TRUST BOARD - 31 March 2021

ITEMS FOR APPROVAL

ITEMS FOR NOTING FOR ASSURANCE

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	BM/21/03/42			
SUBJECT:	**Performance Assurance Framework Review 2021/22**			
DATE OF MEETING:	31st March 2021			
AUTHOR(S):	Dan Birtwistle, Deputy Head of Contracts & Performance			
EXECUTIVE DIRECTOR SPONSOR:	Andrea McGee - Chief Finance Officer and Deputy Chief Executive			
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	SO1 We will.. Always put our patients first through high quality, safe care and an excellent patient experience.	x		
	SO2 We will.. Be the best place to work with a diverse, engaged workforce that is fit for the future.	x		
	SO3 We will ..Work in partnership to design and provide high quality, financially sustainable services.	x		
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): **(*Please DELETE as appropriate)***	#115 Failure to provide adequate staffing levels in some specialities and wards. #134 (a) Failure to sustain financial viability. #134 (b) Failure to deliver the financial position and a surplus #224 Failure to meet the emergency access standard.			
EXECUTIVE SUMMARY ***(KEY ISSUES):***	The Performance Assurance Framework (PAF) outlines how the Trust develops and maintains an effective culture, systems and processes for monitoring, managing and improving performance across the organisation. The PAF is reviewed and refreshed annually. A review of the purpose of the Trust Operational Board (TOB) was paused as a result of the COVID-19 pandemic. Responsibility for oversight of Digital transferred to the Finance & Sustainability Committee (FSC) during 2020/21. It is further proposed that until the review of the TOB is complete, the Strategic Executive Oversight Group (SEOG) will receive a Performance Summary Report which will highlight performance exceptions at CBU level, providing narrative and outlining improvement actions. Additional minor amendments to reflect updates in the organisational structure have also been included in the updated PAF as part of the annual refresh. Updates to the Integrated Performance Report (IPR) Key Performance Indicators (KPIs) for 2021/22 will be made separately in line with the process set out within the PAF.			
PURPOSE: ***(please select as appropriate)***	Information	Approval X	To note	Decision

RECOMMENDATION:	**The Trust Board is asked to:** 1. Approve the transfer of CBU Performance Reporting to the SEOG, whilst the TOB is under review. 2. Approve the amendments to the PAF (in Red) as part of the annual refresh.	
PREVIOUSLY CONSIDERED BY:	**Committee**	Finance & Sustainability Committee
	Agenda Ref.	FSC/21/03/51
	Date of meeting	FSC – 24/03/2021
	Summary of Outcome	Supported
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	Choose an item.	

REPORT TO BOARD OF DIRECTORS

SUBJECT	Performance Assurance Framework Review 2021/22	AGENDA REF:	BM/21/03/42

1. BACKGROUND/CONTEXT

The Performance Assurance Framework (PAF) outlines how the Trust develops and maintains an effective culture, systems and processes for monitoring, managing and improving performance across the organisation. The PAF is reviewed annually to ensure it remains relevant and up to date and reflects changes in the structure of the organisation.

This paper outlines the proposal for amendments to the PAF for 2021/22.

2. KEY ELEMENTS

The following amendments are being proposed to the Performance Assurance Framework and have been incorporated into the updated PAF in **Appendix A.**

- A review of the purpose of the Trust Operational Board (TOB) was paused as a result of the COVID-19 pandemic. Responsibility for oversight of Digital transferred to the Finance & Sustainability Committee (FSC) during 2020/21. It is further proposed that until the review of the TOB is complete, the Strategic Executive Oversight Group (SEOG) will receive a Performance Summary report which will highlight performance exceptions at CBU level, providing narrative and outlining improvement actions.
- A refresh of roles, job titles and the structure of the Trust in line with changes implemented throughout 2020/21.

3. RECOMMENDATIONS

The Trust Board is asked to:

1. Approve the transfer of CBU Performance Reporting to the SEOG, whilst the TOB is under review.
2. Approve the amendments to the PAF (in Red) as part of the annual refresh.

Appendix A

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Performance Assurance Framework – Update for March 2021

Performance Assurance Framework

1. Introduction

1.1 Background

This Performance Assurance Framework (PAF) sets out principles of accountability and the commitment by Warrington & Halton Teaching Hospitals NHS Foundation Trust to establish and maintain an effective culture, systems and processes for managing and improving performance across all levels of the Trust. The PAF was developed to provide clarity of accountability from Ward to Board and is underpinned by a focus on outcomes for patients and the public. All staff are required to understand their role and responsibility in relation to performance and its impact on patient care.

1.2 What is Performance Management/Improvement?

Performance management is about ensuring the delivery of timely, high quality, effective and safe patient care using Trust resources in an efficient manner. This includes understanding how the Trust is performing in relation to national and local indicators, the underlying causes of underperformance, and barriers to performance improvement. This is as an integral part of the day to day management of operational services.

1.3 Scope

The Performance Assurance Framework covers all performance requirements set out in the Trust's Operational Plan, NHS Improvement Oversight Framework, NHS Standard Contract, by the CQC and Foundation Trust Licence. Whilst the framework describes the links to individual accountabilities and the contributions that all staff makes to the delivery of Trust performance, it does not deal directly with individual performance management, which is covered in the agreed Trust performance management policy/incremental pay progression policy.

1.4 Dependencies

The successful implementation of the PAF is dependent upon the production of information dashboard and reports by the Trust's Information Team and the timely supply of data by the Trust's Finance, Quality and HR teams.

1.5 Associated Polices and Strategies

Whilst the Performance Assurance Framework incorporates performance across the whole Trust, it is recognised that the Trust has policies and procedures in place that will contribute to the delivery of this Performance Assurance Framework. The Performance Assurance Framework will support achievement of the Trust vision, mission, objectives and values (**Appendix 1**).

2. Role and Function of the Performance Assurance Framework

2.1 Main Purpose

This Performance Assurance Framework sets out the approach the Trust undertakes in ensuring there are effective systems in place to monitor, manage and improve performance. Prompt reviews will be undertaken where performance is deteriorating, and appropriate actions will be implemented to bring performance back to an acceptable level. The Performance Assurance Framework will:

- Set out clear lines of accountability and responsibility for delivery of performance from Ward to Board.
- Ensure performance objectives are agreed and transparent measurements are set to monitor performance against these standards, targets and plans.

- Ensure performance delivery is focused and is seen as a continual process which is embedded in all aspects of organisational activity.
- Provide assurance to the Board, Governors, Stakeholders and the Public that the organisation has strong systems in place to deliver the highest standards of patient care.
- Support the achievement of the Trust objectives.
- Support the delivery of the requirements of the Trust Foundation Licence, NHS Improvement Oversight Framework and the NHS Standard Contract.
- Provide focus on and assurance of best value for money ensuring that services meet the needs of the local population and local health economy.
- Support the delivery of an engaged and motivated workforce with the right skills and capacity to provide consistent, good quality care.
- Recognise good performance and improvement and share good practice.
- Sets out the process for managing performance risks/issues with a balance between challenge and support.

3. Our approach to Performance Management

3.1 Ward to Board Accountability Structure

The accountability structure provides a line of sight from Ward to Board and Board to Ward as set out in **Appendix 2** and is detailed as follows:

3.1.1 Trust Board Level

The Trust Board meets bi-monthly and receives the Integrated Performance Report (IPR) which is presented with explanation from the Executive Directors. The Trust Board may request one or more performance improvement actions (see 3.3.2) where there is a concern with any area of performance.

KPIs within the Board IPR are reviewed and agreed annually by Board Committees with approval from the Trust Board. KPIs may be changed in year with the minuted support of the appropriate Board Committee and the approval of the Trust Board.

The IPR Dashboard contains the following elements which are designed to provide the Trust Board with assurance around the performance of the Trust against the KPIs and to highlight areas of improvement and good practice:

- Exception Report – the front section of the document is an exception report which highlights KPIs which have been RAG rated Red as well as any movements in KPIs month to month.
- RAG Movements – this section shows a rolling 12 month RAG rating and the movement in performance against each KPI.
- High Level Summary – the IPR is split into 4 key areas; Quality, Access & Performance, Workforce and Finance. A high level summary is provided for each of these areas.
- Dashboard – The dashboard details current and historic levels of performance, reasons for under performance and/or performance deterioration and detail of actions and investigations underway in order to improve performance against the KPI. The dashboard contains Statistical Process Control (SPC) charts which look at data over time to determine if a process is within control or not. These charts are used alongside traditional RAG ratings to identify areas of focus.

There is an annual rolling programme of auditing of KPIs to ensure there is assurance around the quality of the data and reporting processes which is facilitated by MIAA.

3.1.2 Board Committees (Finance & Sustainability, Quality Assurance and Strategic People)
Executive Directors and Senior Managers will present updates on performance relative to the Committee remit as appropriate. The Committee may request one or more performance improvement actions (see 3.3.2) where there is a concern with any KPI. The Committee will escalate any performance concerns to the Trust Board as appropriate via the committee chair report.

Each Committee receives regular performance reports as part of its agenda. The KPIs contained in the Committee reports can be changed by approval of Committee members as there may be occasions where the Committee wants to report at a more granular level. Any changes to KPIs need to triangulate to the Board IPR. All changes must be minuted to include the rationale for the change.

3.1.3 KPI Sub-Committee
The KPI sub-committee chaired by the Trust's Chief Operating Officer will review performance at CBU level. The sub-committee may request one or more performance improvement actions (see 3.3.2) for any areas of concern. The KPI sub-committee will escalate to the Strategic Executive Oversight Group as appropriate.

The KPI sub-committee receives the CBU level IPR. The KPI sub-committee may approve amendments to the CBU Level IPR with a minuted rationale, KPIs at CBU level should triangulate with the Trust Board IPR, however the KPI sub-committee may monitor additional indicators at a more granular level to understand performance in-depth.

3.1.4 Trust Operational Board
The Trust Operational Board (TOB), chaired by the Chief Executive Officer focuses on development and delivery of the Trust's strategy and will review progress of strategic priorities, however the TOB will also receive exception reports from CBUs which will focus on any KPIs which are RAG rated Red. The TOB may request one or more performance improvement actions (see 3.3.2) where there are any areas of concern. The TOB will escalate to the Trust Board as appropriate. The purpose and function of the TOB is under review, however the review has been paused due to the COVID-19 pandemic. As an interim measure, the Strategic Executive Oversight Group will receive a monthly CBU Performance Report which will highlight performance exceptions at CBU level providing narrative and outlining actions. The Strategic Executive Oversight Group may request one or more performance improvement actions (see 3.3.2) where there are any areas of concern.

3.1.5 CBU Partnership Forum Review (QPS)
The CBU Partnership Forum chaired by the CEO will review each CBU's performance in depth in all areas. Discussions will take place to understand any barriers to performance improvement and will look at any additional support required to address these barriers. The CBU Triumvirate will be required to attend this forum twice a year and present their position, highlighting any areas of concern, as well as areas of good practice which can be shared across CBUs. Actions from the forum will be recorded by a member of the Performance Team. If urgent actions are required, the CBU will provide an update to the next available SEOG meeting and will not wait until their next bi-annual review. Prior to the CBU Partnership Forum review, the CBU Triumvirate and Performance Team will prepare a report which contains information relating to progress around priorities identified in CBU business plans which in turn supports delivery of service level strategies and will also focus on the areas of performance around; Quality & Governance and Operational Performance (Quality), People (People) and Finance (Sustainability). The report will also include information about current issues, risks challenges and future plans.

The SEOG may request one or more performance improvement actions (see 3.3.2) where there are any areas of concern. The SEOG may escalate to the appropriate Board Committee or the Trust Board.

The SEOG may ask CBUs to attend SEOG meetings at any time outside of the review process where there is a concern around performance in any area.

3.1.6 CBU Level

The CBU Triumvirate is expected to manage the performance of their services and have appropriate structures/forums in place to do so. The CBUs will be able to access performance information to enable them to monitor and manage performance in real time. CBUs are required to take corrective action to improve areas of underperformance, working with corporate services and other Trust departments as appropriate. CBUs are required to attend a weekly Performance Review Group (PRG) chaired by the Deputy Chief Operating Officer to focus on areas of underperformance. CBUs should escalate any areas of performance concern to the appropriate forum as above. The CBU Triumvirate may request one or more performance improvement actions (see 3.3.2) for an individual Ward, Department, Service or Team where there are any areas of concern.

3.1.7 Ward, Department, Service or Team Level

Ward/Department/Service/Team managers will be able to access appropriate performance reports at that level in order to ensure they are managing day to day performance. Wards/Departments/Services/Teams are accountable to the CBU Triumvirate, who will provide any support, along with corporate services as necessary.

The production of quality, meaningful and timely performance information is fundamental to the delivery of the Performance Assurance Framework. Information must be timely, accurate and complete; and follow the principles set out in the Trust's Information Governance and Data Quality Policy.

3.2 Roles & Responsibilities

Specific roles and responsibilities in relation to the ongoing monitoring, management and improvement for the performance of the Trust are as follows:

3.2.3 Chief Executive

The Chief Executive has overall statutory responsibility for performance across the Trust.

3.2.2 Executive Directors

Executive Directors have delegated authority and responsibility for areas within their portfolio for ensuring effective performance management structures, systems and processes are in place for reporting, managing and improving performance with robust arrangements in place for addressing performance concerns.

3.2.3 Chief Finance Officer & Deputy Chief Executive

In addition to responsibilities outlined in 3.2.2, The Chief Finance Officer & Deputy Chief Executive has delegated authority for ensuring the overarching Performance Management Framework is in place and Executive oversight of the Performance Team activities outlined in 3.2.4.

3.2.4 Performance Team

The Performance Team is responsible for the management, production and development of the Trust and CBU IPR as well as the management of the CBU partnership forum (QPS) process. The

Performance Team is the gatekeeper of the IPR and is responsible for ensuring any changes are approved via the appropriate governance process and once approved are actioned.

The Performance Team will provide training to the CBUs so that all staff have sight and understanding of the performance KPIs they are accountable for and are aware of the associated consequences of not achieving the required standards.

3.2.5 Business Intelligence/Information Team
The Information Team will develop, generate and publish the necessary local reports and dashboards to enable the CBU/Teams to monitor and manage performance and will provide data for the Trust and CBU level IPRs.

3.2.6 Corporate Services
Corporate services (Finance, Governance, HR, IM&T, Strategy) has responsibility for the production and validation of data for Trust & CBU IPR dashboards. Corporate services will provide the necessary support to CBUs in order to improve performance in their area.

3.2.7 CBU Triumvirate
The CBU Triumvirate has responsibility for the management and improvement of performance for their CBU and will implement appropriate performance improvement actions (see 3.3.2).

3.2.8 Ward/Department/Service/Team Managers
The Ward/Department/Service/Team managers have responsibility for the management and improvement of performance for their Ward/Department/Service/Team and will implement any improvement actions requested by the CBU Triumvirate.

3.2.9 All Staff
All members of staff contribute to managing and improving performance and are encouraged to suggest areas for improvement and ideas on how improvement can be made. All staff should have an understanding of how their role contributes to performance of the Trust and the impact this has on patient care.

3.3 Performance Risks/Issues
Where there is a risk to the Trust achieving a standard or target or where performance has fallen below the required standard, this should be highlighted as a performance risk/issue. All actions and interventions relating to performance risk/issues will focus on ensuring patient safety is paramount, be delivery focussed and proportionate to the level of risk identified and there will be a balance between challenge and support, recognising any organisation wide resource needs.

3.3.1 Identification and Management
A performance risk/issue can be identified by any member of staff at any level of the organisation (Ward to Board).

Where a performance risk/issue has been identified, it is the responsibility of the performance oversight group outlined below to oversee appropriate actions in order to resolve the issue as soon as possible.

Performance Issue/Risk Area	Performance oversight Group	Support
Ward, Department, Service or Team Level	CBU Triumvirate	Corporate Services
CBU Level	KPI Sub-Committee Strategic Executive Oversight Group	
Trust Level	Strategic Executive Oversight Group – reporting to: Finance & Sustainability Committee Strategic People Committee Quality & Assurance Committee Trust Board	

3.3.2 Performance Improvement Actions

A. Informal

Some low/medium level performance issues/risks may be managed locally by reviewing processes and making the necessary operational changes. These performance risk/issues may be as a result of a temporary local issue such as a staff shortage or an unexpected increase in demand. In the first instance, these performance issues should be managed and resolved locally with the appropriate authority to do so.

B. Remedial Action Plan

Where a performance risk/issue cannot be resolved in the short term and it is likely to have a medium to long term impact on Trust performance, the performance oversight group will request a Remedial Action Plan. The Remedial Action Plan will outline actions to be taken, impact, timescales and review timescales and will be reviewed at an appropriate forum each month. Once the performance oversight group is satisfied that the actions are complete and performance has returned to a satisfactory level, the Remedial Action Plan will be closed.

C. Deep Dive Review

The relevant performance oversight group may request at any time a deep dive investigation into areas where there is a continued performance concern. The performance oversight group will set out terms of reference including timescales. Once the review has been concluded, the performance oversight group will agree next steps; this may include the implementation of a Remedial Action Plan or the establishment of an improvement committee.

D. Improvement Committee

Where performance issues/risks need additional support in order to return to satisfactory levels, a time limited Improvement Committee will be established. The Improvement Committee will be made up of representatives from corporate and clinical services as appropriate and will be sponsored by an appropriate Executive Director or Senior Manager and will report progress to the performance oversight group.

E. Intensive Support

Where performance has not returned to a satisfactory level after the required support has been provided, the performance oversight group may place a CBU or Team into Intensive Support. Intensive Support is a recovery planning and delivering procedure and is a mechanism to direct additional management focus; it should not be used as a punishment. The performance oversight group will write to the CBU/Team to inform them of the decision and will outline the reasons this action has been taken. The CBU/Team will be expected to report weekly to the performance oversight group actions taken to improve performance and the impact this has had. This effort will

be supported by appropriate corporate resources. The CBU/Team will remain in Intensive Support until the performance issue has been resolved. Once the performance oversight group is satisfied that the performance issue has been sufficiently addressed, the performance oversight group will write to the CBU/Team to inform them of the decision to bring them out of Intensive Support.

