • All new cases reviewed by IPCT and ward staff advised on management • Weekly review of inpatient C.difficile cases by IPCT • Enteric precautions check list undertaken for any toxin attributable case • Antimicrobial Stewardship training part of mandatory training • Hydrogen peroxide fogging available for room / bay decontamination	• IPC environmental and practice audits • End of year review of all cases highlighting key themes to ascertain lessons / actions for next year • Antimicrobial stewardship audits in hot spot areas • Antimicrobial Stewardship Group with TOR • Review process for all toxin attributable cases • NHSI monitor NHSE trajectory for Trust • Health economy collaboration for CDI management and prevention • Cleanliness and PLACE audits	• Environmental constraint due to limited availability of side rooms • Variable medical assessment of D&V • Ward staff may fail to check previous history or respond to flag alert on PMS • Limited medical engagement with case review process • Inability to carry out HPV fogging due to operational restrictions and high capacity constraints	• Lack of evidence regarding proactive action with wards to ensure higher profile of risk of harm from C.difficile (As evidenced by Divisional report to TIPCC) • Lack of challenge at Divisional and Corporate level with regard to mitigating risk from C.difficile • Need to embed the PSIRF process of learning to ensure that actions are completed and evidence of completion provided	20	Extreme	6	Moderate

ID	Opened	Title	Description	Consequence (current)	Likelihood (current)	Rating (current)	Risk level (current)	Hospital Director or Executive Lead	Controls	Assurance	Gaps in controls	Gaps in assurance	Rating (initial)	Risk level (initial)	Rating (Target)	Risk level (Target)
3532	04/07/2017	Risk of CPE spread due to environmental contamination and poor compliance with the CPE policy, leading to patient harm	Laurel wards CPE outbreaks linked to environmental contamination from zonal kitchen as a source. Risk from staff not having good IPC practice in the kitchen and contaminating clean items such as plates etc. There is a risk of non compliance to national UKHSA guidance on management of Carbapenemase-producing Enterobacteriaceae (CPE) cases due to a lack of awareness and knowledge amongst staff. Specific risks include: *Risk of spread in hospitalised population leading to colonisation or infection and colonisation of the environment *Risk of increased length of stay due to CPE infection or colonisation. *Risk of fuelling antimicrobial resistance in the hospitalised population and Worcestershire population. *Risk of failure to undertake screening in accordance with UKHSA guidance and to respond in accordance with the same guidance. 30/08/23 Risk is now wider as there has been CPE identified in other areas kitchens and showers. Further risk of environmental exposure to patients and the risk of colonisation and also active infection.	Major	Likely	16	Extreme	Chief Nursing Officer	• Tristel drain treatment for Laurel wards and Zonal Kitchen • Robust patient CPE screening in place • Outbreak control meetings in place with external stakeholders • Alert of CPE contact or case admitted or new case alert via ICNET surveillance system • Existing revised CPE (gram negative) policy in place • CPE cases actively tracked within IPC Team and at weekly meeting with Consultant Microbiologist • Additional assurance being sort with regards to cleaning and outstanding estates issues • Peracetic acid is now being used in drains	• Cluster of cases relating to Evergreen November 2017 managed in accordance with national guidance	• Staff may not have awareness or knowledge to deal with CPE case or contact • Admission locations need to use the IPC admission assessment tool - not currently embedded in A&E departments. • Current patient population do not meet screening criterion as some have no risk factors for screening • National guidance is currently being reviewed and updated with expected completion in March 2019	• No assurance that CPE screening is undertaken effectively for new admissions • Limited audit evidence of compliance with CPE policy including screening • Lack of assurance that all patients entering the Trust who meet screening requirements are screened, detected and appropriate management is in place	16	Extreme	8	High

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3761	31/05/2018	TELEPHONY - if we do not upgrade the telephone systems, critical services will stop working, leading to patient safety issues	RISK Risk to patient care and safety due to Trust wide telephony system due to becoming End of Life with no vendor support The telephone systems at Kidderminster Hospital & Treatment Centre, and Alexandra Hospital are currently on `best endeavours` support, the manufacture ATOS (formerly Siemens Enterprise Communications Ltd) will no longer issue any system licences to expand the system, this includes no additional extensions, circuits, or cards that will allow external SIP services. All parts that are available to repair faults in the system are refurbished, as manufacturing stopped many years ago. Availability of service engineers is getting more difficult for the limited number of maintainer now available to provide support, as training stopped many years ago, what engineers that were available are reducing significantly.	Major	Likely	16	Extreme	Chief Digital Officer	• Agreement reached with Siemens to support system as a priority within best endeavours • Telecoms have a list of suppliers who can provide spares. • ALX - Supplier design recommendations in place • ALX - Solution stability improved - cessation of system processes that interfered with product • Trust can utilise VoIP system as a temporary solution with very limited functionality, in the event of an emergency if system is faulty over a long period of time. • Netcall IVR System requiring upgrade - order placed with Maintel • WRH telephone system software requires upgrading - PFI raised order with Maintel to install latest version • Cisco Unified Communication Manager (Kings Court) - order placed to upgrade system	• Siemens system health check annually • ALX - Reviewed as part of Acornbury moves • ALX - Updates for Digital Division senior management from Digital team members and suppliers	• Funding for upgrades not met • Version of telephony system not vendor supported • ALX - Segregated network not implemented - Switchboard move prevented this work	• No support for hardware infrastructure • Limited resources with the skill and knowledge for day to day support, maintenance and management within the Trust Digital Division • Software version has known cyber exploits • ALX - Additional Funding for required for telephony upgrades. • Review of phone systems required to define compatibility • Physical split switchboard plan increase complexity of viable technical solution • Agreement of staff use of system technology required	16	Extreme	4	Moderate
3832	01/09/2017	PC07 Workforce Planning	The Model Hospital indicates that the Trust spends more on staff per unit of activity than a typical Trust. There is a risk that the Trust will be seen as inefficient which may result in an increase in cost improvement requirements by Commissioners and concerns about our use of resources from our regulators.	Major	Likely	16	Extreme	Director of People and Culture.	• Best People Programme • STP Academy • Cost Improvement Plans	• WAU figures • Reports to P&C Committee • Reports to Financial Improvement Group • Weekly Pay Panel outcomes • Low vacancy rates	• Higher cost per WTE than peer group	•	16	Extreme	8	High

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3952	14/12/2018	Patients may come to harm from delay in diagnosis and treatment due to insufficient urological staffing for population	RISK: Patients may come to harm from delay in diagnosis and treatment due to insufficient urological consultants for population CAUSE:WAHT serves almost population of 600,000. We have 6.5 Consultant By BAUS recommendation, we need at least 10 consultant. EFFECT: Patients unable to have timely diagnosis and treatment resulting in patients waiting over 104 days for cancer surgery and between 40 and 50 weeks for routine surgery. Resulting in failure to achieve 62 day cancer and 18 week RTT targets. Patients requiring regular check cystoscopy follow up for monitoring of bladder cancer are waiting up to 12 months for a 6 month check. overworked medical/healthcare staff, unable to recruit. Impact: Unable to achieve RTT/2ww performance, poor morale in health care staff	Major	Likely	16	Extreme	Chief Operating Officer	• Cancer standards • RTT standards • Incidents and complaints • Patient feedback	• Annual peer review for cancer • Monthly monitoring against GIRFT recommendations	• Service believes it is short of 3.5 consultants in relation to GRFT recommendations • Service believes it is short of 2 clinical nurse specialists	•	16	Extreme	6	Moderate