The Intensive Support procedure may be deployed in the following circumstances:

- Where there are continued and persistent performance issues within one or more areas.
- Where there is a risk to patient safety, effective delivery of services or any other reasons where it is judged that the level of support is justified by the performance oversight group.
- Where delivery levels against operational performance targets is inadequate, and where no robust corrective plan has been agreed.
- Failure to operate within the financial parameters outlined or evidence of lack of financial controls.
- Any other circumstances where it is judged that a material risk exists which cannot be resolved via normal line management actions or where less intensive recovery actions have failed.

4. Structure and Governance to ensure delivery

4.1 Accountability, Responsibility and Reporting Structure

Appendix 2 sets out the Trust's Accountability, Responsibility and Information reporting structure. Each meeting will have a Terms of Reference, setting out clear roles and responsibilities, objectives and membership and the devolved responsibilities from Board to Ward.

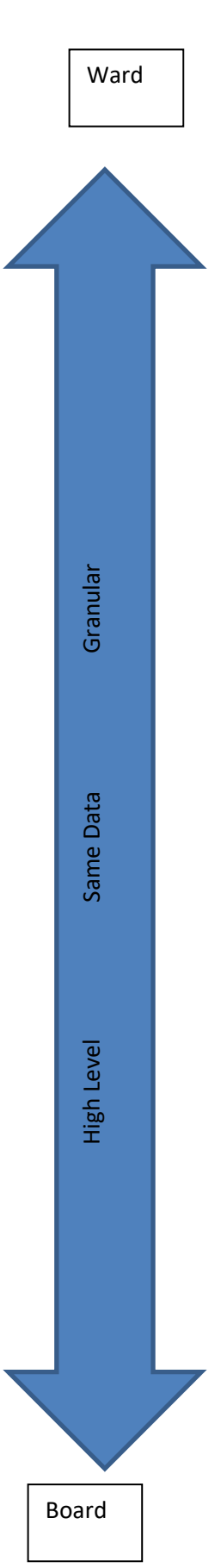
5. Next Steps

This Performance Assurance Framework will be reviewed in March 2022.

Appendix 1

The Trust's Values & Strategic Objectives are currently under review and will be included once these have been approved.

Appendix 2 - Trust Accountability, Responsibility and Information Reporting Structure – Ward to Board



CBU/Ward/Departmental Meetings

- CBUs/Wards/department leaders
- Review performance at granular level weekly and take corrective action as appropriate
- CBU Managers report up to KPI

KPI Sub-Committee

- Full review of performance at CBU level specific
- Identify any risk/issues and agreement of remedial action plans
- Preparation for bi-annual QPS review
- Monitoring of remedial actions arising from QPS

CBU Partnership Forum & Executive Committee/SEOG

- Executive Committee holds CBUs to account
- Performance reports at CBU Level
- CBUs attend bi-annually on a rotational basis

Board Committees

- Executive Director/Senior Leaders attend meetings
- Board Committees review their performance reports/dashboards
- Deep dives requested by Committee where concerns about performance
- Committees assure Board through key issues reports and escalates any issues to Trust Board

Trust Board

- Integrated Performance Report presented by Executive Directors
- Receiving concerns raised by Committee Chairs
- Board request additional actions and assurance where necessary
- Bi-Monthly meeting

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/21/03/43**			
SUBJECT:	**Trust Board Cycle of Business 2021-2022**			
DATE OF MEETING:	24 March 2021			
AUTHOR(S):	John Culshaw, Trust Secretary			
EXECUTIVE DIRECTOR SPONSOR:	Simon Constable, Chief Executive			
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	SO1 We will.. Always put our patients first through high quality, safe care and an excellent patient experience. SO2 We will.. Be the best place to work with a diverse, engaged workforce that is fit for the future. SO3 We will ..Work in partnership to design and provide high quality, financially sustainable services.			
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): **(*Please DELETE as appropriate)***	All			
EXECUTIVE SUMMARY ***(KEY ISSUES):***	In accordance with the Foundation Trust's Constitution 'Board of Directors – Standing Orders' the Board and Committees of the Board are required to review their Terms of Reference and Cycles of Business on an annual basis. Proposed changes to the Trust Board Cycle of Business are highlighted on the attached Cycle of Business.			
PURPOSE: ***(please select as appropriate)***	Information	**Approve √**	To note	Decision
RECOMMENDATION:	The Trust Board is asked to review and approve the 2021-2022 Cycle of Business for Trust Board			
PREVIOUSLY CONSIDERED BY:	**Committee**	N/A		
	Agenda Ref			
	Date of meeting			
	Summary of Outcome			
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None			

PUBLIC TRUST BOARD – CYCLE OF BUSINESS JANUARY 2021-MARCH 2022 DRAFT

		JAN 2021	MARCH 2021	Xxxx 2021	MAY 2021	JULY 2021	SEPT 2021	NOV 2021	JAN 2022	MARCH 2022
	OWNER			YEAR END						
Engagement story (15 mins)		**TBC**	**TBC**		**TBC**	**TBC**	**TBC**	**TBC**	**TBC**	**TBC**
OPENING BUSINESS										
Chairman's Opening Remarks, Welcome, Apologies & Declarations	**CHAIR**	X	X	X	X	X	X	X	X	X
Minutes of Previous Meeting & Action Log	**CHAIR**	X	X	X	X	X	X	X	X	X
Chief Executive's Report (incl CQC Steering Group Report)	**CEO**	X	X	X	X	X	X	X	X	X
Chairman's Report (Inc CoG Report)	**CHAIR**	X	X	X	X	X	X	X	X	X
QPS ASSURANCE										
Integrated Performance Dashboard incl Monthly Nurse staffing report	**EXECS**	X	X	X	X	X	X	X	X	X
PAF/ Review and refresh of Trust Integrated KPIs (April prior to formal signing in May)	**CFO&Dep CEO**		X	X						X
QUALITY										
Annual Complaints Report	**CN&Dep CEO**					X				
Learning From Experience Summary Report	**CN&Dep CEO**	XQ2	X Q3		XQ4		XQ1		XQ2	XQ3
Annual Health & Safety Report	**CN&Dep CEO**					X				
DIPC Report Annual	**CN&Dep CEO**					X	X	X		
DIPC Quarterly Report	**CN&Dep CEO**		XQ3		XQ4		XQ1	XQ2		XQ3
Infection Prevention and Control Board Assurance Framework Compliance Bi-monthly Report	**CN&Dep CEO**		X		X	X	X	X	X	X
Safeguarding Annual Report	**CN&Dep CEO**					X				
CQC Action Plan Update	**CN&Dep CEO**	X	X		X	X	X		X	X
Mortality Review (Learning from Deaths Quarterly Report)	**EMD**		XQ3		XQ4		XQ1	XQ2		XQ3
Medicines Management + Controlled Drugs Annual Report	**EMD**				X					
Annual SIRO Report	**CIO**				X					
Quality Strategy Update	**CN&Dep CEO**				X					
WHH Maternity Services - Compliance with Ockenden	**CN & Dep CEO**	X	X		X	X	X	X	X	X
CNST annual submission TBC	**CN&Dep CEO**					X				
PEOPLE										
NHS Staff Opinion Survey	**CPO**		X							X
Nurse Staffing Bi-Annual report	**CN&Dep CEO**		X				X			X
GMC Re-validation Annual Report incl Statement of Compliance	**EMD**							X		
Engagement Dashboard Quarterly Report	**DC&E**		Q3		Q4YREd	Q1		Q2		Q3

		JAN 2021	MARCH 2021	Xxxx 2021	MAY 2021	JULY 2021	SEPT 2021	NOV 2021	JAN 2022	MARCH 2022
	OWNER			YEAR END						
Engagement Dashboard Year End Report	**DC&E**				X					
Patient and Public Participation + Involvement Strategy Year End Report	**DC&E**					X yr report				
Patient and Public Participation + Involvement Strategy Review (due 03/2022)	**DC&E**									
Guardian of Safe Working Quarterly Report	**GUARDIAN**	X Q3			X Q4		X Q1	XQ2	X Q3	
Freedom To Speak Up – Guardian Bi-annual Report (Jane Hurst)	**CN&Dep CEO**		X				X			X
Hospital Volunteer Annual Report	**CN&Dep CEO**		X							X
Equality Diversity (EDAR) PSED Standard + Workforce Equality Assurance Report (WEAR) PSED Standard sign off annual public	**CPO**				X					
Patient Experience Strategy Annual Review	**CN&Dep CEO**		X							X
SUSTAINABILITY										
Operational Plan & Budgets Approval	**CFO&Dep CEO**		X							X Final
Annual Capital Programme	**CFO&Dep CEO**		X							X
Emergency Preparedness Annual Report	**COO**					X				
Use of Resources Quarterly Update Report	**CFO&Dep CEO**	XQ3			XQ4	XQ1		XQ2	XQ3	
COMMITTEE ASSURANCE REPORTS										
Audit Committee	**TRUST SEC**		X		X		X	X		X
Quality Assurance Committee	**CN&Dep CEO**	X	X		X	X	X	X	X	X
Finance & Sustainability Committee	**CFO&Dep CEO**	X	X		X	X	X	X	X	X
Strategic People Committee	**CPO**	X	X		X	X	X	X	X	X
YEAR END										
Annual Report & Accounts Sign Off (inc Quality Account)	**CFO+Dep CEO/ CN&Dep CEO**			X						
Code of Governance Compliance + Compliance with Licence Annual Return – completion of FT4 Declaration, Condition G6 + certification of training of Governors	**TRUST SEC**			X						
GOVERNANCE										
Strategic Risk & BAF Update	**TRUST SEC**	X	X		X	X	X	X	X	X
Annual Review Scheme of Reservation & Delegation (SORD) & Standing Financial Instructions (SFIs)	**DOF**		X							X
Risk Management Strategy Annual Report	**CN&Dep CEO**					X				
Board Annual Cycle of Business	**TRUST SEC**		X							X

		JAN 2021	MARCH 2021	Xxxx 2021	MAY 2021	JULY 2021	SEPT 2021	NOV 2021	JAN 2022	MARCH 2022
	OWNER			YEAR END						
Board Sub-Committee Cycle of Business forRatification	**TRUST SEC**	QAC	AC & SPC		FSC		COG Cycle + ToR July last yr)		QAC	AC & SPC
Board Sub-Committee ToRs for ratification	**TRUST SEC**	QAC						FSC, SPC	QAC	AC2022& 2024 CROC
Charities Commission Checklist (annually)	**DC&E**	~~X def Mar~~	~~X def July~~			X			X	
WHH Charity Annual Report	**DC&E**	X				X				
Charitable Funds Committee ToR (18 months due Sept 2021)	**CHAIR/TRUST SEC**						X			
Charitable Funds Committee Cycle of Business	**CHAIR/TRUST SEC**						X			
Digital Board Report (wef 11/2020)	**EXEC MED DIRECTOR**	X	X		X	X	X	X	X	X
Committee Chairs Annual Reports:										
Quality Assurance Committee Annual Report	**CHAIR**					X				
Finance & Sustainability Committee Annual Report	**CHAIR**				X					
Audit Committee Annual Report	**CHAIR**				X		X			
Strategic People Committee	**CHAIR**		X							X
CLOSING BUSINESS										
Any other business & Date of next meeting	**CHAIR**	X	X		X	X	X	X	X	X

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/21/03/44**			
SUBJECT:	**Cycles of Busienss 2021-2022** • **Audit Committee** • **Strategic People Committee** • **Finance and Sustainability Committee**			
DATE OF MEETING:	24 March 2021			
AUTHOR(S):	John Culshaw, Trust Secretary			
EXECUTIVE DIRECTOR SPONSOR:	Simon Constable, Chief Executive			
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	SO1 We will.. Always put our patients first through high quality, safe care and an excellent patient experience.			
	SO2 We will.. Be the best place to work with a diverse, engaged workforce that is fit for the future.			
	SO3 We will ..Work in partnership to design and provide high quality, financially sustainable services.			
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): **(*Please DELETE as appropriate)***	All			
EXECUTIVE SUMMARY ***(KEY ISSUES):***	In order to provide assurance to the Trust Board, all Committees of the Board are required to refresh their Cycle of Businesson an annual basis to assure itself that it will support the discharge of its duties before presenting to the Trust Board for formal ratification. Proposed changes to the the following Cycles of Business are highlighted on the attached Cycles of Business, which had been approved at the appropriate Assurance Committees as below. - Audit Committee - Strategic People Committee - Finance and Sustainability Committee			
PURPOSE: ***(please select as appropriate)***	Information	**Approve √**	To note	Decision
RECOMMENDATION:	The Trust Board is asked to review and approve the 2021-2022 Cycles of Business as above			
PREVIOUSLY CONSIDERED BY:	Audit Committee, 25.02.2021 Agenda Ref: AC/21/02/16 Strategic People Committee, 24.03.2021, Agenda Ref: SPC/21/03/20 Finance & Sustainability Committee, 24.03.2021, Agenda Ref: FSC/21/03/58			
PREVIOUSLY CONSIDERED BY:	**Committee**	N/A		
	Agenda Ref			
	Date of meeting			
	Summary of Outcome			
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None			

AUDIT COMMITTEE – CYCLE OF BUSINESS FEBRUARY 2021-MARCH 2022

		FEB 2021	APRIL 2021	JUNETBC 2021	AUG 2021	NOV 2021	FEB 2022
	OWNER			YEAR END			
OPENING BUSINESS							
• Welcome, apologies, declarations of interest, cycle of business	**CHAIR**	X	X	X	X	X	X
• Review Minutes and Action Log	**CHAIR**	X	X		X	X	X
• Review rolling attendance log	**CHAIR**	X	X		X	X	X
• Approve Chair's key issue report items for escalation (post meeting)	**CHAIR**	X	X		X	X	X
QPS ASSURANCE							
• Update from Chairs of F&S, Q&A (inc Clinical Audit) & CFC	**TA/MB/CR/AW**	X	X		X	X	X
• Changes or Updates to BAF	**Trust Secretary**	X	X		X	X	X
INTERNAL AUDIT							
• Internal Audit Plan & Fees	**MIAA**	X					X
• Progress Report on Internal Audit follow-Up actions	**CFO & Deputy CEO**	X	X		X	X	X
• Internal Audit Progress Report on Follow-Up actions	**MIAA**	X			X	X	X
• Internal Audit Progress Report	**MIAA**	X	X		X	X	X
• Head of Internal Audit Opinion	**MIAA**		X				
• Internal Audit Charter Annual Report	**MIAA**		X				
EXTERNAL AUDIT							
• External Audit Plan & Fees	**GT**	~~X def Apr~~	X				X
• Report and Updates from External Audit	**GT**	X	X		X	X	X
• Annual Audit Letter (AC following year-end Audit Cttee)	**GT**				X		
• Renewal/Refresh of External Audit Contract (at term) **due Aug 2022**	**GT/AMcG/JC**						
COUNTER FRAUD							
• **DRAFT** Annual Counter Fraud Plan	**MIAA**	~~Xdef Apr final~~	X				X
• **FINAL** Annual Counter Fraud Plan	**MIAA**		X				
• Counter Fraud Progress Updates	**MIAA**	X	X		X	X	X
• Annual Counter Fraud Annual Report	**MIAA**		X				
FINANCE							
• Review Losses & Special Payments	**CFO & Deputy CEO**	X	X		X	X	X
• Review Quotation and Tender Waivers of Standing Financial Instructions	**CFO & Deputy CEO**	X	X		X	X	X
• Going Concern Report	**CFO & Deputy CEO**		X				
QPS GOVERNANCE AND COMPLIANCE							
• Annual report and accounts timetable and plans	**CFO & Deputy CEO**	X					X
• **Draft** Annual Governance Statement	**Trust Secretary**		X				
• **Draft** Annual Report	**CEO**		X				
• **Draft** unaudited Accounts & Financial Statements	**CFO & Deputy CEO**		X				
• Annual Report	**CEO**			X			

		FEB 2021	APRIL 2021	JUNETBC 2021	AUG 2021	NOV 2021	FEB 2022
	OWNER			YEAR END			
• Quality Account	**Dep Dir Governance**			X			
• **Draft** Annual accounts accounting policies	**CFO & Deputy CEO**	X					X
• **FINAL** and Audited Accounts & Financial Statements	**CFO & Deputy CEO**			X			
• Head of External Audit Opinion Statement	**GT**			X			
• Review other reports and policies as appropriate – eg changes to standing orders – as arise, Freedom to Speak Up • Conflict of Interest Policy – due January 2024/Anti Fraud Policy – due April 2023	**ALL**	~~FTSU Policy def Apr~~ CoI Policy	FTSU Policy Fraud Policy		Treasury Mmt Policy		FTSU Policy
• Code of Governance Compliance + Compliance with Licence Annual Return – completion of FT4 Declaration, Condition G6 + certification of training of Governors	**Trust Secretary**			X			
• Risk Management Annual Report update	**Dep Dir Governance**				X		
• Code of Governance Compliance Declaration – eg changes as required	**Trust Secretary** *(AS RQD)*						
• Review of Trust Registers (eg Conflicts of Interest)	**Trust Secretary**					X	
• Terms of Reference x 2 years (due Feb 2022 + Feb 2024)	**Trust Secretary**						
• Cycle of Business Annual Review	**Trust Secretary**	X					X
• On-Call Annual Update Report	**Chief People Officer**				X		
• Overtime Annual Update Report	**Chief People Officer**				X		
• NW Skills Development Bi-Annual Report	**CFO & Deputy CEO**	X			X		X
• ICON Programme Bi-Annual Report	**CFO & Deputy CEO**	X			X		X
EFFECTIVENESS							
• Committee Chairs Annual Report for Board & Council of Governors	**CHAIR**				X		
• Committee meeting effectiveness - annual review	**CHAIR**		**X (rep Aug)**		X		
DEEP DIVE REVIEWS							
• Commission and receive ANY additional scrutiny projects	**AS RQD Dep Dir Governance**						
CLOSING							
• Private discussions with Internal and External Auditors and Counter-Fraud specialist as required – but at least annually	**CHAIR**	X			X		X
• Any Other Business	**CHAIR**	X	X	X	X	X	X

Finance and Sustainability Cycle of Business 2021-2022

		2021									2022		
	Exec Lead	21.4.21	19.5.21	23.6.21	21.7.21	18.8.21	22.9.21	20.10.21	17.11.21	22.12.21	19.1.22	16.2.22	23.3.22
INTRODUCTION & ADMINISTRATION													
Apologies for Absence	**Chair**	X	X	X	X	X	X	X	X	X	X	X	X
Declarations of Interest	**Chair**	X	X	X	X	X	X	X	X	X	X	X	X
Minutes of the Last Meeting	**Chair**	X	X	X	X	X	X	X	X	X	X	X	X
Matters Arising + Action Log	**Chair**	X	X	X	X	X	X	X	X	X	X	X	X
Rolling attendance log + cycle of business	**Chair**	X	X	X	X	X	X	X	X	X	X	X	X
GOVERNANCE & COMPLIANCE													
Committee Terms of Reference	**Trust Sec**						X						
Committee Cycle of Business	**Trust Sec**												X
Committee Chair's Annual Report to Board	**Chair**	X											X (rep April)
Clinical Recovery Oversight Committee ToR	**Trust Sec**												X
Pay Assurance Report -	**CPO**	X	X	X	X	X	X	X	X	X	X	X	X
Risk Register	**Trust Sec**	X		X	X	X	X	X	X	X	X	X	X
Deep Dive in relation to Risk Register (annual)	**Trust Sec**	X											
PAF Review and Refresh of Trust KPIs	**CFO&DCEO**											X	
Committee Effectiveness Review – 6 month	**Chair/T Sec**						XrepOct	X					
Committee Effectiveness Review – annual	**Chair/T Sec**	X											X repApr
PERFORMANCE													
Corporate Performance Report (incl efficiency, productivity, utilisation, LOS, DNAs)	**COO**	X	X	X	X	X	X	X	X	X	X	X	X
Review of Waiting Lists and Clinical Harm Review report	**COO**	X	X	X	X	X	X	X	X	X	X	X	X
Digital Services Board report incl: - Digital Board minutes - Work Plan	**CIO+SIRO**	X	X	X	X	X	X	X	X	X	X	X	X
Digital Services Deep Dives	**CIO+SIRO**	TBC	TBC	TBC	TBC	TBC	TBC	TBC	TBC	TBC	TBC	TBC	TBC
FINANCIAL ASSURANCE													
Monthly Finance report, + - Capital Planning Group Minutes - Finance + Resources Group Minutes and escalation log - Commissioner Contract minutes	**CFO&DCEO**	X	X	X	X	X	X	X	X	X	X	X	X

Finance and Sustainability Cycle of Business 2021-2022

- CPG detailed projection of each scheme													
Capital Planning Group planning cycle annual review (wef June 2021)	**CFO&DCEO**			X									
Combined Financial Position	**CFO&DCEO**				X			X			X		
Monthly Cost Pressure + CIP Report	**CFO&DCEO**	X	X	X	X	X	X	X	X	X	X	X	X
Indicative Financial cost of harm annual report	**CFO&DCEO**		X										
COVID pay related expenditure	**CFO&DCEO**	X	X	X	X	X	X	X	X	X	X	X	X
Medical Establishment Review	**EMD**	X (def from Feb)											
INVESTMENT													
Annual Capital Programme	**CFO&DCEO**											X	
PLANNING													
Operational Plan & Budgets	**CFO&DCEO**											X draft	X final
Service Line Reporting Quarterly Report	**CFO&DCEO**			Xfullyr 20-21						Q2 Feb 2021/22)		Q3	
Reference Cost Report	**CFO&DCEO**	X finaldef frm Mar				X			X draft		Xfinal		
~~6 month priority review to be deleted~~	~~All~~	~~X~~											~~X~~
PACU Benefits Realisation Report	**CFO&DCEO**					X						X	
CLOSING													
Key issues to the Board	**Chair**	X	X	X	X	X	X	X	X	X	X	X	X
Any Other Business	**Chair**	X	X	X	X	X	X	X	X	X	X	X	X
Next Meeting Date & Time	**Chair**	X	X	X	X	X	X	X	X	X	X	X	X

We are WHH & We are PROUD to make a difference

STRATEGIC PEOPLE COMMITTEE Work Plan 2021-2022

NHS Warrington and Halton Teaching Hospitals NHS Foundation Trust

OPENING BUSINESS	Lead	24.03.2021	19.05.2021	21.07.2021	22.09.2021	17.11.2021	19.01.2022	23.03.2022
Apologies for Absence	Chair	√	√	√	√	√	√	√
Declarations of Interest	Chair	√	√	√	√	√	√	√
Minutes of the last meeting	Chair	√	√	√	√	√	√	√
Matters Arising / action log	Chair	√	√	√	√	√	√	√
STANDING ITEMS								
Chief People Officer Report	Chief People Officer	√	√	√	√	√	√	√
BAF & Risk Register – Staff	Trust Secretary/Deputy Director HR & OD	√	√	√	√	√	√	√
WHH People Strategy Report +Strategic Projects (People) including Equality, Diversity and Inclusion Strategy Update	Deputy Chief People Officer	√		√		√		√
CQC –Moving to Outstanding (Staff)	Chief People Officer	Paused	√	√	√	√	√	√
Policies and Procedures Report (as required)	Deputy Chief People Officer	√	√	√	√	√	√	√
Employee Relations Report	Deputy Chief People Officer	√	√	√	√	√	√	√
Employee Relations Report Detailed investigation/disciplinary report alternate meetings (wef 05/21)	Deputy Chief People Officer		√		√		√	
National Staff Opinion Survey	Deputy Chief People Officer	√						√
Freedom to Speak Up Bi-Annual Report	Chief Nurse & Deputy CEO	√			√			√
Workforce Key Performance Indicator Recommendations for 2020/21 (annual)	Chief People Officer						√	
VIP + Celebrity Visits Policy Annual Report	Director of Communications + Engagement	~~√ def May~~	√					√
Engagement and Recognition Annual Report	Chief People Officer	~~√ def May~~	√					√
Trust Board Monthly Staffing Report – Key Issues Report	Chief Nurse & Deputy CEO	√	√	√	√	√	√	√
Hospital Volunteer Annual Report	Chief Nurse & Deputy CEO						√	
Bi-Annual Health & Wellbeing Guardian report (wef 09/2021) then 03/22 and 09/22	Chief People Officer				√			√
NATIONAL/STATUTORY REPORTS								
HENW/GMC Annual Reports	Executive Medical Director							
GMC Patient Survey Response Report when required	Executive Medical Director							
HENW Local Education Provider (LEP) Report SAR Report TBC by HENW	Executive Medical Director							
HENW Monitoring Visit (Annual Assessment Visit)	Executive Medical Director		√ VISIT TBC					
GMC National Trainee Survey	Executive Medical Director				√ DATE TBC			
GMC Revalidation Annual Report (Medical Appraisal)/NHSE Statement of Compliance + NHSE Annual Organisation Audit (AOA)	Executive Medical Director					√		
Guardian Quarterly Report, Safe Working Hours Jnr Doctors in Training	Executive Medical Director		Q4√		Q1 √	Q2√	Q3√	
EQUALITY DIVERSITY + INCLUSION – Regulated Reports (as required)								
Equality Duty Assurance Report (EDAR) PSED Standard (sign off)	Deputy Chief People Officer		√					
Workforce Equality Assurance Report (WEAR) PSED Standard (sign off)	Deputy Chief People Officer		√					
Equality Delivery System 2 (EDS2) – within OPC Chairs Log	Deputy Chief People Officer	Paused Nationally to 09/2021			√			
Gender Pay Report – within OPC Chairs Log	Deputy Chief People Officer	√						√
Workforce Race Equality Standard (WRES)	Deputy Chief People Officer			√				
Workforce Disability Equality Standard (WDES)	Deputy Chief People Officer			√				
Facilities Time Off Annual Report (for sign off)	Deputy Chief People Officer			√				
GOVERNANCE								
Terms of Reference	Chair /Trust Secretary					√		
Annual Cycle of Business	Chair/Trust Secretary	√						√

We are WHH & We are PROUD to make a difference

STRATEGIC PEOPLE COMMITTEE Work Plan 2021-2022

NHS Warrington and Halton Teaching Hospitals NHS Foundation Trust

Committee Chairs Annual report to Trust Board	Chair/Trust Secretary	**√**						**√**
Committee Effectiveness – Annual survey	Chair/Trust Secretary		**Circl √**	**Report √**				
Committee Effectiveness Survey – 6 month survey	Chair/ Trust Secretary					**Circl √**	**Report √**	
Sub Committee Chairs Log / High Level Briefing Papers/Closing								
Operational People Committee	Chief People Officer	**Paused**	**Paused**	**√ TBC**	**√**	**√**	**√**	**√**
Equality, Diversity and Inclusion Sub Committee	Chief People Officer	**15.01.2021+ 12.03.2021**	**16.04.2021**	**14.05.2021 11.06.2021**	**16.07.2021 10.09.2021**	**Verbal 12.11.2021**	**12.11.2021 10.12.2021**	**14.01.2022= 11.02.2022**
Review of meeting	Chair	**√**	**√**	**√**	**√**	**√**	**√**	**√**

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/21/03/45**			
SUBJECT:	***Amendment to the Standing Financial Instructions (SFIs)***			
DATE OF MEETING:	24 March 2021			
AUTHOR(S):	Alison Parker, Associate Director Procurement			
EXECUTIVE DIRECTOR SPONSOR:	Andrea McGee, Chief Finance Officer & Deputy Chief Executive			
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	SO1 We will.. Always put our patients first through high quality, safe care and an excellent patient experience. SO2 We will.. Be the best place to work with a diverse, engaged workforce that is fit for the future. SO3 We will ..Work in partnership to design and provide high quality, financially sustainable services.	 ✓		
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): **(*Please DELETE as appropriate)***	#134 Financial Sustainability a) Failure to sustain financial viability,			
EXECUTIVE SUMMARY *(KEY ISSUES):*	An amendment to the Trust's Standing Financial Instructions to include a standard tender evaluation criterion based on 60% technical and service capability and 40% related to cost along with the process to be followed for any deviations from this standard.			
PURPOSE: *(please select as appropriate)*	Information	Approval ✓	To note	Decision
RECOMMENDATION:	To approve an amendment to the Trust's Standing Financial Instruction to include ▪ a standard tender evaluation criterion based on 60% technical and service capability and 40% related to cost (60/40). ▪ a requirement that any request to deviate from this 60/40 standard is approved by the Trust Board following the relevant project team/stakeholder group formally outlining their rationale for change.			
PREVIOUSLY CONSIDERED BY:	**Committee**	Finance & Sustainability Committee		
	Agenda Ref.	FSC/21/03/56		
	Date of meeting	24 March 2021		
	Summary of Outcome	Approved		
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None			

REPORT TO BOARD OF DIRECTORS

SUBJECT	*Amendment to the Standing Financial Instructions (SFIs)*	AGENDA REF:	BM/21/03/45

1. BACKGROUND/CONTEXT

The Standing Financial Instructions (SFIs) are established for the regulation of the conduct of its members and officers in relation to all financial matters with which they are concerned and are issued in accordance with the Code of Conduct and Accountability in the NHS issued by the Department of Health and Social Care.

The SFIs detail the financial responsibilities, policies and procedures to be adopted by the Trust. They are designed to ensure that its financial transactions are carried out in accordance with the law and government policy in order to achieve probity, accuracy, economy, efficiency and effectiveness. They should be used in conjunction with the Scheme of Reservation and Delegation adopted by the Trust.

The SFIs detail the procedures relating to Tendering and Contract Procedures for making all contracts by or on behalf of the Trust detailing the basis upon which contracts will be awarded.

2. KEY ELEMENTS

In accordance with the SFI's contacts will be awarded based on the '*Most Economically Advantageous Tender (MEAT)'* that considers technical and service capability in addition to cost.

Currently there is no determination of how tenders will be evaluated in terms of the percentage allocation attributable to both technical/service capability and cost with the decision currently variable based on stakeholder engagement with advice from procurement; technical/service capability and cost are split into two high level categories to be evaluated separately. Each will be given a maximum percentage score, which is weighted according to the relative importance placed upon it. At the end of the evaluation process, the two percentages will be brought together in the Full Evaluation Model to result in an overall percentage score for each supplier.

Contracts must be awarded based on objective criteria that ensure compliance with the principles of transparency, non-discrimination and equal treatment which guarantee that tenders are assessed in conditions of effective competition.

Good industry practice recognises the need for a pre-defined standard that manages expectations at the beginning of a tendering process with an allocation of a 60/40 percentage split as the industry standard; 60% allocated to the technical and service capability and the remaining 40% allocated to cost; this creates an evaluation methodology that underpins the procurement process and aims to select a tender that fulfils all of their requirements in terms of price and quality.

Cost is based on the total cost of the goods or service over the duration of the entire contract not just purchase price with consideration given to all elements such as delivery costs, maintenance and training costs, down time and disposal costs among others, to form a more holistic picture of what it will actually cost to own, or run the goods or services over the life of the contract.

In terms of technical and service capability bids are evaluated based on a combination of the criteria below with other criteria added based on case of need:

- Delivery timescales and ability to meet Trust deadlines
- Suitability and quality of management structure to support delivery
- Quality and suitability of proposed approach or methodology
- Flexibility to manage fluctuations in demand or changes to scope
- Contingency planning, management and resources
- Risk management
- Understanding the overall requirement, aims and objectives of the Trust
- Track record of delivering similar goods or services
- Knowledge and expertise in sector
- Service or supply delivery
- Relationship management approach

Where, for whatever reason the project team/stakeholder group for any specific procurement objects to the standard 60/40 percentage split they will be required to formally outline their rational and recommendation for an alternative percentage split for approval by the Trust Board prior to any procurement activity commencing.; where this is rejected by the Trust Board the 60/40 percentage split will apply.

3. RECOMMENDATIONS

To approve an amendment to the Trust's Standing Financial Instruction to include:

- a standard tender evaluation criterion based on 60% technical and service capability and 40% related to cost (60/40).
- a requirement that any request to deviate from this 60/40 standard is approved by the Trust Board following the relevant project team/stakeholder group formally outlining their rationale for change.

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/21/03/47**	
SUBJECT:	**Amendment to the Constitution – Governor Public Constituencies**	
DATE OF MEETING:	31st March 2021	
AUTHOR(S):	John Culshaw, Trust Secretary	
EXECUTIVE DIRECTOR SPONSOR:	Simon Constable, Chief Executive	
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	SO1 We will.. Always put our patients first through high quality, safe care and an excellent patient experience. SO2 We will.. Be the best place to work with a diverse, engaged workforce that is fit for the future. SO3 We will ..Work in partnership to design and provide high quality, financially sustainable services.	✓ ✓ ✓
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF):	All	
EXECUTIVE SUMMARY *(KEY ISSUES):*	In order to minimise the number of vacant Public Governor constituencies, encourage a greater number of nominations from Foundation Trust members and to support more cohesive working amongst the sitting Governors, the paper sets out a proposal to allow, by the way of amendment to the Trust's Constitution, amendments to the Public Governor Constituencies. The Trust's Constitution states: *45. Amendment of the constitution* *45.1. The Trust may make amendments to its constitution if:* *45.1.1 more than half of the members of the Board of Directors of the Trust voting approve the amendments; and* *45.1.2 more than half of the members of the Council of Governors of the Trust voting approve the amendments.* The current Public Governor electoral wards are grouped in to 15 areas with a single Governor elected to represent each ward with the exception of the Rest of England, which has two representatives. With no vacancies, the total number of Public Governors would be 16. The proposed amendment would reduce the number of wards to 5 areas and increase the total number of Public Governors to 19. The proposal was discussed and approved by the Council of Governors on 18th Febraury 2021	

PURPOSE: *(please select as appropriate)*	Information	Approval ✓	To note	Decision
RECOMMENDATION:	The Board is asked to consider the proposed amendment to the constitution and to approve. These amendments will be entered to create v3.11			
PREVIOUSLY CONSIDERED BY:	**Committee**		Council of Governors	
	Agenda Ref.		**COG/21/02/12**	

	Date of meeting	18th February 2021
	Summary of Outcome	Approved
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None	

REPORT TO BOARD OF DIRECTORS

SUBJECT	Amendment to the Constitution – Governor Public Constituencies	AGENDA REF:	BM/21/03/47

1. BACKGROUND/CONTEXT

The Governor working party regularly reviews the Trust's Constitution and over a number of recent meetings have specifically focussed on the composition of the Trust's Public Governors.
In order to minimise the number of vacant Public Governor constituencies, encourage a greater number of nominations from Foundation Trust members and to support more cohesive working amongst the sitting Governors, the paper sets out a proposal to allow, by the way of amendment to the Trust's Constitution, amendments to the Public Governor Constituencies.

The Trust's Constitution states:

45. Amendment of the constitution

45.1. The Trust may make amendments to its constitution if:

45.1.1 more than half of the members of the Board of Directors of the Trust voting approve the amendments; and

45.1.2 more than half of the members of the Council of Governors of the Trust voting approve the amendments.

The current Public Governor electoral wards are grouped in to 15 areas with a single Governor elected to represent each ward with the exception of the Rest of England, which has two representatives. With no vacancies, the total number of Public Governors would be 16. The proposed amendment would reduce the number of wards to 5 areas and increase the total number of Public Governors to 19.