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4084	09/04/2019	DATACENTRES - by not replacing power or maintaining environment a severe failure will occur, leading to loss of Digital Services	ISSUE - As a result of not replacing our 2 x Data Centers power, a severe failure will occur, leading to loss of all Digital Services Datacentres are being supported by Computacenter and PFI / Estates on a best endeavours basis. ISSUE - Datacentres true power and cooling capability are not known, additional hardware required for critical projects increases load. CAUSE - The datacentres have a number of outstanding issues that are deemed not fit for purpose. CAUSE - The datacentres were not built to the specification requested. IMPACT - PFI & Computacenter will not accept liability should failures occur, they will look at data centre problems at a best endeavours basis. IMPACT - Additional hardware has been added with risk accepted and mitigation plan to shut down additional hardware if required. If hardware does not remain stable this will impact project delivery.	Major	Likely	16	Extreme	Chief Digital Officer	• Tests have been done to determine current and available power usage. • Current power and cooling level are within acceptable limits so at present risk is not critical • IT on-call provides 24/hour cover • Digital Risk Management Group (RMG) ongoing review of the risk • Digital SMT weekly meeting for escalation of concerns • Plan is place to resolve this issue, PEU work must be completed first to allow server swing between sites.	• Monitored via Information Technology Security Forum • Monitored via CC	•	•	16	Extreme	2	Low

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4205	20/08/2019	A risk of not being able to manufacture SACT within the trust and therefore inability to meet patient need.	There is a risk of not being able to provide a SACT compounding service within the trust, therefore being unable to meet patient need and cause patient harm. This is as a result of both aseptic units working at or close to capacity limit despite maximising outsourcing of SACT. Both units are out dated and do not meet current guidance. This could lead to SACT supply disruption and delay as this service is required alongside outsourcing for the supply of SACT especially where SACT is short expiry, urgently required, not available from outsource manufacturer or supply is delayed. This could also reduce income to the trust if patient numbers treated need to be reduced.	Major	Likely	16	Extreme	Chief Medical Officer	• Outsourcing used where possible to support supply with various suppliers	• EL97(52) audit on 18 monthly basis. • Application of national standards in control of environment • Monitoring of workload against capacity plan	• Outsourcing market is fragile and supply unreliable • No control on demand and patient numbers	• External standard expected to change and be more prescriptive on layout and monitoring	12	High	8	High

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4481	25/08/2020	Long delays (breeches over 65 weeks) for new patient OPA'sin Gastro may cause harm and poorer outcomes for disease progression.	Clinical and endoscopies may have to be cancelled which could result in long waiting times for patients leading to complaints ,poor outcomes for patients which could lead to patient harm caused by COVID pandemic 16/1/23- Risk reviewed and renamed to reflect the additional concern of vacancies as well as COVID backlog on patients' timely access to services 29/4/24- risk re worded in line with the consistently long delays for New routine Gastro OPA's due to insufficient capacity. The Trust is currently unable to meet or maintain the NHSE expectation of no 65 weeks breeches and patients are at risk of poorer outcomes and disease progression as assessment and treatment is delayed	Major	Likely	16	Extreme	Chief Medical Officer	• Clinical validation of waiting lists for follow ups • All patients above 18 weeks are being validated monthly • Patients advised to call medical secretaries if symptoms / condition changes • Email advice and guidance system to support GP's to manage patients in primary care and reduce admission / attendance at A&E • Patients above 40 weeks to be reviewed by consultants • IBD and Liver nurse (CNS) assisting to manage long term disease	• All patients on the cancer pathway are being reviewed and escalated daily by the DMT • All patients over 18 weeks are being reviewed monthly • Restart clinics will contain those of a higher clinical risk and those chronological long waiter	•	•	16	Extreme	4	Moderate

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4773	06/09/2021	CLINICAL APPLICATIONS -by not implementing EPR on time, quality benefits will not be met, ensuring patient safety issues remain	There is a risk that if there are delays to the implementation of the Digital Care Records Programme, this may lead to the financial model being compromised resulting in failure to make improvements on identified patient safety issues. Quality and safety benefits will not be realised in line with the benefits realisation structure, delaying improvements to patient care as outlined in the EPR business case. This will have a negative impact on patient care.	Major	Likely	16	Extreme	Chief Digital Officer	• Alignment of DCR programme teams to Digital PMO / Enterprise Wide Application teams • Deployment of industry standard methodologies e.g. Managing Successful Programmes (MSP) and PRINCE2 • PAS and DCR plans scrutinised by the Digital Steering Group - including onward reporting & escalation to TME, FPC, Board as required • Clinical Reference Group • Digital Nursing Shared • Governance Meeting • Digital Programme • Enhancement Business Case • NHS Digital / Frontline Digitisation oversight and scrutiny	• Validation of all plans by all Technical Partners • Programme Assurance Group • Finance Assurance Group • Engagement of an appropriately skilled Clinical Safety Officer • DCR Portfolio Steering Group (Programme Board) • Digital Steering Group (Exec / Non-Exec Scrutiny)	• Impact of other critical Trust Transformation programmes on the DCR • Lack of centralised overarching change programme for the Trust – SIM coming • Alignment of infrastructure remediation plans • Access to Allscripts programme resources during P0 • Data centre remediation (electrical infrastructure)	• Governance is complex • Clinical risks are all logged, but again this is a complex area	25	Extreme	12	High
4875	28/01/2022	Ambulance Rapid Release Protocol	If the ambulance service rapid release protocol is enacted, there is a risk that the operational management of safe patient care may be compromised, leading to severe patient harm.	Major	Likely	16	Extreme	Chief Operating Officer	• Fit to Sit Policy • Deflection and Divert to maximise countywide capacity • Use of chair spaces in Minors • Streaming to SDEC • Full Capacity Protocol • Mobilisation of Senior Clinical Decision Makers to ambulance handover area • Standard ED escalation and pathway processes	• Incident reporting rates • GRAT performance • ED capacity dashboard	•	•	20	Extreme	6	Moderate