2. KEY ELEMENTS

The current Public Governor electoral wards are grouped in to 15 areas as shown below in Table 1:

Table 1

Area	Constituency (16 public)	Number of Governors to be elected
1	Daresbury, Windmill Hill, Norton North, Halton Castle	1
2	Beechwood, Mersey, Heath, Grange	1
3	Norton South, Halton Brook, Halton Lea	1
4	Appleton, Farnworth, Hough Green, Halton View, Birchfield	1
5*	Broadheath, Ditton, Hale, Kingsway, Riverside	1
6	Lymm, Grappenhall, Thelwall	1
7	Appleton, Stockton Heath, Hatton, Stretton and Walton	1
8	Penketh and Cuerdley, Great Sankey North, Great Sankey South	1
9	Culcheth, Glazebury and Croft, Poulton North	1
10	Latchford East, Latchford West, Poulton South	1
11	Bewsey and Whitecross, Fairfield and Howley	1
12	Poplars and Hulme, Orford	1
13	Birchwood, Rixton and Woolston	1

14	Burtonwood and Winwick, Whittle Hall, Westbrook	1
15**	Rest of England and Wales	2
*constituency currently vacant; **currently one vacancy	**Total**	**16**

As part of the Governor Working Party, a benchmarking exercise was undertaken to compare the composition of the Council's Public Governors with other local Foundation Trusts, details of which are described in Table 2 below:

Table 2 -

Trust	No of Constituencies	No of Public Governors	No of Public Governors per Constituencies
Bridgewater Community Healthcare NHS FT	3	14	Warrington 4 – Halton 4 – Rest of England - 6
Wrightington, Wigan & Leigh NHS FT	4	14	Wigan 4 – Leigh 4 – Ashton – in – Makerfield 2 – Rest of England 4
Royal Bolton NHS FT	4	20	Bolton North East 6 – Bolton South East 6 – Bolton West 6 – Rest of England 2
Royal Liverpool & Broadgreen University Hospitals	3	16	City North 7 – City South 7 – North West & Wales 2
North West Boroughs Healthcare NHS FT	6	9	Warrington 1 – Halton 1 – Knowsley 2 – Sefton 2 – St Helens 2 – Wigan 1
Lancashire Teaching Hospitals NHS FT	1	18	Whole of Trust Area

Compared to other Trusts in the region it is clear that Warrington & Halton Teaching Hospitals NHS FT is an outlier in respect of the number of Public Governor Wards.

As part of its review, the Governor working party considered the populations of both Warrington and Halton Parliamentary constituencies and the associated Trust membership in these areas:

Warrington North Population - circa 110,000
Warrington North Members - 2424

Warrington South Population - circa 98,000
Warrington South Members - 3287

Halton Population - circa 127,000
Halton Members - 3442

*Please note that there are an additional 2062 members classed as Rest of England

The population and membership of the Halton Parliamentary constituency was broken down further as detailed below:

Runcorn Population - 63,457
Runcorn Members - 2443

Widnes Population - 63,446

Widnes Members - 999

3. PROPOSAL

Following the review of the current Public Governor constituencies, and for the reasons described in Section 1, it is proposed to reduce the number of Public constituencies to 5 and increase the number of Public Governors to 19 as detailed below in Table 3:

Table 3 – Proposed Public Constituencies (with effect 1st April 2021)

Area	Constituency	Proposed number of elected Governors
1	Warrington North	5
2	Warrington South	5
3	Runcorn	4
4	Widnes	4
5	Rest of England	1
	Total	**19**

The amendments would be effective from 1st April 2021 in preparation for the next Governor Elections scheduled to take place in November 2021.

If approved and implemented from 1st April 2021, existing Governors would be re-categorised into the new Constituencies.

Current constituencies and their Governors are detailed below in Table 4

Table 4 – Current Public Governor Constituencies

Area	Constituency (16 public)	Governor
1	Daresbury, Windmill Hill, Norton North, Halton Castle	Alison Kinross
2	Beechwood, Mersey, Heath, Grange	Linda Mills
3	Norton South, Halton Brook, Halton Lea	Dave Marshall
4	Appleton, Farnworth, Hough Green, Halton View, Birchfield	Colin McKenzie
5	Broadheath, Ditton, Hale, Kingsway, Riverside	**VACANT SINCE June 2018**
6	Lymm, Grappenhall, Thelwall	Janice Howe
7	Appleton, Stockton Heath, Hatton, Stretton and Walton	Sue Fitzpatrick
8	Penketh and Cuerdley, Great Sankey North, Great Sankey South	Paul Bradshaw
9	Culcheth, Glazebury and Croft, Poulton North	Keith Bland MBE
10	Latchford East, Latchford West, Poulton South	Erin Dawber
11	Bewsey and Whitecross, Fairfield and Howley	Susan Hoolachan
12	Poplars and Hulme, Orford	Colin Jenkins
13	Birchwood, Rixton and Woolston	Anne M Robinson
14	Burtonwood and Winwick, Whittle Hall, Westbrook	Norman Holding (**Lead Governor**)
15	Rest of England and Wales	Kevin Keith
15	Rest of England and Wales	**VACANT SINCE 18.03.2019**

Based on the current model, three of the existing Constituencies contain areas that fall into both Warrington North and Warrington South. These areas are:

10	Latchford East, Latchford West, Poulton South	Erin Dawber
11	Bewsey and Whitecross, Fairfield and Howley	Susan Hoolachan
14	Burtonwood and Winwick, Whittle Hall, Westbrook	Norman Holding (**Lead Governor**)

It is suggested that the Governors who currently represent areas 10,11 and 14 as detailed above, represent the constituencies in which they live under the proposed future model.

If the amendments to the Constitution are approved, the composition of the Public Council of Governors at 1st April 2021, would be as detailed below in Table 5

Table 5 – Proposed composition of the Public Constituencies and associated Governors

Area	Constituency	Proposed number of elected Governors	Governor Representatives	Vacancies
1	Warrington North	5	Norman Holding (Lead Governor), Keith Bland MBE; Colin Jenkins, Anne M Robinson	1
2	Warrington South	5	Janice Howe, Sue Fitzpatrick, Paul Bradshaw, Erin Dawber, Susan Hoolachan	0
3	Runcorn	4	Alison Kinross, Linda Mills, Dave Marshall	1
4	Widnes	4	Colin McKenzie	3
5	Rest of England	1	Kevin Keith	0
Total		**19**		**5**

4. RECOMMENDATIONS

The Board is asked to consider the proposed amendment to the constitution and to approve. These amendments will be entered to create v3.11

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/21/03/48**			
SUBJECT:	**Annual Report of the Strategic People Committee 2020 - 2021**			
DATE OF MEETING:	31 March 2021			
AUTHOR(S):	Michelle Cloney, Chief People Officer			
EXECUTIVE DIRECTOR SPONSOR:	Michelle Cloney, Chief People Officer			
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	SO1 We will.. Always put our patients first through high quality, safe care and an excellent patient experience.			
	SO2 We will.. Be the best place to work with a diverse, engaged workforce that is fit for the future.	✓		
	SO3 We will ..Work in partnership to design and provide high quality, financially sustainable services.			
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): **(*Please DELETE as appropriate)***	#1135 Failure to deliver an emergency and elective healthcare service caused by the global pandemic of COVID-19 resulting in major disruption to service provision. #1124 Failure to provide adequate PPE caused by failures within the national supply chain and distribution routes resulting in lack of PPE for staff. #115 Failure to provide adequate staffing levels in some specialities and wards. #1134 Failure to provide adequate staffing caused by absence relating to COVID-19 resulting in resource challenges and an increase within the temporary staffing domain. #145 a. Failure to deliver our strategic vision.			
EXECUTIVE SUMMARY *(KEY ISSUES):*	This years Annual Report is provided in the context of a Covid-19 Pandemic which has significantly impacted on the business of the Trust and the deployment of the workforce, the reduction in the length of each meeting, a change from physical meetings to the use of a virtual IT platform to conduct the meeting, and a re-prioritisation of the agreed work programme. The first 'wave' resulted in a national lockdown commencing in March 2020 followed by a further two waves during the year, a series of regional responses reflecting regional variations in community prevalence, calls for re-starting services, implementation of staff testing, enhanced Infection, Prevention and Control measures and significant work to maintain the workforces health, safety and wellbeing. This report seeks to deliver assurance from the Strategic People Committee that the Committee has met its Terms of Reference and has gained assurance throughout the reporting period of the Trust's performance.			
PURPOSE: *(please select as appropriate)*	Information	Approval ✓	To note	Decision
RECOMMENDATION:	The Trust Board is asked to accept this comprehensive annual report from the Strategic People Committee which aims to provide assurance that the Terms of Reference and Business Clycle have			

	been met in the context of a Pandemic and the in year amendment to priority areas as a result of local, regional and national guidance.	
PREVIOUSLY CONSIDERED BY:	**Committee**	Strategic People Committee
	Agenda Ref.	SPC/21/03/21
	Date of meeting	24 March 2020
	Summary of Outcome	Annual Report Approved
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	Choose an item.	

REPORT TO BOARD OF DIRECTORS

SUBJECT	Annual Report of the Strategic People Committee 2020-21	AGENDA REF:	SPC/21/03/48

The Strategic People Committee is required to report annually to the Board outlining the work it has undertaken during the year, and where necessary, highlighting any areas of concern. This paper presents the Strategic People Committee Annual Report which covers the reporting period 1st April 2020 to 31st March 2021.

This Annual Report is provided in the context of a Covid-19 Pandemic which has significantly impacted on the business of the Trust and the deployment of the workforce, the reduction in the length of each meeting, a change from physical meetings to the use of a virtual IT platform to conduct the meeting, and a re-prioritisation of the agreed work programme. The first 'wave' resulted in a national lockdown commencing in March 2020 followed by a further two waves during the year, a series of regional responses reflecting regional variations in community prevalence, calls for re-starting services, implementation of staff testing, enhanced Infection, Prevention and Control measures and significant work to maintain the workforces health, safety and wellbeing.

The Strategic People Committee (the Committee) is accountable to the Board of Directors (the Board) for providing oversight and assurance on all aspects of the workforce, including strategy, Equality Diversity and Inclusion, recruitment and retention, delivery, organisational development, staff engagement, medical education, leadership and culture, employee wellbeing and the regulatory standards relevant to workforce experience and resourcing.

The Strategic People Committee is accountable to the Board for ensuring that the three Strategic People Objectives set by the overall Trusts Strategy is implemented throughout the organisation and that organisational strategic workforce risks are managed appropriately.

This report details the membership and role of the Committee and the work it has undertaken during the reporting period.

During the reporting period, the Committee has been composed of 2 Non-Executive Directors with a quorum of 2 (including the Chair). Any Non-Executive Director is able to attend the Committee to cover any absence. During the reporting period, there were 6 meetings.

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1.	Terms of Reference, Business Cycle and Assurance

The Committee's Terms of Reference were approved in Quarter 4 (March 2020) for implementation in 2020/21, as was the business cycle, to ensure they remained fit for purpose. During August / September 2020, the Equality Diversity and Inclusion portfolio for the Trust was reviewed, resulting in the creating of the EDI Sub-Committee with assurance on Workforce priorities reported to the committee and assurance on Patient & Service Users priorities reported to the Quality Assurance Committee. The Strategic People Committee continues to focus on assurance monitoring, with its reporting sub committees meeting on a more frequent basis to deliver the agenda. The Operational People Committee was paused during 2020/21 to enable operational managers to focus on responding to the Covid-19 service pressures, resulting in Chairs Actions being escalated as appropriate to the committee. High level briefings are provided to the Strategic People Committee for assurance purposes. Reporting sub committees are constantly under review, ensuring ongoing scrutiny.

2.	Refreshed People Priorities for 2020/21

In July 2020, the Committee reviewed the People Priorities and submitted these to Trust Board for approval.

1. **'We will create the conditions to promote wellbeing and enable an engaged workforce to improve patient and staff experience.'**

    - Further develop interventions to tackle MSK related sickness absence
    - Implement an enhanced mental health offer to support our workforce during and following COVID-19 pandemic
    - Introduce team support programmes, for teams reforming and developing following the pandemic
    - Clarify and promote the WHH offer
    - Review and refresh of line managers development opportunities.

2. **'We will attract and retain a diverse workforce aligned to our culture and values, to ensure that we have the staff with the skills to deliver excellent patient care.'**

    - Focus on new approaches to marketing WHH as the best place to work
    - Develop international recruitment
    - Utilise the NHS Improvement Cultural Change Programme to enhance and build on the positive cultural changes that have occurred during the pandemic
    - Develop and embed new ways of working based on comprehensive workforce plans.

3. **'We will develop a collaborative, compassionate and inclusive culture of collective leadership and organisational learning.'**

    - Introduce compassionate leadership development programmes and recruitment approaches
    - Implement the NHS Leadership Academy Talent Management and Succession Planning Framework
    - Introduce a framework for learning from formal HR processes

4. **'We will build and maintain a diverse and representative workforce that is empowered, engaged and supported to demonstrate inclusive behaviours.'**

- Develop a programme of work to increase diversity in decision making
- Implement a programme of work around civility and respect, based on the SPF Call to Arms.
- Improve visibility and celebration of diversity across the Trust
- Introduce Staff Networks for disabled staff and LGBTQ+ staff.

5. **'We will work to ensure that the Trust has inclusive and diverse leadership across all levels of the workforce.'**

- Introduce reverse mentoring
- Launch targeted career management support
- Delivery the Model Employer action plan and goals

A Workforce Strategy Report is provided each meeting to provide committee members with assurance on the delivery of the People Priorities set out above.

3.	Frequency of Meetings and Summary of Activity

The Committee met 6 times during the year, using Microsoft Teams. A summary of the activity covered at these meetings follows.

The Committee has had regular updates in relation to the strategic People Priorities for the Trust, as a result of local, regional and national workforce priorities during a pandemic.

3.1	May 2020 Committee Meeting (Pandemic Wave One)

The Committee received a range of updates to provide assurance on the response to Covid-19, strategic people priorities and workforce health, safety and wellbeing.

3.1.1	Recommendation to Pause and /or Amend Business cycle 2020 to 2021:

Recommendation from Chief People Officer to pause activity/reporting in line with national guidance - approved by Committee:

- CQC – Moving to Outstanding (Staff)
- Employee Relations Report
- National Staff Opinion Survey Update
- Equality Duty Assurance Report (EDAR) PSED Standard
- Workforce Equality Assurance Report (WEAR) PSED Standard
- Equality Delivery System 2 (EDS2)
- Gender Pay Report
- Workforce Race Equality Standard (WRES)
- Workforce Disability Equality Standard (WDES)
- Facilities Time Off Annual Report

Recommendation from Chief Nurse & Deputy CEO to pause activity/reporting - approved by Committee:

- Trust Board Monthly Staffing Report – Key Issues Report
- Hospital Volunteer Annual Report

Recommendation from Acting Executive Medical Director to note rescheduling date - approved by Committee:

- HENW Monitoring Visit (Annual Assessment Visit)

Recommendation from Chair of Committee to pause - approved by Committee:

- Committee Effectiveness – Annual survey

3.1.2	HR and OD Directorate Services: COVID-19 Response (May 2020)

The Committee noted and were assured by the following responses to the Covid-19 Pandemic in order to support the workforce.

- **Occupational Health**

There had been a huge increase in demand on the Occupational Health (OH) Service and the team had worked quickly, efficiently and flexibly to meet that demand. A COVID-19 nursing advice line has been created, to provide a range of advice and guidance to the workforce.

Key themes included:

- Staff experiencing COVID-19 symptoms
- Self-isolation
- Underlying conditions
- Pregnancy
- Shielding letters
- A range of anxieties relating to COVID-19

To support this, an OH call centre had been created, which enabled all calls to be answered and triaged by a team of administrators. The OH Service has also developed the co-ordination and advice service for staff testing. Fast-track pre-employment checks are supported. Face to face clinics were temporarily replaced with telephone clinics for OH Doctor, Nurse and Physiotherapy. In order to support the above functions, the OH Team introduced 7 day working.

- **Wellbeing**

An enhanced wellbeing offer was developed, linked to learning from Wuhan, Italy and the British Psychological Society. A specialist extranet page was developed which included all national wellbeing offers, and links to discounts for our NHS staff during this period of time. Mental health wellbeing drop in sessions were introduced across both Warrington and Halton sites, with a specific wellbeing email address created for any enquiries to the wellbeing hub. Facilitated conversations were made available to staff working on COVID-19 wards, as well as face to face counselling and alternative therapies such as relaxation therapy.

The need for additional wellbeing and mental health support continued throughout the recovery period. This included additional on-site counselling capacity and dedicated wellbeing space on both the Warrington and Halton sites.

- **Employee Engagement Activities**

A decision was taken nationally to pause Staff Friends and Family Test. The Trust paused any specific work related to the 2019 Staff Survey Results as well as reward and recognitions processes including Employee and Team of the Month as these activities were not appropriate for the workforce during the current pandemic. The Committee noted that restarting reward ad recognition schemes would be reviewed as part of recovery planning.

- **Workforce Welfare Hub**

A Workforce Welfare Hub was established by the Director of Strategy & Partnerships to support the practical needs of our workforce. Key successes included the provision of free childcare, free accommodation, hot meals and the introduction of staff welfare champions. The Workforce Welfare Hub was mainstreamed into the Trusts Health and Wellbeing Services in July / August 2020 as appropriate to the national guidance, for example, the provision of free accommodation ceased to be provided across the NHS.

- **Equality, Diversity and Inclusion**

Statutory reporting was paused nationally, including Gender Pay Gap, Workforce Disability Equality Standard and Public Sector Equality Duty. Internally, the EDI agenda continued to be an important part of supporting the workforce during the pandemic. Examples of key pieces of work included:

- Guidance for managers and staff on Ramadan during a pandemic has been produced and shared.
- The Black, Asian and Minority Ethnic (BAME) network continued to be supported and was growing and meeting virtually.
- Risk assessments were introduced for BAME staff in recognition of the emerging picture and national concerns relating to COVID-19 and BAME communities.
- New Equality Impact Assessments and associated guidance produced for the restarting of clinical services.

- **Organisational Development**

A number of strategic OD work streams were paused as a result of the pandemic including the launch of the WHH Leadership Model, level 5 coaching training, team development and the Growing as a Leader programme. The Committee noted that these activities were not appropriate for the workforce during the current pandemic. Some specific team-based OD work continued where it was deemed to be vital to the on-going effectiveness of teams.

- **Learning and Development**

Corporate Induction day one was changed to a hard copy information booklet. Clinical Induction was condensed and included:

- Resuscitation,
- Manual Handling and
- Palliative care training
- Safeguarding

Role Specific and Mandatory Training was paused for existing staff who had not changed role as per NHS Employers guidance, where staff are working in a frontline patient facing role and do not have capacity/opportunity to complete the training. For those who were able to continue to complete the training this was encouraged via ESR. Local management decision on training requirements are made for staff who have changed role.

- **Widening Participation**

Levy payments for those continuing with learning continued, as had support to managers with apprentices and guidance and support to the apprentices themselves. In many cases distance learning was offered by training providers. Breaks in learning were applied where requested. Work experience, widening participation and the Step into Health work streams were paused.

- **Resourcing: Recruitment and Bank and Agency Teams**

Both teams continued to support the Trust via their 'business as usual' processes. In addition, the following groups of staff have been brought into the organisation:

- Medical Students
- Nursing Students
- AHP Students
- Medical 'Returners'
- Nursing 'Returners'
- AHP 'Returners'

Following national guidance amendments were made to the pre-employment check process to support speedier recruitment:

- Verification of original documents: able to accept scanned and emailed copies of original documentary evidence for urgent appointments.
- Fast Track DBS Checks – urgent appointments related to COVID were fast-track check against the children's and/or adults barred lists, which was turned around within 24 hours of DBS receiving it.
- References and Employment History – seeking at least one reference from the individual's current or previous employer (previously had to cover last 3 years). Where it has not been practically possible for a reference to be obtained, recruitment decisions were based on what information could reasonably be obtain about the individual such as latest payslips verifying their last/current employment and position.
- Work health assessments – fast track OH clearance were sought, with a 24 hour turnaround.
- Inductions were scheduled for weekly providing much more flexibility with start dates.
- Conditional offer letter were sent via email and requested the candidate to supply all the information required via email (enabled because of the changes to the Verification of original documents, see above). Support was still given to those candidates unable to complete their checks via email.
- Contractual change letters were emailed using the information supplied on the contractual change form (ECF).

- **Payroll and Pensions**

The Payroll and Pensions department continued as normal, processing weekly/ monthly salaries and supporting individuals wishing to retire. Due to the number of policy changes and changes to working arrangements there was a significant increase in demand on the department. The team responded efficiently and flexibly to meet that demand.

- **Workforce Information**

The Workforce Information hub continued as normal, processing weekly / monthly reporting requirements. In addition, the hub undertook the work required to produce daily NSHI/E SITREPs for staff testing and staff absence, as well as internal reporting requirements e.g. weekly HROD SEOG report. The Team provided dedicated support to CBUs and Departments to move to 'live' reporting of sickness absence, to facilitate the daily SITREP requirements.

- **Human Resources**

All services and support continued as usual, with social distancing or virtual arrangements put in place where required. The HR Team established the Temporary Workforce Redeployment Hub in March 2020. The purpose of the hub was to identify staff who were available for redeployment and match them with demand in order to ensure that key clinical services were supported. The hub was very successful in supporting staff to safely transfer to the areas where they are most needed.

3.1.3	Partnership Working

The Committee were asked to note that partnership working with staff side colleagues continued as a vital part of supporting the workforce. Formal negotiation and consultative committees were stood down however a twice weekly meeting took place with the Chief People Officer and the Staff Side Chair & Deputy Staff Side Chair. In addition, a weekly meeting took place with the Medical Director, Deputy Chief People Officer and Regional BMA Representative. Correspondence took place with Unison, Unite and RCN to provide assurance on the Trust approach to Personal Protective Equipment.

3.1.4	Social Partnership Forum Statement – Version 1 (March 2020)

The SPF Agreement was noted by the Committee, specifically around the following aspects:

- New temporary ways of working
- Partnership Principles – no surprises, transparency, finding common ground and mutual respect
    - Streamlining partnership working practices - Formal meetings may need to be replaced with close and regular virtual working arrangements between leaders and staff side chairs.
    - Facilities time
- Managing change during the emergency - The partners will aim to ensure that no member of staff or group of staff is disadvantaged by the emergency conditions arising from the pandemic.
    - Local agreements
    - Temporary changes to working practices
    - Industrial disputes
    - Organisational change
- Disciplinary matters, grievances and other procedures - Employers will pause disciplinary and other employment procedures (for example, sickness and capability triggers) while the crisis lasts, except where the employee requests proceeding as it would otherwise cause additional anxiety, or where they are very serious or urgent.
    - There are some particular issues to consider:
        - Where there is a safety risk, members of staff may be placed on suspension or restricted or alternative duties pending the resumption of disciplinary proceedings.
        - Where employees raise urgent grievances, for example, concerning health and safety, then these should be considered in the normal time frames set by agreed local policies.
        - Other grievances, appeals and procedures (and all relevant time frames) should be paused on the understanding that they may be taken up at a later date by the employee without detriment.
        - Where hearings and procedures go ahead then natural justice and the terms of the employer's policies should continue to apply, especially the right to union representation.
        - The use of virtual meetings may be considered with the consent of the employee and union representative.

*Review - **by 30 June 2020**.*

3.1.5	Workforce Reporting

Workforce considerations were central to the Trust response to the COVID-19 pandemic. Daily representation and reporting to the Trust Tactical, Operational and Strategic Executive Oversight Group (SEOG) meetings took place. The SEOG receive a weekly overview of HR and OD Directorate activity to provide assurance relating to workforce needs. In addition, the NHS E/I daily SITREP requirements on staff testing and absence were met.

3.1.6	Workforce Recovery

Workforce recovery is key to the overall recovery of the NHS following the pandemic. Learning from events such as the Manchester attack, Wuhan and Italy show that workforce recovery is likely to be long term and the response from the Trust must be evidence based. The HR and OD Teams had begun to produce and act on a detailed plan to deliver the support required for workforce recovery.

3.1.7	Freedom to Speak Up (FTSU) Update

29 April 2020 Letter, Simon Stevens, NHS Chief Executive and Amanda Pritchard, NHS Chief Operating Officer '*SECOND PHASE OF NHS RESPONSE TO COVID19* ' – was the recognition of the impact of Covid19 on the workforce. A specific reference was made to FTSU:

> "Now more than ever a safety and learning culture is vital. All our staff should feel able to raise concerns safely. Local Freedom to Speak Up Guardians are able to provide guidance and support with this for any concerned member of staff. As we know, diverse and inclusive teams make better decisions, including in the Covid19 response."

The FTSU Ambassador promoted FTSU Champions via daily communications (6 May 2020) and the Trust's Safety Huddle.

The Committee received information that no issues had been raised via FTSU related to Covid19 or health and safety concerns. The FTSU Ambassador asked the Committee to note that it was their view that staff were not accessing the FTSU route to raise concerns about Covid19 or health and safety matters because of the additional support put in place for staff during the pandemic such as the Personal Protective Equipment (PPE) Champions and Staff Welfare Champions.

In addition the FTSU Ambassador delivered bespoke presentations to new starters at the Trust such as Medical Students to raise awareness of FTSU and how to access this within the Trust.

3.1.8	Guardian of Safe Working for Junior Doctors - Q4 Report - 1st Jan 2020 – 31st March 2020

The Committee noted the report findings and progress made with implementing the Junior Doctor Contract and the level of assurance given that the Junior Doctors are working safely for their own health, and wellbeing and the safety of patients.

3.1.9	Safe staffing response plan for nursing during COVID-19 surge – May 2020

The staffing response to the COVID 19 pandemic was undertaken in a gradual and systematic approach in order to manage the demands in activity and workforce challenges. The response was against a background of a nurse vacancy position of 107 wte and 84 HCA's. Another significant challenge in managing the workforce demands was the sudden increase in staff sickness absence rates which reached 11.15% for registered nurses and 14.46% for health care assistants in April 2020.

In order to expand respiratory care provision in critical care, acute and supportive wards revised staffing models were undertaken across the organisation. These staffing models used a systematic evidenced based acuity data (SNCT) model in order for WHH to meet the needs of patient acuity on the critical care unit and respiratory wards. This required an overall uplift of 60.5wte registered nurses and 72.78wte health care assistants.

The expansion of ICU was undertaken using national and local best practice guidance. Caring for a critical care patient required staff with a specific skill set and expertise which isn't used in any other part of the Trust. Therefore in order to expand the critical care unit into the theatre footprint WHH accessed off-framework agencies Thornbury Nursing Services and Greenstaff Medical Agency. In normal circumstances the Trust do not use off-framework agencies as they do not provide the same assurances as on framework agencies which have stringent criteria set by recognised framework providers. Therefore the senior nursing team reviewed demand and usage of these agencies on a weekly basis with a focus on reducing the number of shifts requested as soon as activity permitted. As demonstrated the WHH nursing and midwifery COVID 19 staffing plans followed a systematic, gradual and responsive approach to meet the needs of our patients to ensure that they received the best possible care delivered in a safe and compassionate way.

3.1.10	COVID-19 – Governance - People (Trusts and FTs)

The Committee received assurance from the completion of the MIAA Workforce Governance Checklist.

Governance Considerations: COVID-19

The Committee noted that a number of areas would come under increasing pressure during the pandemic which impact on workforce arrangements. In order to support organisations to manage workforce issues, a raft of guidance was published. In particular, the Department of Health and Social Care (DHSC), NHS England and NHS Improvement, Public Health England (PHE), Health Education England and NHS Employers collated the latest workforce advice into one central resource for workforce leaders in the NHS (COVID-19 guidance for NHS workforce leaders - NHS Employers).
The checklist provided a framework against which to assess HR governance arrangements in place for the organisation. This checklist focused on the following key areas of HR governance:

3.2	July 2020 Committee Meeting

The Committee received a range of updates to provide assurance on the response to Covid-19, strategic people priorities and workforce health, safety and wellbeing.

3.2.1	HR and OD Directorate Services: COVID-19 Response Update (July 2020)

- **Occupational Health**

There continued to be a significant demand on the Occupational Health (OH) Service. The team continued to flex the service to meet increasing demand as required. In addition to the COVID-19 nursing advice line, the team worked in partnership with clinical services to deliver antibody testing across the workforce, supported the process of BAME staff risk assessments and shielding staff risk assessments, and updated guidance, advice and processes in line with rapidly changing government guidance such as the Test and Trace service.

The Committee noted that the OH Team had begun to reintroduce 'business as usual' services in line with Trust processes and focus on delivering the Flu Campaign 2020.

- **Wellbeing**

The enhanced wellbeing offer continued to be offered and developed further, in line with recovery plans. The Committee received a detailed update on the developing offer for individual staff, teams and departments.

- **Employee Engagement Activities**

Reward and recognitions processes, including Employee and Team of the Month, remained under review with a view to restarting in 2020/21.

The Committee noted that notification was received that the 2020 NHS Staff Survey would take place in September 2020 as scheduled.

- **Equality, Diversity and Inclusion**

Notification was received that statutory reporting requirements had recommenced and work had begun on the Workforce Disability Equality Standard and Workforce Race Equality Standard submissions.

Internally, the EDI agenda continued to be an important part of supporting the workforce during the pandemic, with a notable increase in awareness and visibility. Examples of key pieces of work include:

- Weekly meetings with the Black, Asian and Minority Ethnic (BAME) network Chair
- Compliance monitoring with risk assessments for substantive BAME staff
- Introduction of the LGBTQA+ staff network

- **Organisational Development**

The Organisational Development (OD) Team received a significant increase in the number of team development requests, as services began to move forward and teams reform. The OD Team play a vital role in supporting the recovery of the workforce following the pandemic. A detailed update was provided to the committee.

- **Learning and Development**

The first day of the Corporate Induction continued to be offered via a hard copy pack and positive feedback was received from new starters.

The Committee was informed that the frequency of courses on offer may need to be increased to mitigate the impact on training compliance where the maximum number of attendees was restricted due to social distancing requirements. Where it had not been possible to recommence training that is only available face to face (de-escalation training only), the subject matter experts had completed a risk assessment.

- **Resourcing: Recruitment and Bank and Agency Teams**

Both teams continued to support the Trust via their 'business as usual' processes. Activity remains higher than usual for recruitment especially clinical roles.

The Committee was assured that a streamlined approach to recruitment was based on following national guidance amendments to the pre-employment check process to support speedier recruitment. Processes continued to be updated as national guidance changed.

- **Payroll and Pensions**

The Committee was asked to note that the Payroll and Pensions department continued to process weekly/ monthly salaries and to meet the increasing demand due to the increase in the recruitment of staff during the Pandemic. Due to the number of policy changes and changes to working arrangements there were significant increases in demand on the department. The team continued to meet that demand and provide a bespoke service to the Trust.

- **Workforce Information**

The Committee noted that the Workforce Information hub continued as normal, processing weekly / monthly reporting requirements. In addition, the hub undertook the work required to produce daily NSHI/E SITREPs for staff testing and staff absence, as well as internal reporting requirements e.g. weekly HR&OD Strategic Executive Oversight Group report. The Team continued to provide dedicated support to CBUs and Departments on 'live' reporting of sickness absence, to facilitate the daily SITREP requirements.

➢ **Human Resources**

All services and support continued as usual, with social distancing or virtual arrangements put in place where required. The Committee noted that the deployment of staff remained a priority for the directorate to ensure resources were safely deployed. The Temporary Workforce Redeployment Hub established in March 2020 had exhausted all available staff however it was expected that further redeployment opportunities would become available as shielding staff returned to work at the end of the first lockdown (August 2020).

3.2.2	Workforce COVID-19 Risk Assessments

The Committee was assured that in order to support those in our workforce who may have vulnerabilities relating to COVID-19, a COVID workforce risk assessment was developed. This evolved over the period of the pandemic (Wave 1), as new evidence and guidance emerged. The NEW COVID-19 Workforce Risk Assessment Tool was developed by the HR and OD Team and launched in July 2020. The electronic tool enabled all members of staff to undertake a self-assessment and request a risk assessment from their manager where required. The implementation of the tool was supported by guidance, virtual training and regular reporting. A regular audit of risk assessments was undertaken to ensure that a robust discussion has taken place and that the agreed controls have been implemented.

In relation specifically to Black, Asian and Minority Ethnic (BAME) staff, all members of staff in work had received a letter outline the importance of risk assessments and the need to have a Manager Risk Assessment as a priority. Committees received assurance that those who were not currently in work e.g. maternity leave, shielding staff, those on long term sick leave would receive a risk assessment prior to return. All BAME staff risk assessments were quality checked and returned to managers for further action where appropriate. An audit of controls and actions took place week commencing 13 July 2020 and outcomes were reported to Strategic Executive Oversight Group.

3.2.3	Strategic Workforce Priorities: National, Regional and Local

NHS England and NHS Improvement (NHS E/I) confirmed that the NHS People Plan was to be revised in line with learning from the COVID-19 pandemic. Notification was received that the plan was likely to be published at the end of July or August 2020 and include the following key elements:

- Looking After our People - People Promise (Health and Wellbeing)
- Inclusion and Belonging - health inequalities
- Working Differently - beneficial changes to be reflected
- More People - returners, student nurses
- Delivering Together - across systems

In addition, work was led regionally by the North West Chief People Officer, NHS E/I, to agree a set of North West workforce priorities as follows:

- Workforce Supply
- Workforce Transformation
- HRD and Employer Support
- Colleagues Experience
- Leadership and Talent / Organisational Development
- Equality, Diversity and Inclusion

3.2.4	Committee Structure Review

In March 2020 the Committee received and approved the proposed strategic priorities for 2020/2021, however there was clearly a renewed need to revisit these objectives in light of the learning from the COVID-19 pandemic and the national and regional objectives. These revisions are provided in the section (2) – Refreshed People Priorities 2020/21

Following the suspension of Equality, Diversity and Inclusion (EDI) Sub-Committee during the COVID-19 pandemic (Wave One), the opportunity was taken to review the meeting and ensure that it continued to meet the evolving needs of the Trust and its workforce. The Committee noted the proposals and requested further work via Strategic Executive Oversight Group and Quality Assurance Committee before it was represented to the committee in September 2020.

3.2.5	Social Partnership Forum Statement – Version 2 (July 2020)

The SPF Agreement Version 2 was noted by the Committee, specifically around the following aspects:

More planning is being done in regions and in local systems for restarting services (phase two, May to August) and opening up the NHS while managing COVID-19 (phase three, July to March 2021). The SPF Agreement outlines the importance of strong social partnership arrangements at all levels to engage trade unions in the planning and implementation. This statement aimed to provide practical support on how we work in partnership at a local and ICS level during the next phases.

- **Partnership working**
  - Continuing with **Partnership principles** outlined in Version One
  - **Revising ways of working**: Partnership working practices were streamlined during the initial response, with formal meetings replaced with more regular discussions, often just between leaders and staff side chairs. These streamlined arrangements were needed for rapid emergency decision making. Partners should now review their arrangements, include full staff side membership, and consider the gradual return to normal ways of working. Staff side chairs may still need to take a lead role on behalf of trade unions, where emergency issues arise, in supporting their partnership colleagues and providing feedback on issues that span organisations into system, regional and national forums, where appropriate.
- **Facilities time**
- **Restarting services and maintaining the response to COVID-19:** Engagement should now be done through formal partnership arrangements rather than the temporary arrangements used at the start of the emergency.
- **Managing change during the pandemic:** Employers and trade unions locally should monitor equality and wellbeing. They should ensure that no member of staff or group of staff is disadvantaged by the working arrangements in place during the pandemic.
  - **Local agreements**: Variations to existing local trust policies and protocols may need to continue during the next phase. Any extension to these variations should be agreed in partnership, unless covered by emergency plans or protocols.
- **Temporary changes to working practices**: Employers should review working practices so that they are in line with the latest national guidance on scope of practice. Homeworking for staff who can work from home, should be facilitated and expected as normal during this period.
- **More substantive changes to working practices**: Where employers and trade unions agree that some changes are beneficial and in line with Long Term Plan and Interim People Plan,

they may wish to use normal processes to make temporary changes more permanent. Contractual variations should be made in the normal way through agreement.