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5041	23/10/2022	There is a risk of the current Unisoft endoscopy reporting tool losing reports or failing	There is a risk that the current endoscopy reporting tool (unisoft) due to it needing an upgrade to (Solus) has issues around reports and data being lost from the system, this could result in inaccurate audits and KPI data being submitted.	Major	Likely	16	Extreme	Chief Operating Officer	• Pushing forward with the upgrade to solus • Data cleansing in progress to ensure that only relevant details are transferred from the old system to the new system • Patient procedure report is created at the time of the procedure	• Annual audits carried out, previous audit report had mitigation embedded explaining reason for underachievement • Any previously created endoscopy report is visible on EZ notes, as long as scanned on appropriately • A project has started to implement a replacement system (Medilogik, EMS). • Go Live of EMS planned for April 2024.	• The roll out of the new system has been delayed due to the trust IT service being monopolised by EPR initiative • The procedure reports created have occasionally disappeared from the unisoft system, therefore when searched for it yields no reports for that patients • It is likely that these errors may herald a catastrophic failure of the system	• Exact date of solus rollout is unknown • Scanned reports on EZ notes are only available and in the correct place as long as the correct cover note is attached.	16	Extreme	4	Moderate
5189	28/03/2023	Risk of loss of acute MRI service at WRH as a result of MRI scanner being end of life	There is a risk the MRI scanner will breakdown as a result of it being end of life. This could lead to loss of the acute MRI service at WRH.	Major	Likely	16	Extreme	Chief Operating Officer	• Regular service / maintenance of the Scanner • Regular service / maintenance of the H&C systems • Quality Assurance Tests • Safety protocols to prevent the need for User Initiated Quench • MRI available at Alex site	• Breakdowns and issues with equipment reported and actioned promptly	• Equipment is end of life and due a replacement • Reduced capacity countywide if scanner breaks down • Loss of Acute IP/A+E MRI at WRH if scanner breaks down – patient transfer • Increased risk of spontaneous Quench	• More equipment faults expected as MRI scanner is end of life • Possible reduction in image quality • Increase in downtime due to equipment faults • Support and parts may become limited due to age – best effort fixes	16	Extreme	4	Moderate

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5260	28/06/2023	Patients will not receive adequate nutrition nurse input trust-wide due to lack of capacity - this will cause significant harm	There is a significant risk to patients not receiving adequate nutritional specialist input, guidance and support due to the insufficient resourcing of work force of the nutrition team for the trust. This will lead to delay to care, delay to feeding, delay to discharge and result in increased length of stay, malnutrition and harm to patients.	Major	Likely	16	Extreme	Chief Nursing Officer	• Nutrition MDT weekly to discuss patients referred for long term nutrition or patients who are complex • 1 Full time Nutritional nurse in post • Dietetic service providing cross site cover • Gastroenterology consultant rotation to provide MDT support • Monthly N & H steering group held. • Policy development	• Monitoring incidents via Datix system • Discussions held with DCNO in relation to service gaps • Nutritional nurse overseeing service • Gastro consultant rotation to provide MDT support	• No dedicated nutritional consultant lead • No cover for Nutritional nurse service for AL, sickness, study leave etc. • Limited cover at the Alexandra hospital due to staffing • No succession planning for nutritional nurse service. • Risk to current nutritional nurse of burnout and poor job satisfaction due to service demands. • Many policies are out of date or do not • Management of parenteral nutrition – lack of 'Nutrition Team' to review patients trust wide • Lack of adequate training provision for nursing staff for NG insertion	• No current business plan in progress to improve service • No clear plan for consultants return	16	Extreme	4	Moderate
5265	06/07/2023	Risk of Analysers (Microbiology) failing as coming to the end of life and delays in the Tender process	There is a high risk that 3 major pieces of equipment will fail as they have come to the end of their life due to the network tender process being delayed by at least 12 months. This will lead to the department not being able to offer a TB culturing service, the ability to process urine, no urgent Covid/fLu and confirmations for C.difficile, Norovirus (Ward infection control will be affected). The risk will result in failure of Microbiology to provide a service, affect patient care and the ability to assist with patient flow and bed management.	Major	Likely	16	Extreme	Chief Operating Officer	• Equipment is under service agreement within managed service contract • Departmental maintenance schedule compliance	• Microbiology contingency procedure relating to downtime - to refer work to an external laboratory if required • Monitor any incidents via DATIX with a link to this risk	• Instrument under managed service may no longer be supported due to age	• Delays to turn around time if you have to refer work	16	Extreme	4	Moderate

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5374	19/10/2023	There is a risk of harm to patients who are overdue their follow up appointment	On a review of the follow up waiting list as part of the Trust requirement to reduce OP follow up activity, there are a total of 28000 patients within the Specialty Medicine division who are overdue their follow up appointment according to OASIS	Major	Likely	16	Extreme	Chief Operating Officer	• Continual review and monitoring of follow up waiting list by specialty • Additional WLI undertaken in some specialties	• Continual review and monitoring of follow up waiting list by specialty	•	•	16	Extreme	9	High
5448	12/01/2024	Bedding patients on Aconbury zero	There is a risk of patient harm and poor patient experience due to patients being bedded in what is essentially an outpatient facility This is due to lack of inpatient resource: Inpatient drugs no CD or pharmacy cover Lack of pharmacy oversight - no review of drug charts daily Lack of toilets - two toilets for up to 30 patients No showering facilities No isolation facilities/open bays/no screens Reduced catering facilities - AMU hostess trolley accommodates 15-20 meals only Difficulty when ordering light bites for patients - these meals do not come with puddings - limited choice after AMU patients have their puddings Lack of ward clerk impacting on updating loved ones and delays in answering phones No housekeeper - lack of stock e.g. pads/ conti wipes / wash bowls. Borrowing from AMU which depletes their stock if they are awaiting a delivery No porter - jobs have to go through the lodge - this can delay transfers / discharges when patients go to the discharge lounge to await	Major	Likely	16	Extreme	Chief Operating Officer	• Transfer team from AMU / HCAs on Aconbury 0 are able to support with taking charts to pharmacy / taking patients to other wards • Shared bathroom /toilet on neighbouring AMU • Consultants reviewing and safety checking drug charts • Washing bowels and toiletries available • Keep patient number at 24 for IPC purposes and to allow for cohorting • 'Light bites' sought daily to make up short fall on hostess trolley • Nursing staff answer phones as able and update relatives/take orders • Ward clerk on AMU help with certain tasks • Block booking of well-known agency to take charge of ward at night • Borrowing of drugs from neighbouring AMU and other wards, including controlled drugs • If no familiar agency to take charge overnight, substantive from AMU/MSSU are deployed	• Quality impact assessment • Senior nurse audits • Datix incident reporting - Aconbury zero now has a location on datix • IPC RA/Environmental RA	• Limited toilet and bathroom on AMU leading to queues and poor patient experience and IPC risk • Agreed number of patients often exceeded due to site pressures, especially overnight/weekend • If known agency staff are not available an unfamiliar nurse may be deployed causing a risk	• No pharmacy cover for area	16	Extreme	6	Moderate

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			transport/family Reliance on non-substantive staffing No Therapies - risk of deconditioning MSDEC staff do not work nights so ward not covered at night with ward substantive staff													

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5498	05/03/2024	DIGITAL STORAGE - by not procuring new data Storage, significant failures will occur, leading to loss of clinical systems	DIGITAL STORAGE - by not procuring new data Storage, significant failures will occur, leading to loss of clinical systems. The affects staff productivity, and impacts upon timely patient care. We have implemented new Hardware for a production environment, to address legacy infrastructure debt, however due to the increasing about of clinics and use of imaging services, our forecast storage will reach capacity as soon as we migrate systems to the new production environment. The current Production environment consist of over 500 servers running all our Digital Systems (expect EPR and PAS). The biggest area of storage consumption is PACs images. We require funding to procure a Vendor Neutral Archive storage solution, which is attached storage to our new production environment. This storage will be used primarily to storage our medical images and the M drive data. We are already experienced various issues including but not limited to 1- M Drive saving issues 2- Backup failures 3- Performance issues across numerous systems Estimate costs for this VNA solution will be £900K	Major	Likely	16	Extreme	Chief Digital Officer	• Digital Teams monitoring capacity on weekly basis (Task and Finish group)	•	•	•	16	Extreme	1	Low