- **Organisational change**: Unless partners agree otherwise, changes should remain paused where they are:
  - not necessary for the response to the pandemic and the safe re-start of services, or
  - not required for a statutory reason, or
  - contentious or likely to lead to disputes
- **Industrial disputes**: Avoiding industrial disputes, and the potential causes of them, remains a high priority in the next three months for both employers and unions. Parties should aim to resolve disputes quickly or consider pausing disputes, through preserving the status quo.
- **Disciplinary matters, grievances, and other procedures:**
  - **Reviewing cases** – Consistent with the principles set out in Improving People Practices
  - **Hearings and procedures** - The principles of natural justice and the employer's policies should continue to apply where hearings and procedures do go ahead, especially the right to union representation.
  - **Partners recognise the following adjustments need to be considered**:
    - **Timescales**: These may need to be extended beyond those set out in local policies, by agreement and on the basis of no detriment. Extra preparation time may also be needed. Urgent grievances or concerns, for example, around health and safety, should be a priority and every effort made for these to meet the normal timeframes in local policies.
    - **Virtual meetings**: Given social distancing rules and restrictions on travel, virtual meetings can be used following a joint assessment of all the relevant factors for the employee, their representative and the employer. For example, considering the equalities impact or whether the hearing is likely to result in dismissal. Also relevant are meeting platforms allowing employees to confer privately with their representative, protocols and training on equipment use, ensure the full visibility and audibility of participants and limits on screen time with regular breaks.
    - **Physical meetings**: It may be necessary to hold a meeting physically. Strict social distance rules must be observed. Parties should agree with the arrangements put in place following an appropriate risk assessment. If these arrangements are not in place on the day, parties have the right to withdraw.

Review of these temporary provisions by ***Wednesday 30 September 2020***.

3.3	**September 2020 Committee Meeting**

The Committee received a range of updates to provide assurance on the response to Covid-19, strategic people priorities and workforce health, safety and wellbeing.

3.3.1	**NHS People Plan and WHH People and EDI Strategies**

- *We are the NHS: People Plan 2020/21* - action for us all, from NHS England and NHS Improvement (NHSEI) and Health Education England (HEE) was published in July 2020.
  - A detailed delivery plan was produced to deliver all elements of the NHS People Plan.
  - An integrated strategic delivery plan was presented to the Committee for the Trust People Strategy, the workforce elements of the EDI Strategy, and the Workforce Recovery Plan, with the NHS People Plan and the NW NHSE/I People Priorities.

3.3.2	Equality, Diversity and Inclusion – Commissioned Review into Embedding ED&I

The Committee noted the update regarding the Commissioning of a Review into the ED&I assurances provided. The Committee noted that a Trust Board development session was held on June 2020 which focused on the Trusts response to Covid-19 for the workforce.

It was acknowledged that a review of the existing resources and capacity to deliver and respond to the emerging and existing legislative and regulatory requirements for EDI should be undertaken by the Chief People Officer and an acknowledgement that there was a requirement for additional expert advice on the role of Trust Board in seeking and receiving assurance on the Trusts regulatory responsibilities for EDI as it responds to emerging information and external / national scrutiny on health and workforce inequalities and the need to address these as part of the Phase 3 – Restoration of NHS Services.

The Committee took assurance that the Chief People Officer in August 2020, commissioned an externally expert (JS Associates) in EDI to undertake a review of:

- Current EDI regulatory and legislative response by the Trust to meet, for example, our Public Sector Equality Duties,
- the role of Trust Board and Sub Committees in seeking assurance
- Provision of a Board development session, and
- Confirmation of action planning and identification of next steps.

Phase 1: Vision and Ambition		
Activity	**Who & What**	**Date**
45 minutes – 1-1 Zoom Interviews	One to one interviews with Executive Directors and nominated Non-Executive Directors: • Chair of Quality Assurance Committee • Chair of Strategic People Committee • Non-Executive Director & Senior Independent Director and member of Strategic People Committee	Aug – Sept 2020
Short Survey	Short survey to be developed by JS for managers including HR	Sept 1st – 15th 2020
Phase 2: Awareness and Challenge		
Audit & report	Desk top review (website) of performance in line with equality legalisation, NHS standards and best practice. List of documents to be requested by JS Associates to support the audit.	Sept 1st – 23rd 2020
Thematic review of interviews with board	Interview with board members will be transcribed and analysed to understand where the Board and the organisation needs to be & want to	Sept 15th – 20th
Phase 1 & 2 – integrated report	Bringing together the analysis from the interviews, survey, and desk top research & recommendations	Sept 25th 2020
Board / Executive development day	Overview of the E&D Landscape & role of the board Share findings and recommendations of the review & gain feedback	1st Oct 2020
Submission final report & agreement on phase 3	General feedback on phase 1&2 and agreement on next steps and phase 3	Oct 15th, 2020

Committee members were informed that they would receive the final report and recommendations for Next Steps in November 2020 responding to the findings of the EDI review of WHH current performance, Trust Board assurance and intended improvement journey.

3.3.3	**Health and Wellbeing at Work – Sickness Absence Levels**

The Committee noted that in July 2020:

- Trust sickness absence levels had reduced to 5.5%, which was in line with sickness absence levels in July 2019.
- Sickness absence remained above target and further improvement were required.
- The Trust received a letter regarding sickness absence from Anthony Hassall, Regional Chief People Officer (NW), NHS England and Improvement (NHS E/I), on 21 August 2020. The letter set out concerns about sickness absence rates across the North West and highlighted high levels of absence at this Trust, and an additional 9 Trusts, in particular.
- The Chief Executive responded to the letter. The response acknowledged a need to further reduce absence levels and set out the activity in place to do so.
- A Cheshire and Merseyside approach to high levels of sickness absence was to be the focus of NW Regional NHSE/I with the proposal to hold a sub-regional conference to share best practice from within the NHS and other industries (date to be determined).

3.3.4	**COVID-19 Workforce Risk Assessments**

The Committee noted that NHS E/I submissions were requested from all NHS Trusts on COVID-19 Workforce Risk Assessments. The committee received information on the Trusts compliance with Risk Assessments and the continued work.

3.3.5	**Nursing Times Workforce Award 2020**

The Committee was notified that the Trust had been shortlisted for two national awards within the Best Recruitment Experience category.

3.3.6	**Workforce Validation Engine – WoVEn ESR Data Quality**

WHH was recognised as ***Best in the North West*** by NHSE/I.

The Committee noted that the Workforce Validation Engine (WoVEn) is a monthly data quality report on data in the Electronic Staff Record (ESR). It was designed in 2015 to support Trusts improve their data quality in recognition that data continues to become increasingly important for organisations. Improving the quality of ESR data enabled NHS Digital to replace burdensome data collections and at a local level it instils confidence in using such data to make informed decisions, which have a positive impact on the care of our patients. The WoVEn process helps to ensure that the quality of this data continues to improve and provides national rankings for data quality scores against an agreed list of criteria. Aware of the importance of good data the teams inputting into ESR and the related systems have quality control measures in place to maintain the quality and since Feb 2016 the Trust's average number of monthly errors is 3 out of 448 fields. Often the Trust will report 0 errors, ranking number one nationally, demonstrating an ability and commitment to maintaining data quality in ESR.

Following the announcement by NHSE/I of this achievement the Workforce Intelligence Hub in HR & OD Directorate was approached by Cheshire & Merseyside Health and Care Partnership to request the

submission of a Case Study for inclusion in the system People Plan. This was submitted on 15 September 2020.

3.3.7	Workforce Race Equality Standard (WRES)

The Committee was asked to note the analysis of the WRES data and proposed approach to developing the WRES action plan.

3.3.8	Workforce Disability Equality Standard (WDES)

The Committee was asked to note the analysis of the WDES data and proposed approach to developing the WRES action plan.

3.3.9	Committee Structure Review – ED&I proposal (following July SPC)

The Committee approved the proposed changes to the reporting arrangements, frequency, membership and Terms of Reference of the EDI Sub- Committee.

3.3.10	Facilities Time Off Annual Report – national Extension to September 2020

The Committee was asked to note and approve the report prepared for publication as required by the Trade Union (Facility Time Publication Requirements) Regulations 2017.

In May 2019, the government added the following paragraph to the advice published on its website: *"The Civil Service is leading by example and demonstrating that greater accountability can result in sensible savings, demonstrating effective use of taxpayers' money. The Government strongly encourages all public sector organisations to ensure facility time spend represents value for money by aiming to reduce facility time spend to 0.06% of pay bill as achieved by the Civil Service."*

The Committee noted that the Trust was at ***0.03%*** of the pay bill, which indicated that the Trust comfortably met the target of 0.06%.

3.3.11	On-Call Harmonisation report

Following an audit of on-call by MIAA, a recommendation had been made to the Trust Audit Committee that on-call arrangements are harmonised across the Trust. An update report was provided to Audit Committee in July 2020. As a result of the pandemic, the Audit Committee agreed that the on-call harmonisation process would remain on hold, to be reviewed in September 2020 via the Committee.

In agreeing to continue to pause this workstream the Committee noted the content of the National Social Partnership Forum (SPF) statement on 1 April 2020 on industrial relations during the pandemic. In practice, the agreement meant that organisational change processes were 'paused'. A further statement released on 1 July 2020 confirmed that changes should remain paused where they are:

- not necessary for the response to the pandemic and the safe re-start of services, or
- not required for a statutory reason, or
- contentious or likely to lead to disputes

A further statement from the National SPF is expected by the end of September 2020.

It is likely that the organisational change processes relating to on-call harmonisation will be contentious in some services. It is therefore proposed that the process remains on hold until the further National SPF statement is published and is reviewed in September 2020.

3.3.12	Employee Relations Report

The Committee noted that in May 2019 Baroness Dido Harding, Chair of NHSI/E, wrote to all NHS trusts and NHS foundation trusts Chairs and Chief Executives setting out a series of recommendations relating to improving 'people practices'.

A review of the Trust current position against the recommendations was undertaken and presented the Committee in July 2019. An action plan was then produced to address any recommendations not fully met. Success measures were agreed by the Committee in July 2020.

The Committee noted that the Deputy Chief People Officer is currently undertaking a review of current employee relations processes against the ACAS Code of Practice. This includes the delivery of Improving People Practices recommendations. Findings will be reported to the Chief People Officer and Chair of Strategic People Committee in October 2020, followed by a report to the Committee in November 2020.

3.3.13	Safer Staffing Report (June and July 2020)

The Committee accepted the report on Nurse Staffing and noted the following key points from the report:

- CHPPD in June 2020 is 7.7 which is an improvement from January and February 2020 when the rate was 7.1.
- Due to the temporary pause of data submission to Unify there is no CHPPD data available during March to May 2020.
- The progress that continues to be made across the organisation in nursing and midwifery staffing levels as the number of wards reporting staffing levels below the 90% and CHPPD levels remain consistent.

3.3.14	Safe Staffing Escalation Audit May – June 2020

The Committee noted that the results of the audit have demonstrated improvement against all standards providing significant assurance. The audit was undertaken during the COVID-19 Pandemic response, during this time there was a senior nurse on duty to support with staffing 8am until 8pm 7days a week. This senior support provided oversight and responsive action to the nurse staffing processes across the Trust at this time.

The Committee accepted the recommendation to repeat the audit in 6 months time.

3.3.15	WHH Physician Associate Governance Framework 2020

The Committee received an overview of the WHH Physician Associate Governance Framework which supports the employment, clinical practice, supervision and development of the Physician Associate within Warrington and Halton Teaching Hospitals NHS Foundation Trust.

The Committee noted the following assurance provided from the introduction of a Governance Framework:

- Provision of an assurance mechanism to the Trust Board, managers, staff and patients

- Support the development and implementation of the role of the Physician Associate within the Trust
- Ensure consistency and standardisation of practice
- Support the management of the role of the Physician Associate
- Support the clinical practice of the Physician Associate

3.3.16	**Freedom to Speak Up Bi-Annual report**

The Committee noted that from April 2020 to August 2020 there have been 15 FTSU disclosures, of which nearly all relate to relationships and bullying and 7 of the 15 relate to Women's and Children's CBU. The FTSU team was working closely with the CBU and the Organisational Development Team to support actions highlighted.
The Committee accepted the report and noted its onward journey to the Trust Board (September 2020).

3.3.17	**Quality Visit Report, School of Medicine, University of Liverpool** – Warrington Hospital

The Committee received the Quality Report from the University of Liverpool School of Medicine following a visit on 15 July 2020.

Specifically the Committee noted that the Dean of the School of Medicine commented on the commitment of the Trust to the quality of medical education and the considerable effort made to support the development of undergraduates despite the challenging circumstances of COVID pandemic. Positive educational developments were noted. Aspects assessed included: job planning, induction, clinical skills provision, administrative staff, clinical staff and educational supervision. Notable practice and recommendations were made within a letter from Dean of Medical School. Medical Education department will progress with recommendations and a further update from the University School of Medicine on 4 November 2020.

3.4	**November 2020 Committee Meeting**

The Committee met in the context that Warrington and Halton Boroughs were in Tier 3 (local lockdown with specific public health restrictions) as a result of increasing community prevalence (North West – Pandemic Wave 2).

The Committee received a range of updates to provide assurance on the response to Covid-19, strategic people priorities and workforce health, safety and wellbeing.

3.4.1	**Temporary Medical Staff Induction**

The Committee received an update on adherence and compliance to current induction processes for temporary medical staff. The Committee noted progress following a review of induction process /methodology and quality improvement work stream in order to improve compliance. The Committee requested further updates as limited assurance provided.

3.4.2	**Strategic People Committee (SPC) – Revised Terms of Reference**

The Committee (SPC), as a Board Assurance Committee, has assumed responsibility for oversight of the Equality, Diversity and Inclusion Sub Committee from a People/Staff perspective. The Quality

Assurance Committee (QAC) will have oversight from a Patient and Service User perspective. Amendments have been supported at the QAC on 3 November 2020.

To reflect the amendment to the reporting arrangements proposed changes to the Terms of Reference include:

- Amendment to Section 6 Reporting
- Add – Equality, Diversity & Inclusion Sub Committee.
- DoF, Chief Nurse, HR&OD, Director Community
- Engagement and other titles updated to reflect current roles.
- Proposed amendments to the ToR are detailed in the Revision Tracker.

The Committee approved the amended Terms of Reference to be presented to the Trust Board for formal ratification.

3.4.3	**Medical Appraisal and GMC Revalidation Annual Report: November 2020**

The Committee received the report which seeks to provide assurances to the Trust Board that the system for medical appraisal and the processes for monitoring the completion of annual appraisals to support GMC revalidation for the medical workforce are robust.

The Committee noted that doctors who practise medicine in the UK must be registered and hold a licence to practise. Both registration and licensing are delivered by the GMC. Every licensed doctor who practises medicine must revalidate. Revalidation is an evaluation of a doctor's fitness to practise. It supports professional development, drives improvements in clinical governance and gives patients confidence that the doctor is up to date. GMC revalidation is based on annual whole practice appraisals; information from systems of clinical governance and a five yearly revalidation recommendation. All doctors have a legal obligation to revalidate and failure to comply with the requirements may result in withdrawal of their licence to practise.

The Committee noted that most licensed doctors are supported with their appraisal and revalidation through connection to a 'designated body'. Within that organisation, a 'responsible officer' oversees the process of revalidation and makes a recommendation to the GMC about whether a doctor should be revalidated. The designated body is the organisation in which the doctor undertakes most or all of their practice and their responsible officer is a senior doctor within that organisation. The relationship between a doctor, their designated body and responsible officer is known as their 'connection details'.

The Trust maintains the list of doctors for whom it is the designated body. The responsible officer is Dr Alex Crowe, Executive Medical Director. The responsible officer must:

1. make sure doctors have access to appraisal systems and processes for collecting and holding information
2. make a recommendation to the GMC every five years, indicating whether the doctor is up to date, fit to practise and should be revalidated. The GMC sets clear guidance on the requirements for annual appraisal and the supporting information that a doctor must present. Doctors at WHHFT collate their supporting information using CRMS - a web based system enabling the secure storage of documentation. Since 2012 WHHFT has had processes and systems in place to enable, track and monitor appraisal completion rates.

The Committee noted the following Key Results:

- In 2019/2020 96% of appraisals were completed
- Within WHHFT 234 doctors require an annual appraisal
- There are 71 trained appraisers

- Monitoring and recording of appraisal completion across the Trust was maintained during the first wave of the COVID pandemic. Doctors in the front line were allowed to have an approved missed appraisal

3.4.4	Equality, Diversity and Inclusion – Commissioned Review into Embedding ED&I

In September 2020 the Committee were informed that the Chief People Officer had commissioned Jagtar Singh, Director, JS Associated Limited to undertake a strategic review of equality, diversity, and inclusion practice within the organisation. The Committee accepted the Final Report of work undertaken to date and noted the 10 Key Recommendations set out below identified to help support capacity within the organisation.

1. Develop a compelling story/narrative that goes beyond compliance.
2. Support board members to develop inclusive and cultural competence as the culture will be set by their behaviours.
3. EIA development including EDI risk management for all executive directors and middle management and committees to strengthen governance.
4. Integrate EDI and shadow board plans and reverse mentoring.
5. Review and support the work of the various staff networks and measure their impact and establish a Disability Staff Network.
6. Integrate the concept of 'Belonging' as part of the EDI work & invest in developing capacity across the organization developing cultural and inclusive ambassadors/allies.
7. Review evidence and data and links between equality strands and the relationship between the patient and the staff experience.
8. Review existing patient experience policy/practice and integrate EDI considerations, the role of the board and governance.
9. Performance indicators/benchmarking of EDI practice and integrate this into reports.
10. Build EDI, continuous improvement and academy.

The Committee noted that the report indicated that the Trust had much to be proud of in terms of EDI and the progress made so far and that these recommendations provide a real way forward to move beyond a tactical approach towards compliance towards embracing strategic inclusivity.

3.4.5	Public Sector Exit Payments

The Committee noted the implementation of a £95,000 cap on exit payments in the public sector received final approval from parliament in October 2020. The cap was intended to be applied to any exit after 4 November 2020.

The Committee was informed that employers were instructed that they must:

- Ensure any exit payment made does not exceed the public sector exit payment cap.
- Publish information about any decisions to relax the cap. The government recommends that this information is published in annual accounts.
- Disclose in their annual accounts information about exit payments paid during the financial year.
- Keep a record of exit payments made to an employee.
- At the end of the financial year, publish a list of:
    - the amounts and types of qualifying exit payments made in respect of which the relaxation power was exercised in that financial year
    - the dates on which that power was exercised
    - and the reasons why that power was exercised.

***Please note** that after implementation of this national cap on Exit Payments from 4 November 2020, the government made a prompt decision to overturn this cap. There were no staff eligible for an Exit payment in 2020/21 – redundancy, severance scheme etc and therefore the cap implementation did not impact on the Trust.*

3.4.6	**Supporting Staff to Stay Safe During COVID-19**

The Committee noted that on 1 November 2020 the Government announced new national restrictions which would come into force on 5 November 2020. The new guidance included information on protecting people more at risk from coronavirus.

The Committee took assurance in the report that all relevant Trust processes and guidance were updated appropriately. The table below sets out the approach to supporting staff to Stay Safe During COVID-19.

All Staff
• **Workforce Risk-Assessment** must be completed and kept under review. Link to the tool is available here: • **Check in Conversations** should be held with all staff to ensure that they are supported. Embed template document. • **PPE and Social Distancing** guidance must be followed. Top ten things to remember link. • **Working from Home** should be considered. Embed template document. • **Mental Wellbeing** remains an important priority. Link to the website
Clinically Extremely Vulnerable
• Staff members are being supported to work from home. • Staff must provide managers with evidence e.g. G.P. letter. • A central log is held within the HR Team. • Support to managers is provided via the Redeployment Hub.
Clinically Vulnerable
Staff members should already have a Workforce Risk Assessment and control measures in place if required. If this is not completed or individual's circumstances have changed then the below steps should be followed: • COVID-19 Workforce Risk Assessment must be completed. • Control measures identified must be put in place. • Does not require a routine Occupational Health assessment but if there are complexities that require Occupational Health advice, a referral can be submitted clearly highlighting the reason for the referral.
Ethnicity, Gender and Age (over 60)
Staff members should already have a Workforce Risk Assessment and control measures in place if required. If this is not completed or individual's circumstances have changed then the below steps should be followed: • COVID-19 Workforce Risk Assessment must be completed. • Control measures identified must be put in place. • Does not require a routine Occupational Health assessment but if there are complexities that require Occupational Health advice, a referral can be submitted clearly highlighting the reason for the referral.

The Committee noted that as at 16 November 2020 there were **107** confirmed Clinically Extremely Vulnerable (CEV) staff across the workforce, **73** clinical staff members and **34** non-clinical staff members.

The Committee received an update on Risk Assessment compliance. In relation to workforce risk assessments across the entire workforce, compliance as at 16 November 2020 was set out below:

Have you offered a Risk Assessment to all staff?	**Yes**
What % of all your staff have you Risk Assessed?	**84.63%**
What % of risk assessment have been completed for staff who are known to be "at risk", with mitigating steps agreed where necessary?*	**96.51%**
What % of risk assessment have been completed for staff who are known to be from a BAME background, with mitigating steps agreed where necessary?	**97.34%**

The Committee was assured of the process and the ongoing work to identify and support all staff requiring a Manager Risk Assessment – including for example, new recruits, students on placement, staff returning for Maternity Leave, and those returning from Long Term Sick.

3.4.7	**Asymptomatic Staff Testing**

- **PCR Testing Pilot**

The Committee received information that on 11 October 2020 the Trust was informed by NHSE/I of the requirement to carry out COVID-19 testing for asymptomatic staff within a specified cohort of staff groups. The Trust was 1 of 11 pilot sites across the North West. The pilot involved a one-off PCR test. The Trust opted to commence testing over a 10-day period from 20 October – 29 October 2020 inclusive. The pilot was successfully led by the Chief Finance Officer and Deputy CEO, supported by staff across the Trust. In total 3,072 were undertaken, with a positivity rate of 1.92%.

- **Lateral Flow Testing**

The Committee was informed that on 9 November 2020 the Trust volunteered to be 1 of 3 Trusts in the North West to roll out Lateral Flow Testing for asymptomatic staff. The project involves twice weekly self-testing for all patient-facing staff. The Lateral Flow Test gives a result in 30 minutes. The pilot is being led by the Chief People Officer, supported by staff across the Trust.

All 3 pilot Trusts undertook a small 'test' roll out on 13 November 2020 of circa 25 staff. All staff members who reported results for WHH were negative. A full roll out commenced 17 November 2020 for all frontline staff (circa 2500 staff).

The Committee noted the resource demands to support pilot work on asymptomatic testing and the importance of this work in providing a safer workplace for staff and for patients to receive care. The Committee extended thanks to all those staff supporting the programme of work and for staff participating in the testing regime.

3.4.8	**Workforce Race Equality Standard**

The Trust WRES data against the indicators was presented to the Committee in September 2020. The Committee noted some particular areas of concern relating to formal disciplinary processes, bullying and discrimination. In September 2020, the Committee requested that a more detailed review be undertaken by the Deputy Chief People Officer to understand the issues which are set out below:

- There are no concerns regarding the 9 specific employee relations cases relating to BAME staff, which form part of the 2020 WRES data submission.
- The review of undertaken by the Deputy Chief People Officer should be repeated in Q4 2020/21.

- Of the 3 indicators relating to staff survey results, 2 have improved since 2019 and 1 has declined (staff experiencing harassment, bullying or abuse from staff). All 3 indicators suggest that BAME staff experience more harassment, bullying, abuse or discrimination than white staff.
- A high percentage of staff within Digestive Diseases CBU reported experiencing harassment, bullying or abuse from both patients and staff in the 2019 staff survey. It is not possible to understand whether this related to ethnicity.
- Freedom to Speak Up data collection does not include equality monitoring information relating to the staff member making a disclosure. This should be explored as soon as possible, with support from the Head of Employee Engagement and Wellbeing. It is acknowledged that this may be challenging due to the method of disclosures.
- The information received relating to Freedom to Speak Up disclosures and incidents reported via Datix do not indicate any trends, although this should be reviewed again when the work around Civility and Respect is commenced.
- The low number of cases relating to ethnicity reported via Freedom to Speak Up, Datix and HR indicate that there may be more work to do in relation to support staff disclosures.
- In order to further explore the underlying issues relating to indicators 5, 6 and 8, information on Freedom to Speak Up disclosures, Datix incidents, HR processes and related staff survey results were reviewed.

The WRES action plan was approved for publication by the Chair of the Committee in October 2020 and has since been updated on the basis of the review outlined above.

The review specifically looked at Indicator 3:

Indicator 3: Relative Likelihood of BAME staff entering the formal disciplinary process, compared to white staff			
There were 31 cases which fell within the reporting criteria for WRES data submission; 29 related to white staff, 9 related to BAME staff and 1 related to a member of staff who had not declared their ethnicity. The table below sets out the allegations, outcome and additional relevant details of the 9 cases relating to BAME staff.			
1	It is alleged that the employee amended the anaesthetic chart of a patient and these amendments were not in line with the accepted and recommended methods of making changes to documentation	Verbal	Outcome letter demonstrates that mitigation was explored and taken into consideration when sanctions were considered.
2	It is alleged that while completing a booking appointment the employee, provided a pregnant patient with tobacco for their own personal use.	First and Final	Outcome letter demonstrates that mitigation was explored and taken into consideration when sanctions were considered
3	It is alleged that the employee has inappropriately used E-Rostering system and the use of another member of Trust staffs password which is a breach of the Trust IT policy.	No case	There was potential fraud in this case. MIAA reviewed – no formal action. A more senior member of staff was also involved and received a verbal warning, This employee received no formal outcome but information action, e.g. IG training

4	It is alleged that the employee posted a photo on duty in PPE and uploaded to Facebook, in which a patient was visible.	Written warning	This case was referred to the fast track process
5	Various fraud-related allegations.	Written warning	Outcome letter demonstrates that mitigation was explored and taken into consideration when sanctions were considered.
6	It is alleged that you have falsified or completed an inaccurate statement within an official Trust document (i.e. patient record).	Action Plan	Clear explanation in outcome letter – could this not have been arrived at within investigation?
7	It is alleged that the employee was issued with a police caution under section 39 – assault against a child.	Written warning	Outcome letter demonstrates that mitigation was explored and taken into consideration when sanctions were considered.
8	Allegations relating to violent behaviour	First and Final	Outcome letter demonstrates that mitigation was explored and taken into consideration when sanctions were considered
9	Safeguarding-related allegations	Dismissal	Outcome letter confirms that no mitigation was presented by the employee.

The Committee noted and were assured that the conclusion presented by the Deputy Chief People Officer indicated that in all 9 cases the formal process was instigated appropriately, there was a fair and proportionate outcome and that the approaches taken demonstrate that the process was executed fairly.

3.4.9	**Workforce Disability Equality Standard**

The Trust WDES data against the indicators was presented to the Committee in September 2020. The Committee noted some particular areas of concern relating to, bullying, career progression and pressure to attend work. The Committee requested that a more detailed review was undertaken to understand the issues and presented back to the Committee in November 2020.

The Committee noted the following findings:

- Of the indicators highlighted, 1 has improved since 2019 and 3 have declined. All 4 indicators suggest that disabled staff have a more negative than nondisabled staff.
- A high percentage of staff within Digestive Diseases CBU reported experiencing harassment, bullying or abuse from both patients and staff in the 2019 staff survey. This CBU is also within the highest negative results relating to equal opportunities for career progression. It is not possible to understand whether this related to disability.
- Freedom to Speak Up data collection does not include equality monitoring information relating to the staff member making a disclosure. This should be explored as soon as possible, with support from the Head of Employee Engagement and Wellbeing. It is acknowledged that this may be challenging due to the method of disclosures.
- The information received relating to Freedom to Speak Up disclosures and incidents reported via Datix do not indicate any trends, although this should be reviewed again when the work around Civility and Respect is commenced.
- The low number of cases relating to disability reported via Freedom to Speak Up, Datix and HR indicate that there may be more work to do in relation to support staff disclosures.

- There remains a high number of staff who have not declared whether or not they have a disability via ESR and there should be a further campaign around this.
- The Disabled Staff Network should be engaged as part of the process of reviewing the current Attendance Management Policy later this year.

The Committee accepted the WDES action plan which was approved for publication by the Chair of the Committee in October 2020 and noted that it had since been updated on the basis of the review.

3.4.10	**People Strategy Update**

The Committee noted that the Strategic People Delivery plan 2020/21 includes 184 actions, which cut across the Trust People Strategy, the Trust EDI Strategy and the NHS People Plan. 59 of those actions require delivery from external bodies such as NHS England and Improvement (NHS E/I), prior to local implementation at Trust level. The table below sets out progress to date against the plan.

Actions complete	45
Actions due Q3	38
Actions due Q4	42
Actions awaiting external delivery	59
Total actions	184

The services and offers available to staff via the HR and OD Directorate have been rebranded:

➢ **<u>Priority: Implement an enhanced mental health offer to support our workforce during and following COVID-19 pandemic</u>**

The Committee noted the following update on activity:

- Enhanced On-site Staff Counselling Service implemented – additional 2 FTE staff counsellors (3 in total) and extended hours.
- Bite Size Wellbeing Sessions online launched and available via Trust extranet
- Health and Wellbeing Extranet Page created to promote internal offers, wider NHS offers and external support available to staff
- Mental Health Hubs are available to staff, services include:
  - Mindfulness workshops
  - Relaxation sessions
  - Meditation sessions
  - Counselling sessions
  - Mental Health First Aid
  - Group Therapy
  - Mental Health workshops

- Facilitated Debrief Conversations are delivered in partnership between the OD Team and Wellbeing Team
- Coordinated Support Groups include bereavement, working from home and weekend virtual forums.
- Check in Conversations launched for managers to support staff, including mental and physical health needs. These have been promoted by NHS Employers as an example of best practice.
- The HR and OD Directorate team have approached the Peace Centre to explore opportunities for partnership working to provide additional psychological support to staff, over and above that which is already in place.

➢ **Introduce team support programmes, for teams reforming and developing following the pandemic**

43 teams have been provided with bespoke offers, with a further 14 in the scoping phase or paused due to pandemic. The areas covered include:

- Maternity
- Paediatrics
- Emergency Department
- Finance and Commercial Development
- Facilities
- Neonatal Unit
- Medical Education

➢ **Introduce compassionate leadership development programmes and recruitment approaches**

- A Self-Compassionate at Work online programme has been launched to support staff to feel happier, less stressed and more resilient at work.
- A Compassionate Leadership Coaching programme will be launched in December 2020. The programme is aimed at band 8B and above initially and will run in cohorts of 5/6 staff members. Funding is secured to ensure places for all CBU Triumvirate Teams and Corporate leadership teams. Working is on-going to finalise the first cohorts. It is anticipated that the CBU Triumvirate cohorts will commence in April 2021 due to current operational pressures.

- Bite-size On-Line videos have been launched by the OD Team and are available via the 'How am I Developed?' section of the Trust extranet. Topics include:
  - Compassionate Leadership
  - Coaching Skills
  - Psychological Safety
  - Resilience

➢ **Introduce Staff Networks for disabled staff and LGBTQ+ staff**

- The BAME Staff Network continues to flourish. There are currently 43 active members of the network. Network infrastructure is in place, including network chair, protected time, virtual meetings and regular meetings with Chief People Officer. Support is provided to the network by the Head of Employee Engagement and Wellbeing.

- The LGBTQA+ Staff Network has been launched. There are currently 76 members of the network. Network infrastructure is in place, including network chair, protected time, virtual meetings and regular meetings with Chief People Officer. Support is provided to the network by the Head of Employee Engagement and Wellbeing.
- The Disabled Staff Network was launched in October 2020 and has met 3 times to date. Discussions have focused on staff experience and also input into the WDES action plan. The next meeting was scheduled to focus on the WDES action plan in terms of delivery and how staff members can support the delivery of this. The group have also input into the EDI calendar for the rest of the year with initial planning for national Disability Awareness days.

➢ **Introduce reverse mentoring**

The Committee noted that an application to the NHS Leadership Academy had been made to take part in the Reciprocal Mentoring for Inclusion programme. The programme provides opportunities for individuals from under-represented groups (such as BAME, LGBTQ+, disability) to work as equal 'partners in progress' with senior executive leaders in a relationship where knowledge and understanding of both sides of lived experiences creates awareness, insights and action that directly contributes towards the creation of a more equitable and inclusive organisation where the factors that generate inequity are positively and proactively addressed.

3.4.11	Employee Relations Report (Up to end of October 2020)

The Committee received an overview of the partnership landscape across the Trust and assurance in relation to high risk employee relation cases and the delivery of Improving People Practices recommendations. The Committee noted the partnership working arrangements in place during wave 2 of the COVID-19 response and covered key themes emerging:

- Staff Facilities
- Covering Colleagues Principles
- SAS Job Planning
- Local Clinical Excellence Awards

The management of employee relations activity across the Trust is key to maintaining a safe environment for both patients and staff and aids the Trust in mitigating employment-related risks.

3.4.12	Safe Staffing Assurance Report: August and September 2020

The Committee received the report and noted assurance on the following matters:

- Ward staffing data continues to be systematically reviewed to ensure the wards and departments were safe.
- Mitigation was provided and the action when a ward falls below 90% of planned staffing levels.
- Sickness absence rates were recorded at 6.28% in August 2020 and 6.31% in September 2020 for nursing and midwifery staff.
- In the month of August 2020 it was noted that 17 of the 21 wards were below the 90% target during the day, with an improvement noted in September with 14 of the 21 wards below the 90% target.
- In order to ensure safe staffing levels, mitigation and responsive plans were implemented daily to ensure that the safe delivery of patient care.
- CHPPD in August 2020 was 7.8 and 7.5 in September 2020, with a year to date rate 7.9.
- As part of the COVID-19 Pandemic response in line with NMC guidance a total of 133 nursing students were welcomed to the Trust and supported the wards during the pandemic. 29 of the students who are due to register in September 2020 have accepted a substantive post at Warrington and Halton Hospitals.

- WHH have joined Wrightington, Wigan and Leigh NHS Foundation Trust to participate in a regional pilot for recruitment of international nurses. Following a successful business case we are working on the plans to recruit 30 registered nurses to join the Trust in the next 3 months.

The Committee specifically noted that in September 2020 the Trust had commenced the COVID Wave 2 staffing response plan as we started to see case numbers rise in the Trust. The staffing response was being undertaken in a gradual and systematic way in order to manage the demands in activity and workforce challenges.

3.4.13	**Guardian of Safe Working for Junior Doctors** **Combined Report for Q1&2 - April – September 2020**

The Committee noted that the Trust had become more rigid in not permitting compensatory payment or TOIL after 2 weeks, if there has been no attempt to contact the supervisor following a report. Whilst the Trust encourages exception reporting (to highlight persistent issues in training or workload of our juniors), it is important that trainees realise that they must be signed off if compensation is to be awarded.

The Committee noted two 'Immediate Safety Concerns' were raised by the urology trainees which were addressed quickly and one work schedule review planned for Ophthalmology ST3+ trainees.

No fines were submitted by the Guardian in Q1 or Q2. To conclude, the Trust continues to provide fully compliant and safe rotas for the junior doctors, and all doctors are in line with safe working hours in our organisation. Persistent issues are dealt with in a timely manner.

3.4.14	**Equality Diversity and inclusion (EDI) Sub- Committee** High Level Briefing Paper (October 2020)

Assurance Committees:

- Patient Equality, Diversity and Inclusion - Quality Assurance Committee
- Workforce Equality, Diversity and Inclusion – Strategic People Committee

The Committee received the High Level Briefing on Workforce Equality, Diversity and Inclusion priorities and accepted this report.

3.5	**January 2021 Committee Meeting (North West Wave Three / National Wave Two)**

The Committee met in the context that the North West was experience a Wave 3 of the pandemic and a national lockdown had been re-instated.

The Committee received a range of updates to provide assurance on the response to Covid-19, strategic people priorities and workforce health, safety and wellbeing.

3.5.1	**COVID-19 Response Wave 3: Workforce**

➢ **<u>Occupational Health</u>**

The Committee gained assurance that the Occupational Health COVID-19 response service remained in place. The service includes a call handling team of non-clinical staff and a team of nursing staff. Opening hours have been extended from 4 January 2021 in response to the increase in demand for the service. This will be reviewed in early February 2021.

- **COVID-19 Testing for Staff and Household Members**

The Committee noted that COVID-19 testing for symptomatic staff and their household members was available via the Occupational Health Department and was delivered by nursing staff based in Halton Urgent Care Centre. Same day testing was available and an escalation process was in place to increase capacity according to demand. Rapid testing was available dependent upon service impact.