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5511	21/03/2024	Aging Mandolite (fire retardant material) used at Alexandra Hospital	Mandolite is an in situ product; it was applied to the compartment walls and timber fire doors installed within metal frames at Alexandra Hospital Its purpose is to provide fire protection and to upgrade the fire performance of concrete structural elements. It's believed that 90% of the walls / compartmentation lines have got Mandolite; it is also believed that its reaching end of life and a solution to ensure integrity of the building needs to be agreed. Leaving it to deteriorate will lead to smoke and fire spread should a major fire occur. Mandolite was used when the hospital was originally designed. In addition with differing repairs to the building there are drill holes within the walls that need to be filled to protect and prevent smoke / fire spread.	Major	Likely	16	Extreme	Director of Estates and Facilities	• Formal Fire Risk Assessment conducted by STK (External specialist) 2023 • Monthly fire audits conducted; internally • Ongoing PPM work • Monthly meetings held to discuss this issue and plan / act; Chaired by H&S and members are from capital and estates	• AFE March 2024; concern but not critical	• An agreed solution and program to address is not in place as this affects the whole hospital therefore the right solution must be agreed.	•	12	High	4	Moderate

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3603	13/10/2017	CYBERSECURITY - by not securing our Digital estate, a significant Cyber-attack will occur, leading to loss of patient info	IF we do not take adequate precautions to secure our IT systems, and the patient data within them, THEN there is a risk that the Trust will be subject to a cyber-attack RESULTING in loss of personal data, disruption to core services and reputational damage. The Cyber Security Action Plan (restricted access document) has detailed actions on outstanding cyber risk and is used to support the outstanding actions in this risk. High level risks are: Operating systems Access Control Supported Hardware Digital Procurement Constantly changing / developing landscape in cyber security Human factors	Major	Almost certain	20	Extreme	Chief Digital Officer	• New windows OS build being rolled out to ensure endpoint environment is up to date • Upgrade to server OS has been funded • All generic username requests are subject to secondary approval in the NGSD workflow • 3rd party suppliers are to provide named users and not have generic accounts set up • All requests for external access to ICE are now managed by Trust app support team. • A log of all external users is now being maintained. • IG team are also part of the on-boarding process. • PC specification reviewed every 12 months for updating • Revenue budget in place to support PC upgrades • Software specification review are in place • ICT have regular meetings with System Administrators about the infrastructure that is managed outside of ICT control. • ICT provide operating system updates to servers that have been requested by System Administrators • Additional checks with suppliers to meet Trust cyber requirements • Requirement to use the ICT Request for Change (RfC) process communicated to all system managers and suppliers	• NHS Digital & other 3rd party have completed a security audit of our infrastructure identifying areas of weakness and good practice • Accounts are reviewed irregularly • Digital Procurement - Additional information contained within the MARS solution • Regular meetings with System Administrators and ICT to ensure solutions are being managed. • Digital/Computacenter Technology Meetings System Admin Forums	• Outdated medical devices managed through departments outside of ICT • Staff awareness around phishing emails • Staff using their own devices on to access Trusts network/systems/email • Clinical service leads do not communicate ICT clauses in service contracts to Trust ICT. • New systems introduced into the ICT environment by SPC and other 3rd parties through divisions • ICT systems managed by clinical system admins with regard to ICT security requirements • Server OS upgrade is projected to take 18 months • A comms plan for cyber awareness is required • Staff with elevated privileges require additional controls - Privileged Access Management not ready to be implemented. • Server OS - Production environment ESX - Upper Path limit of 1024 risk (CC Risk 603) • Existing generic user accounts are not being made secure • Review of password history for generic accounts required - some set to do not expire and/or weak password config. • Clinical/Corporate application vendors not providing support for applications on latest Widows Server platform	• Centralised software solution to consolidate event logs not yet implemented • System Administrators outside of ICT do not monitor software/ hardware for compliance to patching and security standards • Clinical Information System Administrators do not know terms of contractual arrangements for supporting ICT equipment they are responsible for. • Clinical service leads do not communicate ICT clauses in service contracts to Trust ICT. • Generic accounts are not regularly reviewed and removed when not required. • Generic accounts that are used as backend system accounts are not set to remove the ability to be interactive and can be used to log onto servers. • Passwords are not compliant to latest standards/Trust policy • System Administrators do not provide all information to ICT relating to the solution that is managed outside of ICT	16	Extreme	6	Moderate

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									• Governance Systems Managers' Meeting to ensure system managers follow ICT procedures and processes • Database capturing all systems in Trust - MAARS Monthly Microsoft • Security patching of all pcs, laptops and servers • Anti-Virus scanning on all pc's, laptops and servers • Implemented Microsoft Early Threat Detection • Across the estate 98% of the network switches have been replaced • National CareCERTS advisories are reviewed and acted upon where appropriate for our organisation • Improved password security • Governance Systems Manager Meetings • Midlands cyber security forum with early warning systems in place • ICT Change Advisory Board to agree all new applications and changes to applications		• Not enough skilled resources to support testing of clinical applications on Windows Windows Server 2012 and above • Some desktops are not up to specification to run the latest Windows operating systems. • Clinical systems not managed by ICT, may have a managed service provided by the supplier. • The checks by the supplier are not auditable by ICT. • Procurement of clinical services that include digital elements • Equipment procured through ordering systems • Changes to system are not defined to ICT standards • System Owners do not follow best practice as set by ICT • Clinical Information System Administrators do not know terms of contractual arrangements for supporting ICT equipment they are responsible for. • Clinical service leads do not communicate ICT clauses in service contracts to Trust ICT. • New systems introduced into the ICT environment by SPC and other 3rd parties through divisions • New systems introduced into the ICT environment by SPC and other 3rd parties through divisions • Outdated medical devices that connect to Trust infrastructure are managed					

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											through departments outside of ICT • Human factors					
5033	11/10/2022	Risk of patient harm as a result of pharmacy workforce shortages affecting service provided by ward-based teams	There is a risk that patients will not receive expert medicines optimisation review and essential medicines supply including time critical medicines as a result of reduced numbers of suitably trained Pharmacy staff providing the ward-based clinical service.	Major	Almost certain	20	Extreme	Chief Medical Officer	• Interim service delivery plan • Clinical prioritisation tool to assess pharmaceutical care needs • Outreach discharge team available in the afternoons • Daily huddle attended by pharmacy clinical and operational team members to prioritise afternoon service	• Evidence of risk register reviews, incidents, complaints	• Existing patients where they have been assessed as no longer requiring any pharmaceutical care needs	• Referral of medicines related issues to ward pharmacy team by medical and nursing teams not undertaken	20	Extreme	4	Moderate

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5133	31/01/2023	TELEPHONY - not upgrading from analogue to digital lines, critical services will stop working, leading to patient safety issue	TELEPHONY - Risk to external telephone lines and services - BT Exchange Decommissioning BT Openreach are in the process of decommissioning their legacy telephones exchanges that operate using ISDN and analogue technology. These services are what currently provide external telephone connectivity to the Trust at all of its sites. The deadline for completion of the UK wide switch-off is 2025, however dates for individual switch-off will be phased over the period leading up to 2025 which in reality could be much sooner for the Trust. The current information available to the Trust is that with effect from as early as August 2023 no new orders or requests for changes will be allowed for services connected to the Worcester exchange. Therefore the Trust will need to ensure funding is made available to upgrade its telephony infrastructure and switch to PSTN SIP services ASAP.	Major	Almost certain	20	Extreme	Chief Digital Officer	• Paper reviewed at Capital Group	• Issues escalated via Estates/Digital senior managers	•	•	20	Extreme	15	Extreme

ID	Opened	Title	Description	Consequence (current)	Likelihood (current)	Rating (current)	Risk level (current)	Hospital Director or Executive Lead	Controls	Assurance	Gaps in controls	Gaps in assurance	Rating (initial)	Risk level (initial)	Rating (Target)	Risk level (Target)
5138	10/02/2023	Due to equipment failure, there is potential risk and delay to treatment of patients presenting with AMI	There is a risk that increasing issues with x-ray machines in cath lab that require input from external engineers causing downtime, resulting in elective patients being cancelled and as a result of this inpatient waits for procedures may increase.	Major	Almost certain	20	Extreme	Chief Medical Officer	• Second cath Lab can be used if available	• Continued chase of Equans/Architects for results of feasibility study	• Cath lab 2 second X-ray room (Artis One) has no scheduled replacement date as gifted to the trust, but service support for the device ends July 2023. • Artis Q Cath lab Xray machine renewal overdue and machine not functioning efficiently. • Artis Q X-ray machine in Cath lab 1 was due to be replaced by Siemens June 2021.	•	20	Extreme	4	Moderate
5162	24/02/2023	BMA - Junior Doctors I.A - Strike Action 2023 which will compromise patient safety and outcome	Patients' safety will be compromised due to inadequate numbers of Doctors in the right environment, at the right time with the right skills to meet patient acuity and dependency This presents a position that harm will not be avoidable. The risks of the potential disruption are: • Patient harm due to insufficient doctors to meet demand through Emergency Departments • Patient harm due to insufficient doctors to meet demand of patients needing acute admission (all specialties) • Patient harm due to insufficient doctors to ensure inpatient areas have medical cover • Patient harm due to insufficient doctors to maintain patient flow resulting in increased crowding and delays • Patient harm due to insufficient doctors to ensure outpatient areas have medical cover	Catastrophic	Likely	20	Extreme	Chief Medical Officer	• Risk Assessment to be completed and reviewed regularly • Deployment of local Business Continuity Plans • Review resources available to staff services over planned strike days • Junior Doctors not striking will be deployed as usual • Deploy other staff to support Emergency and in-patient care • All study leave to be cancelled in the interest of patient safety • More effective control measures to be implemented to mitigate the risk. • ACPs back filling post of junior doctors • Review resources available to staff services over the strike days • Focus on resources that are available on delivering urgent care, emergency care and in-patient care. • Doctors acting down; will be paid acting down rates. • Action Plan gives a clear process of calling in Junior Doctors if a Critical	• Junior Doctors will be pulled from strike action if a state of emergency is declared • Daily meetings of Industrial Action Group	• Doctorss can choose to strike on the day without prior warning, leaving areas short • Unplanned sickness or gaps in shifts covered by locums will impact staffing • Using paper based forms for some consultants - can slow TTO's down	• There is no assurance that there will be sufficient and, competent, skilled and experienced staff to provide safe and effective care to patients at all times and across all care settings.	25	Extreme	1	Low

ID	Opened	Title	Description	Consequence (current)	Likelihood (current)	Rating (current)	Risk level (current)	Hospital Director or Executive Lead	Controls	Assurance	Gaps in controls	Gaps in assurance	Rating (initial)	Risk level (initial)	Rating (Target)	Risk level (Target)
			• Patient harm due to insufficient doctors to ensure theatre activity is maintained Possible effects • Patients not receiving timely assessment and care in acute areas including wards • Patient harm due to increased delays across all areas • Cancellation of outpatient and surgical activity resulting in further backlog for cancer and elective work *Note The Trust received notice given by the BMA council chair, Professor Phil Banfield of the notice of industrial action in accordance with section 234A of Trade Union and Labour Relations (Consolidation Act 1992) on 24th March 2023. The dates of industrial action will commence at 7am on Tuesday 11th April 2023 – 7am on Saturday 15th April 2023. Impact expected on: • Elective surgery • Staffing levels (prioritisation of urgent services and care) • Outpatient service provision • Theatre activity • Endoscopy activity • Clinical diagnostics The Trust view on this industrial action will compromise safe and effective care to patients during the 72-hour period of industrial action by Junior Doctors.						Incident/Major Incident is declared • Action Plan gives clear information for communication/contacts							

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5249	16/06/2023	Risk of losing multiple accreditations in all departments within Pathology demonstrating non compliance with standards	There is a risk of losing multiple accreditations in all departments of Pathology because of the lack of focused resource at Directorate level on all matters relevant to quality. This may result in being viewed as a sub standard lab (reputational risk) and impact on patient care (patient safety). Sub optimal quality is already being noted via increased incidents. 10/05/2024 Interim quality manager in post for 3 months to move forward and job matching of a permanent role progressing. Still to secure funding for long term position.	Major	Almost certain	20	Extreme		• Most staff conducting double roles to ensure quality is maintained • Directorate manager acting as conduit to pulling quality processes together • Cellular pathology quality manager picking up additional tasks • Risk assessment to be completed	• Incidents logged on datix and escalated as appropriate • Directorate Manager has oversight of accreditation and quality management systems	• No dedicated quality manager to oversee accreditation and or quality management systems • Delays likely when directorate manager is absent due to no oversight of quality management systems	• No dedicated quality manager to oversee accreditation and or quality management systems • Limited skills and resource within team to be utilised as current quality manager	16	Extreme	4	Moderate
3908	13/11/2018	Ambulance handover delays	Patients are at risk of their condition deteriorating and coming to severe harm if the Trust is unable to offload ambulance arrivals within 15 minutes , patients in the wider community are at risk of not getting an ambulance when needed meaning delays in their treatments.	Catastrophic	Almost certain	25	Extreme		• SDEC pull patients from WMAS and ED • Extra corridor capacity opened December 23 in Aconbury • Aconbury zero has opened creating an extra 24 capacity • Extra capacity opened in Spec Med Avon 4 at WRH and ward 15 at AGH • Any patient waiting 1 hour plus to off load has a GRAT completed by an RN • HALO on site 5/7 a week 10-6 who liaise with ambulances outside • Escalate to site team when there is no capacity in ED to offload • ED Safety Huddles • ED allocated GRAT nurse each shift • HomeFirst workstreams	• HALO escalating sick patients • GRAT tool for recognising at risk patients • Time to triage assessment (15 min review) • HomeFirst report – WREN • Any patient coming to harm from ambulance delays are captured through the Datix system and Investigated by the Trust	• Lack of flow from ED	• Lack of Trust response on escalation	12	High	2	Low

ID	Opened	Title	Description	Consequence (current)	Likelihood (current)	Rating (current)	Risk level (current)	Hospital Director or Executive Lead	Controls	Assurance	Gaps in controls	Gaps in assurance	Rating (initial)	Risk level (initial)	Rating (Target)	Risk level (Target)
4843	09/12/2021	Emergency Department Waiting room crowding	If sick patients who have been triaged cannot move into the department they will be at risk of harm as the waiting room is not a clinical area with equipment or staff to monitor the patient	Catastrophic	Almost certain	25	Extreme	Chief Operating Officer	• Nurse allocated to waiting room when staffing allows • Patients are triaged, aim is within 15 minutes of arrival • Refreshment round extended to waiting room promoting visibility of patients waiting by staff • Waiting room GRAT tool	• Monitoring of incidents by governance team	• TTIA within 15 mins not always possible	•	10	High	4	Moderate
4964	06/06/2022	ED crowding & exit block	If extreme crowding occurs in ED due to exit block then this will result in delays to timely review, tests and treatments, leading to the trust being unable to deliver effective clinical care, resulting in significant patient harm, poor patient experience and impacting on staff morale.	Catastrophic	Almost certain	25	Extreme	Chief Medical Officer	• GRAT tools in use for patients in ED, after 6 hours and then 2-4 hourly • The process of ambulance diversions in place in times of surge • Level 4 bed pressure actions implemented when EDs are overwhelmed • Safety matrix is completed 2 hourly in ED escalating concerns as required to site lead • SDEC work streams and AMU • There is a process to board patients in corridors on wards in order to increase hospital capacity • Additional 24 beds open in Aconbury 0 Dec 23 • Surge SOP • OPEL framework in place	• GRAT tool, KPI, complaints, incidents, friends and family tests	• Timely flow out of assessment units to ward-based areas to ensure onward flow • Timely flow out of wards to community pathway-based care to create ward-based capacity • Lack of hot clinic provision to support SDEC pathways and improve efficiency of acute pathways • Actions within surge SOP not being followed	•	20	Extreme	9	High

ID	Opened	Title	Description	Consequence (current)	Likelihood (current)	Rating (current)	Risk level (current)	Hospital Director or Executive Lead	Controls	Assurance	Gaps in controls	Gaps in assurance	Rating (initial)	Risk level (initial)	Rating (Target)	Risk level (Target)	Direction of Travel
5483	23/02/2024	BAF 2024 - Leading the NHS on Carbon Reduction	There is a risk that, as an anchor institution, the capital investment, resource and approval required to achieve the NHS Greener Plan and the 'Big Move' carbon reduction is not available, leading to an inability to meet compliance with the 10 point plan and national targets.	Minor	Almost certain	10	High	Chief Strategy Officer	• Sustainability grants • Green Steering Group • Foundation Group Support	• Capital planning	• Lack of capacity to prepare or respond to grant requests in a timely way • Lack of capital funding • Lack of resource to provide programme support • Not being awarded sustainability grants when available	• Over commitment and/or reduction in SALIX funding • Over commitment of capital funding schemes prioritsed to operational or remedial work	10	High	6	Moderate	
5474	19/02/2024	BAF 2024 - Culture	There is a risk that, if we fail to sustain a positive change in organisational culture and communicate the 4ward improvement system, the trust will fail to have the best people and be unable to deliver safe and effective high-quality compassionate treatment and care.	Moderate	Likely	12	High	Chief People Officer	• People and Culture 3-year plan • Behaviour Charter • 4ward Improvement • FTSU Guardian and Champions • Staff Inclusion Networks • 4ward Advocates	• JNCC • Freedom to Speak Up • Culture Steering Group • NHS Staff Survey	• Enduring and stable leadership • Staff engagement and confidence in FTSU and other processes • Effective leadership at all levels • Clear and universally understood vision for organisational culture	• Variability in ward to board implementation • Poor response to the NHS Staff Survey	15	Extreme	6	Moderate	
5475	19/02/2024	BAF 2024 - Health and Wellbeing	There is a risk of significant negative impact on staffs' health and wellbeing (including sickness absence, low morale), their experience and retention due to operational pressures, industrial action and workloads.	Moderate	Likely	12	High	Chief People Officer	• Staff Health and Wellbeing Service (which includes free counselling) • National NHS well-being support apps • Clinical psychologist support • Health and Wellbeing Brochure/Bulletin • Effective interventions in response to well-being issues • Menopause support group • Health@work service available to meet requirements of the Trust. • Wellbeing Plan	• JNCC feedback • Finance and Performance Executive • Board Integrated Performance Report • ICS 'great place to work' project group • Best People Steering Group	• Speed and delivery of ICS-wide review of occupational health services • Inability to plan rotas around ongoing industrial action and other staff absences	• Expediency of future Occupational Health and Wellbeing Services structure and their ability to meet the Trust's requirements and wider across the ICS	15	Extreme	9	High	

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5480	22/02/2024	BAF 2024 - Digital Strategies to Support 'Big Moves'	There is a risk of a delay to the delivery of benefits and the future capital funding of digital infrastructure to support 'Big Moves' due to the scale, number and complexity of individual projects and the change/transition requirements of the workforce.	Major	Possible	12	High	Chief Digital Officer	• Digital Governance Framework to address: training; workforce; oversight • Risk management Project management (including scope of delivery) • Annual business planning cycle	• Digital strategy group	• Change management and training of staff • Staff engagement • Work pressures and availability of staff to be released to attend training • Lack of resilience in resource plans • Impact of the introduction of digital strategies across all stakeholders • Uncertainly of national priorities and funding for delivery of digital strategies • Competing digital priorities internally/system-wide • Oversubscription of digital initiatives against base resources	•	16	Extreme	12	High	➡
5484	23/02/2024	BAF 2024 - Maturity of PLACE	There is a risk that, due to the immaturity of PLACE, PLACE is unable to achieve their objectives or provide sufficient system assurance to reduce inequalities and improve sufficiently the 'home first mindset', to provide support to more people at home, which would enable WAHT to deliver on its objectives.	Moderate	Likely	12	High	Director of Strategy Planning and Improvement	• Frailty strategy • Revised governance and repurposed integrated PLACE delivery groups • Primary and secondary interface group • Being well strategy • Fuller action plan • Worcestershire PLACE communications cell	• New PLACE Board (from April 2024) chaired by CEO • New Integrated Delivery Board (from April 2024) chaired by HWHCT CEO • Health Inequalities Programme Board with HI champions	• Lack of co-designed PLACE plan • PLACE development director vacancy • Emergency pathway approach eg frailty, LTC • Lack of coherent demand and capacity plan/use of single bed base PLACE strategy	• BI resource to support PLACE-level management oversight • Clarity on roles and responsibilities (emergent)	15	Extreme	6	Moderate	➡

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5486	23/02/2024	BAF 2024 - Partnership with large specialist providers	There is a risk that tertiary partnerships will be unable to deliver and improve upon existing local, regional and system-wide services (including fragile services) resulting in a failure to deliver appropriate tertiary care and improve patient outcomes.	Major	Possible	12	High	Director of Strategy Planning and Improvement	• Clinical services strategy • WM Diagnostic network • SM Pathology network • WM Cancer Alliance • Fragile Services CMO/COO forum at ICS and Foundation Group level • Regional Trauma Network	• Elective, Cancer & Diagnostic Delivery Group • ICS Programme Board • SM Partnership Board • ICS CMO/COO forum • TRID System - Trauma Incidents	• Identifying areas of opportunity for future tertiary partnerships • Tertiary partnership work programme • Delivery of partner performance targets • Impact of delegation of specialist commissioning to ICB	• Refreshed CSS 2024 to clarify strategy and review strategic partnerships to support strong MDT working • Lack of clear commissioning oversight by ICB	12	High	6	Moderate	➡
5492	27/02/2024	BAF 2024 - Capital Investment to support delivery of the 10 Point Plan	There is a risk that capital funds are not sufficient to meet the collective requirements of the Trust, not limited to the delivery and investment in key estates and digital infrastructure plus Trust medical equipment due to a restriction on the capital resources available to the Trust which could lead to a worsening of the condition of the Trust's estate and/or an inability to procure essential ICT systems and medical equipment resulting in adverse impacts on healthcare delivery.	Moderate	Likely	12	High	Chief Financial Officer	• Capital planning and prioritisation of key schemes and equipment • Holding contingency funds for adhoc emergency requirements • Seeking further capital funding from available outlets • Operational planning process • Capital risks and opportunities analysis	• Project teams and programme board structure in place for major schemes • Estates and Facilities Delivery Board • Capital Planning and Delivery Group • Business case approval process in line with Standing Financial Instructions • Financial reports to Board	• Ability to determine emergency capital spend requirements • Approval of capital fund applications • Capital funding provided is not sufficient to meet whole requirement • Uncertainty regarding level of future funding resource	•	15	Extreme	9	High	➡

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5473	19/02/2024	BAF 2024 - Workforce	There is a risk to achieving the Trust's 10 Point Plan due to: staff shortages; being unable to recruit to clinical, nursing and support staff vacancies; and, failure to achieve staffs' full operating capabilities - resulting in the use of locum staff (and an inability to comply with agency caps), increasing costs, a lack of capacity to deliver national standards, local plans and to address service fragility.	Major	Likely	16	Extreme	Chief People Officer	• Workforce Plan • Recruitment Plan • Retention Plan • Staff Offer • Agency Reduction Plan • e-rostering • Use of NHS Professionals • International Recruitment	• Best People Steering Group • Board Integrated Performance Report • Finance and Performance Executive • Integrated People and Culture Report	• Governance process to allow Advance Practitioners to fulfill their maximum operating capabilities • Agenda for change does not support competitive salaries required for some roles (eg digital and informatics posts) • National shortages of clinical staff, both medics and registered nurses • Operational pressures impacting on the ability of managers to complete timely recruitment and retention processes • Uncertainly of the impact of industrial action • Clear workforce plan that addresses opportunities within the ICS	• National compliance with directive on nil off-framework agency usage • Expediency of ICS-wide initiatives • National long-term plan	20	Extreme	12	High	➡
5479	21/02/2024	BAF 2024 - Ability of System to Manage Flow Across the Urgent and Emergency Care Pathway	There is a risk that the system is unable to enact the measures required to avoid the need for hospital care, the management of discharge pathways and the unblocking of barriers which, in turn, places unrelenting pressure on the Trust's urgent and emergency care pathway increasing the risk and scale of patient safety incidents, poor patient experience and quality of care.	Major	Almost certain	20	Extreme	Chief Operating Officer	• System-wide Silver Meetings • Winter Plan • Single Point of Access • Same-day Emergency Care • Urgent Care Response/Call Before You Convey • Discharge Planning	• Hospital Flow Delivery Group	• Additional financial burden as a result of inability to mitigate additional activity at the 'front door' • Winter plan/pathway initiatives untested • Ability to prevent 4 and 12 hour ED breaches and improve system flow	• System oversight of discharge delays and capacity • Availability of Quality Impact Assessments to support surge and escalation activity • Plan to address mission creep to 'business as usual'. • Normalised bed capacity greater than 100%	20	Extreme	8	High	➡

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5481	22/02/2024	BAF 2024 - Cyber Security	There is a risk to the achievement of the Trust's 'focus on flow' and 'Big Moves' objectives plus overall service delivery due to potential system failure due to cyber security attacks.	Catastrophic	Likely	20	Extreme	Chief Digital Officer	• Cybersecurity action plan • Trust and Digital division risk management process • Perimeter level cyber security mechanisms • Risk-based approach to cyber and infrastructure funding • Monitoring mechanisms and resource to monitor cyber events • Exercises eg phishing, desktop business continuity • Business continuity plans • Capital planning programme	• National Digital Maturity Score • Data Security Protection Toolkit • Contract monitoring reported to Digital Strategy Group • EPRR Core Standards	• Oversubscription to digital/systems against baseline support levels and resources • Uncertainty of funding • Effective asset management process and controls • Staff training to enhance skills and awareness of cyber risks	• Cyber risk results from the continually changing landscape of actors and methods, which all organisations struggle to keep pace with. • Dashboard in place but requires embedding and assurances around completeness • Frequency of reports (nationally)	20	Extreme	10	High	↑
5485	23/02/2024	BAF 2024 - Operational Capacity Plans and Delivery	There is a risk that the Trust will be unable to achieve its productivity and activity plans as a result of factors not limited to: staff shortages; pace of improvement; industrial action; access to outsourced and insourced capacity; and, sub-optimal urgent pathways. These factors, either individually or collectively, will severely impact on productivity and operational capacity plans that deliver safe elective, cancer, emergency and critical care.	Catastrophic	Likely	20	Extreme	Chief Operating Officer	• Additional staffing in place • Increased use of the Kidderminster Treatment Centre • Escalation plans • Group and system-wide mutual aid • Ring-fenced elective pathways • Increased use of the Alex site to support elective surgery • Increased diagnostic capacity provided	• Daily reporting and escalation • Finance and Performance Executive reports • Trust Board Integrated Performance Report • RTT and cancer PTL reviews	• Additional duty payment (NROC) negotiation • Ongoing impact of industrial action Increase in non-elective activity leading to capacity constraints	• Expediency of estates/site improvements • Staff engagement • Clearly documented VFM assessment of additional capacity that may be required.	25	Extreme	10	High	→

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5491	27/02/2024	BAF 2024 - Delivery of Financial Plan	There is a risk that the financial plan will not be achieved in year or an improvement made in the medium term due to the: scale of efficiencies (CPIP) and productivity required; impact of inflationary pressures; and, risks to achieving the full income target and the 10 point plan. This could lead to a worse than planned in-year and underlying deficit resulting in regulatory action and a shortfall in cash to meet obligations.	Catastrophic	Likely	20	Extreme	Chief Financial Officer	• Financial strategy aligned to a sustainable clinical strategy • Recovery plan • CPIP devolved as part of divisional budget for identification and delivery • CPIP targets agreed by divisions • Established process for identification and monitoring of CPIP delivery • Activity plan implementation • Enhanced financial controls • Appointment of Turnaround Director	• Oversight by Finance Recovery Board • Monthly Finance and Performance Executive review of CPIP delivery • Integrated performance report to Trust Board • ICS Finance Forum - NED-led to oversee system financial performance • System Investment and Expenditure Ctte - Management-led oversees adherence to the enhanced financial controls	• Clinical strategy • Financial stragety Recovery plan • Action plans in place for medical and nurse agency reduction • National inflationary pressures • Process of early identification and capture of full CPIP plan • Lack of recurrent efficiencies within the programme • Trust policies and processes require strengthening to ensure compliance	• Absence of work on a sustainable clinical strategy • Trust medical and nurse agency reduction routine review of action plans and compliance with controls • Trust policies and processes require strengthening to ensure regular monitoring and reporting • CPIP plans not fully identified to meet targets • CPIP Audit Report • Impact of newly-formed Improvement Board	25	Extreme	10	High	➡

Acronym	
AAU	Acute Admissions Unit
AEDB	Accident & Emergency Delivery Board
AHP	Allied Health Professional
AKI	Acute Kidney Injury
AMU	Ambulatory Medical Unit
A&E	Accident & Emergency Department
ATAIN	Avoidable Term Admissions into Neonatal Units
BAF	Board Assurance Framework
BAME	Black, Asian and Minority Ethnic
BAPM	British Association of Perinatal Medicine
BCF	Better Care Funding
CAMHS	Child and Adolescent Mental Health Services
CAS	Central Alert System
CAU	Clinical Assessment Unit
CCU	Coronary Care Unit
C. Diff	Clostridium Difficile
CCG	Clinical Commissioning Group
CPIP	Cost Productivity Improvement Plan
CNST	Clinical Negligence Scheme for Trusts
COPD	Chronic Obstructive Pulmonary Disease
COSHH	Control Of Substances Harmful to Health
CCOSMOS	CNST, CQC, Ockenden 1, Single Delivery Plan (SDP), Maternity Self-Assessment Tool, Ockenden 2 and Saving Babies Lives
CQC	Care Quality Commission
CQUIN	Commissioning for Quality & Innovation
CNST	Clinical Negligence Scheme for Trusts
DOLS	Deprivation of Liberty Safeguards
DCU	Day Case Unit
DNA	Did Not Attend
DTI	Deep Tissue Injury
DTOC	Delayed Transfer Of Care
ECIST	Emergency Care Intensive Support Team
ED	Emergency Department
EDD	Expected Date of Discharge
EDS	Electronic Discharge Summary
EPMA	Electronic Prescribing & Medication Administration
EPR	Electronic Patient Record
ESR	Electronic Staff Record
FAU	Frailty Assessment Unit
FBC	Full Business Case
FOI	Freedom of Information
F&F	Friends & Family
FRP	Financial Recovery Plan
FTE	Full Time Equivalent
GAU	Gilwern Assessment Unit
GE	George Eliot Hospital
GIRFT	Getting It Right First Time
GMC	General Medical Council

HASU	Hyper Acute Stroke Unit
HCA	Healthcare Assistant
HCSW	Healthcare Support Worker
HDU	High Dependency Unit
HIE	Hypoxic-Ischaemic Encephalopathy
HSE	Health & Safety Executive
HFMA	Healthcare Financial Management Association
HAFD	Hospital Acquired Functional Decline
HSMR	Hospital Standardised Mortality Ratio
HV	Health Visitor
ICS	Integrated Care System
IG	Information Governance
IV	Intravenous
JAG	Joint Advisory Group
KPIs	Key Performance Indicators
LAC	Looked After Children
LAT	Looked After Team
LMNS	Local Maternity and Neonatal System
LOCSIPPS	Local Safety Standards for Invasive Procedures
LOS	Length Of Stay
MASD	Moisture Associated Skin Damage
MBRRACE	Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries
MEWS	Maternal Early Warning Scores
MCA	Mental Capacity Act
MCA	Maternity Care Assistant
MES	Managed Equipment Services
MHPS	Maintaining High Professional Standards
MIS	Maternity Incentive Scheme
MIU	Minor Injury Unit
MLU	Midwifery Led Unit
MNSI	Maternity & Newborn Safety Investigations
MRSA	Methicillin-Resistant Staphylococcus Aureus
MSSA	Methicillin-Sensitive Staphylococcus Aureus
MSW	Maternity Support Worker
NEWS	National Early Warning Scores
NEWTT	Newborn Early Warning Trigger and Track
NHSCFA	NHS Counter Fraud Authority
NHSLA	NHS Litigation Authority
NHSR	NHS Resolution
NICE	National Institute for Health & Clinical Excellence
NIV	Non-invasive ventilation
OBC	Outlined Business Case
OOC	Out Of County
OOH	Out Of Hours
PALS	Patient Advice & Liaison Service
PAS	Patient Administration System
PCIP	Patient Care Improvement Plan
PIFU	Patient Initiated Follow Up
PPE	Personal Protective Equipment
PFI	Private Finance Initiative
PID	Project Initiation Document

PIFU	Patient Initiated Follow Up
PLACE	Patient Led Assessment of the Care Environment
PHE	Public Health England
PMR	Perinatal Mortality Rate
PROMs	Patient Reported Outcome Measures
PROMPT	PRactical Obstetric Multi-Professional Training
PSIRF	Patient Safety Incident Response Framework
PTL	Patient Tracking List
QIA	Quality Impact Assessment
QIP	Quality Improvement Programme
RAG	Red, Amber, Green rating
RCA	Root Cause Analysis
ReSPECT	Recommended Summary Plan for Emergency Care and Treatment
RGN	Registered General Nurse
RRR	Rapid Responsive Review
RTT	Referral to Treatment
SAA	Surgical Assessment Area
SCBU	Special Care Baby Unit
SDEC	Same Day Emergency Care
SDP	Single Delivery Plan (maternity)
SOP	Standard Operating Procedures
SOC	Strategic Outline Case
SSNAP	Sentinel Stroke National Audit Programme
SHMI	Summary Hospital Level Mortality Indicator
SI	Serious Incident
SIRI	Serious Incident Requiring Investigation
SLA	Service Level Agreement
SOP	Standard Operating Procedure
STF	Sustainability and Transformation Funding
STP	Sustainability and Transformation Plan
SWFT	South Warwickshire NHS Foundation Trust
TMB	Trust Management Board
TIA	Transient Ischemic Attack
TOR	Terms of Reference
TTO	To Take Out
TVN	Tissue Viability Nurse
UTI	Urinary Tract Infection
WAH	Worcestershire Acute Hospitals
WTE	Whole Time Equivalent
WHO	World Health Organisation
WVT	Wye Valley NHS Trust
WW	Week Wait
YTD	Year To Date
#NOF	Fractured Neck of Femur