- **Mental Health and Wellbeing – sanctuary email**

The Committee noted that a range of mental health and wellbeing offers are available to support the workforce. Offers have been designed and implemented to support front line staff, those working from home, team managers and leaders. Offers include but are not limited to:

- One to one counselling
- Group counselling support sessions e.g. bereavement
- Team drop in sessions with counsellors
- Team development
- Facilitated debriefs
- Coaching
- Compassionate Leadership Programmes

In addition, the Committee noted the bespoke interventions provided across the Occupational Health, Wellbeing and Organisational Development Teams, in response to the immediate and changing needs of staff.

The Committee noted that the mental wellbeing sanctuary was opened in December 2020. 'The Sanctuary Hub' was designed to provide an environment conducive to staff wellbeing and recovery. The £35K Hub was funded by NHS Charities Together and the League of Friends of Warrington Hospital in response to the COVID-19 pandemic and was highlighted in the Cheshire and Merseyside Health and Social Care Partnership newsletter.

- **Resourcing**

The Committee noted that the Workforce Redeployment Hub continued to support the redeployment of non-clinical staff to support the COVID-19 response. This included the redeployment of Corporate Services staff, where available, and supported Clinically Extremely Vulnerable staff to work from home.

The Committee was informed that the Trust had recently been notified that over 100,000 non-clinical military personnel would be redeployed to support the NHS. The Trust submitted a request for 258 workers to support roles such as Porter, Domestic, Ward Runner and Administrator. *Unfortunately, the offer of non-military personnel was withdrawn – notification of this decision was provided by the North west NHSE/I Regional People Team.*

Due to the re-instatement of the National Lockdown Clinically Extremely Vulnerable staff were asked to shield. The Workforce Redeployment Hub worked with line managers to ensure that those who could continue to work from home were able to and that appropriate IT kit was made available as appropriate.

3.5.2	COVID Vaccine

The Committee received assurance on the Trusts response to the setting up of a Covid Vaccination Hub. It noted that a multidisciplinary team of staff from across the workforce, led by the Director of Strategy and Partnerships, have successfully launched a COVID-19 Vaccination Programme. Over 5000

vaccines have been delivered to date - over 3000 to WHH staff, over 500 to staff from our local care homes and other NHS organisations and over 1500 to patients and family and friends, who are over 70 or Clinically Extremely Vulnerable (CEV). Analysis is underway to ensure that there is equitable access to the vaccine across the workforce.

3.5.3	North West Social Partnership Forum Statement December 2020

The Committee noted the North West SPF Statement issued on 15 December 2020:

"NHS organisations and trade unions in the North West have been in discussion through the regional social partnership forum (SPF) as the second phase of the COVID-19 pandemic has unfolded. We wish to place on record our thanks to all NHS staff across the North West who are working hard to deal with this repeated challenge for the health service, guiding patients and staff through this unprecedented and rapidly changing situation.

Staff are our most important asset at all times and are critical in developing and delivering safe, high quality care and services for our patients. This is even more so during the unprecedented times we find ourselves in within the NHS. In the spirit of partnership working for the good of our staff and services, the North West SPF agreed to share some suggested guiding principles for employers and trade unions at this time.

It is recognised that the period leading up to and immediately following any change will be a time of uncertainty for staff. This will naturally be exacerbated during a Pandemic when staff will also be concerned for their own health, that of their families and friends, and will be cognisant of economic impacts for their communities. Therefore NHS Trusts and staff side organisations will always work in the spirit of partnership, working collaboratively and communicating clearly and sensitively with any affected staff groups where changes to working arrangements are considered that cannot be paused until the demands of the pandemic have substantially subsided.

Existing policies will remain unchanged for organisational change, however approaches to consultation and communication may be adapted to take account of social distancing measures whilst still ensuring every effort is made to include all key stakeholders in discussions. A large number of staff moves during the pandemic have been short term measures enacted at pace to cope with the unprecedented demands of Covid-19. In these instances it is expected that staff will return to their substantive arrangements at a point where emergency arrangements across the NHS are stepped back down. If there is a need to review any temporary arrangements that may be proposed to become a permanent arrangement organisational change policies will be followed where required in line with local Trust arrangements.

Other measures to manage employee relations activity during the Pandemic will be managed sensitively and progressed on a case by case basis to ensure fairness and consistency."

Committee members were asked to note that working practices across the Trust continued to be in line with the principles set out in the statement above and that the partnership approach within the Trust had been a positive one.

3.5.4	Asymptomatic Staff Testing

- **Lateral Flow Testing (LFT)**

The Committee received an update on progress for staff asymptomatic testing using Lateral Flow Testing (LFT). Lateral Flow Testing was available to all patient-facing staff and all staff working in

Clinical Business Units. To date, ***2174 staff members*** had volunteered to take part in the programme and there is a weekly positivity rate of 0.52%.

- **Loop-mediated isothermal amplification (LAMP) Testing**

The Committee noted that in January 2021 the Trust had received notification that Cheshire and Mersey Trusts would be required to transfer from LFT to LAMP Testing for asymptomatic staff and the Trust had been assigned a tentative 'go live' date of 5 March 2021 – subject to approval of funding and ordering of resources.

The Committee were asked to note the transfer to LAMP testing and acknowledge that this would require a significant amount of infrastructure to be set up. It was also reported that LAMP Testing would provide a range of benefits for staff including:

- Method: the test is minimally invasive; saliva samples are likely to be more tolerable and acceptable to staff than the more invasive swabs, thereby improving testing compliance.
- Frequency: the frequency of testing is once per week.
- Specificity: the of LAMP is comparable to PCR, therefore there is no requirement for a confirmatory RT-PCR test

3.5.5	North West BAME (Black Asian and Minority Ethnic) Assembly

The Committee noted that on 18 November 2020, Chairs and Chief Executives in NW NHS organisations received a letter from Bill McCarthy, Regional Director NHSE/I & Co Chair of the BAME Assembly and Evelyn Asante-Menah, Chair Pennine Care NHS Trust and Co-Chair of the BAME Assembly. The NW BAME Assembly provided information on their vision, mission and priority areas.

The Committee noted that the Trust was requested to prepare and submit by 22 December the following:

- How you are planning to share the statement with your staff and engage them in conversations about racism and inequalities.
- How you plan to link with the Assembly and its members, to support the development of your response to our statement
- How you plan to build on the work already done in your own organisation – and by others – on promoting the health and wellbeing of your staff and the outcomes from the risk assessments carried out so far, particularly in relation to the roll out of the COVID vaccination programme.

The Committee acknowledged that the Trust submitted a response as requested and this was provided to the Committee. Feedback to each Trust was expected from NHSE/I in January/February 2021 – this is still to be received (March 2021).

The Committee noted that to support this work within the Trust, the letter, mission, vision and priorities for the BAME Assembly were shared with the BAME Staff Network Chair (December 2020) and the Equality, Diversity and Inclusion Sub-Committee (15 January 2021). A webpage was set up to share the information provided from the NW BAME Assembly and a survey monkey – *Lets Talk About Racism* – was circulated to the Trusts BAME workforce in December 2021. Over 80 members of staff responded by 10 January 2021. The results will be collated and help to support any actions scheduled along with the feedback from NHSE/I on the submission overseen by the EDI Sub-Committee.

The Committee noted that the Trust Board would receive a full briefing in March 2021 on the NW BAME Assembly and the programme of work for the Trust to meet the requirement to become an Anti-Racist Organisation.

3.5.6	Local Induction Process for Medical Staff – update regarding adherence and compliance of process

The Committee noted that further work was continuing to improve the local induction processes for Medical Staff and in particular the reporting of compliance. This matter will continue to be monitored via the Committee until assurance has been concluded that a robust and consistent process has been implemented.

3.5.7	On Call Harmonisation

The Chief People Officer asked the Committee for approval to continue to pause the scheduled work related to On Call Harmonisation. The Committee approved this request but noted that in line with the Social Partnership Forum statement organisational change would be progressed on a case by case basis and that any changes to oncall arrangements would be aligned to the Trusts approved On Call policy.

3.5.8	ED&I Objective

The Committee noted that Strategic Executive oversight Group had approved the proposal put forward by the committee in (November 2020) for Executives to include an ED&I objective in all staff PDRs from April 2021

3.5.9	Workforce Key Performance Indicator Recommendations for 2021-22 (annual review)

The Committee noted that the Trust Integrated Performance Report (IPR) Dashboard was reviewed annually in line with the Trust's Performance Assurance Framework (PAF) to ensure all indicators remain relevant and up to date. The Committee was asked to approve the recommendation that no Key Performance Indicators would be removed in this round and that there would be additional Covid specific information added to the reporting related to Turnover and Retention as set out below. The Committee approved this recommendation to go to Trust Board for approval.

Indicators to be Updated

KPI	Change	Rationale
Turnover	For both Turnover and Retention, it is proposed to keep the existing standards which measure turnover and retention of all staff (both temporary and permanent). It is proposed to include an additional line on the graph to show turnover and retention of all permanent staff only.	Due to the impact of COVID-19, the Trust has had a significant number of temporary staff join the Trust to support ward/services during these challenging times. However as these staff leave the Trust; it has a significant impact of retention and turnover. Including the additional information will accurately reflect the change in position of the Trust substantive workforce.
Retention		

3.5.10	Attendance Management Deep Dive (Interim Report)

The Committee noted that at the November 2020 Trust Board meeting, members raised concerns about absence levels across the Trust to the Chief People Officer, who consequently made a commitment to undertake a deep dive into Trust absence.

The Committee noted the purpose of the deep dive was to understand the causes of consistently high levels of sickness absence across the workforce, to explore the impact of attendance management practices and to identify actions to drive improvement in attendance levels. In addition the Committee noted that due to the increased operational pressures being experienced within the Trust due to Wave 3 Covid-19 and increased local population Covid prevalence the progress in completing the deep dive had been slower than intended – specifically around the engagement with line managers which was considered to be a vital part of the process.

The Committee proposed that additional action on the following areas be taken:

- Further work in February and March 2021 to engage with line managers to increase understanding, including:
    - What local practices are in place for monitoring and managing attendance and is good practice shared?
    - Are line managers confident and competent in the application of the policy?
    - What support is provided to line managers in the application of the policy and is this the right level of support?

This Committee further noted that the deep dive outcomes should be reported back to the Committee and when accepted to the Trust Board, with appropriate recommendations:

- Consideration of moving to an electronic unplanned absence management system that will enable the Trust to realise associated benefits.
- Comprehensive review of the Absence Management Policy utilising exemplar cited policies such as the Walton Centre policy and other public sectors.
- Renewed consideration of Equality and Diversity impact matters relating to absence management

The Committee noted the importance of the deep dive and continued progress to address the Terms of Reference for the review and therefore it was agreed that between meetings a further update on progress would be made by the Deputy Chief People Officer to the Chair of committee and the Chief People Officer.

3.5.11	**Hospital Volunteer Annual Review 2019-20**

The report was accepted by the Committee. The report outlined key statistics on recruitment and highlighted the many programmes and opportunities where Volunteers have impacted the work of staff in both clinical and non-clinical settings.

Through engaging volunteers the Trust have supported improvements in patient experience, complimented health care and enhanced the quality at Warrington and Halton Teaching Hospitals (WHTH).

3.5.12	**Employee Relations Report**

The Committee noted the overview of Employee Relations casework and the partnership landscape across the Trust. It was assured in relation to high risk employee relation cases and the delivery of Improving People Practices recommendations.

The Committee noted that the period covered related to the partnership working arrangements in place during wave 2 of the COVID-19 response and sets out the key themes emerging. It was noted that the management of employee relations activity across the Trust

is key to maintaining a safe environment for both patients and staff and aids the Trust in mitigating employment-related risks.

3.5.13	**Improving People Practices**

The Committee received an update on compliance with the Improving People Practices recommendations as set out by Baroness Dido Harding, Chair of NHSI/E, in the letter of May 2019 sent to all NHS trusts and NHS foundation trusts Chairs and Chief Executives.
An action plan was presented to the Committee in July 2019 to address any recommendations not fully met. Progress against each recommendation are set out below:

Recommendation 1
1(a) Adhering to best practice guidance
i. The development and application of local investigation and disciplinary procedures should be informed and underpinned by the provisions of current best practice guidance, principally the Acas 'code of practice on disciplinary and grievance procedures' and other non-statutory Acas guidance; the GMC's 'principles of a good investigation'; and the NMC's 'best practice guidance on local investigations' (when published).

Trust Disciplinary Policy and all associated guidance documents and templates are underpinned by the Acas 'code of practice on disciplinary and grievance procedures' and the GMC's 'principles of a good investigation'. The NMC's 'best practice guidance on local investigations' has not yet been published.

ii. Employers should take every measure to ensure complete independence and objectivity is maintained at each stage of an investigation and disciplinary procedure, and that identified or perceived conflicts of interest are recognised and appropriately mitigated (this may require the sourcing of independent external advice and expertise).

Care is taken to ensure the independence and objectivity is maintained at each stage of the disciplinary process. This is set out in the Terms of Reference template document and is evident in practice, for example the use of external investigators to ensure objectivity.

1(b) Applying a rigorous decision-making methodology
Consistent with the application of 'just culture' principles, which recognise that it is not always appropriate or necessary to invoke formal management action in response to a concern or incident, employers should apply a decision-making methodology that provides for full and careful consideration of context and prevailing factors when determining next steps.

A guidance document produced by the HR Team 'Is It a Disciplinary Issue' recognises that it is not always appropriate or necessary to invoke a formal disciplinary process and sets out a range of options, depending on the circumstances of the case. The Terms of Reference template document requires a commissioning manager to confirm why a formal process is required.

1(c) Implementing a common management framework
The procedures established by 'Maintaining High Professional Standards in the Modern NHS (a framework for the initial handling of concerns about doctors and dentists)' should inform the development and implementation of a common management framework for handling concerns relating to all NHS Staff, regardless of profession, role or the type of NHS organisation they work for. Once implemented, CQC should consider including the application of the common management framework by employers, together with scrutiny of the quality and outcomes of local investigation and disciplinary procedures, within the 'Well-led' assessment domain.

A common management framework has not yet been published. Upon publication, the framework will be implemented and monitored via Operational People Committee.

Recommendation 2
The Advisory Group recommends that people are fully supported and resources appropriately committed to ensure the professional conduct of investigation and disciplinary processes, as follows:

2(a) Ensuring people are appropriately trained and competent
Employers should only appoint individuals as case managers, case investigators and panel members who have received up to date comprehensive training and who, through such training, are able to demonstrate the aptitude and competencies (in areas such as objective critical thinking and assessment of information, awareness of relevant aspects of employment law and best practice, and appreciation of race and cultural factors) required to undertake these roles.

Currently, internal training is in place for case investigators. The Terms of Reference template document require the case manager to state whether investigator has attended training and if not, to state how they are assured that the investigator has the skills/knowledge to complete a fair and thorough investigation in line with Trust Policy.

External training has been provided to case managers for MHPS cases. Training for panel members and case managers for non-MHPS cases is outstanding and has been delayed due to the COVID-19 response. Plans are in place to commence this by 31 March 2021 and any risk is mitigated by the provision of HR support to case managers and panel members.

2(b) Allocating sufficient time and resources
Before commencing investigation procedures, organisations should ensure that appointed case managers, case investigators and other individuals charged with specific responsibilities are allocated sufficient time and resources that will fully support the timely completion of investigation and disciplinary processes.

A consideration of time and resources is required at commissioning stage and explicitly included in the terms of reference for an investigation. Where a suitable investigator with the capacity required is not available, external investigators are utilised.

2(c) Following a rigorous process in deciding to apply suspensions
Employers should ensure that a decision to suspend an individual is not taken by one person alone, or by anyone who has an identified or perceived conflict of interest. Where such action is required as a response to immediate safety or security issues, senior level opinion should be secured at the earliest opportunity following the decision. Any decision to suspend should be a measure of last resort that is proportionate, timebound and only taken when there is full justification for doing so. The continued suspension of any individual should be subject to appropriate senior-level oversight.

A Suspension or 'Action Short of Suspension' decision making process is in place which requires the decision making manager to document the rationale for the action, answer a series of questions relating to the decision and to confirm that Director level input has been sought.

2(d) Protecting the health and wellbeing of staff involved in disciplinary Processes
i. Concern for the health and welfare of individuals involved in investigation and disciplinary procedures should be paramount and continually assessed, and appropriate professional occupational health assessments and interventions (together with signposting to Employee Assistance Programmes, where available) are provided to any member of staff who either requests or is identified as requiring such support.

Referrals are routinely made to the Occupational Health Department where required, this is evident in practice. Where an employee becomes unwell during an investigation, the process is paused until OH clearance is confirmed. In addition, the Trust Employee Assistance Programme (EAP) provides objective, confidential support to staff – prompts for manager to share details of the EAP are included in template documents.

ii. A communication plan should be established with individuals who are the subject of an investigation or disciplinary procedure and this plan should form part of the associated terms of reference. The underlying principle should be that all communication, in whatever form, is timely; comprehensive and unambiguous; sensitive; and compassionate. Wherever possible, contact with individuals should be undertaken in person, or otherwise verbally, and supported in writing.

The Terms of Reference Template Document includes the allocation of a named workplace contact for the employee, to ensure employees have an open communication channel.

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The Terms of Reference Template Document includes the allocation of a named workplace contact for the employee, to ensure employees have an open communication channel with the Trust. Where the employee declines, updates are provided by the investigator and case manager.

iii. Where a member of staff who is the subject of an investigation or disciplinary procedure suffers any form of serious harm, whether physical or mental, this should be treated as a 'never event' which therefore is the subject of an immediate independent investigation commissioned and received by the board. Further, the board should take prompt action to address the identified harm and its causes.

There have been no cases of members of staff who are the subject of an investigation or disciplinary procedure suffering any form of serious harm.

iv. In cases where legal proceedings conclude that an individual has been wrongfully treated as a consequence of a poorly or inappropriately applied investigation and/or disciplinary process, NHS England and NHS Improvement should obtain assurance that the employer has taken/is taking appropriate measures to: understand how the situation arose; mitigate the same mistakes being replicated; hold responsible persons to account for any wrongful actions; and provide support to the wronged individual. In this latter respect, consideration should be given to extending participation in the whistle-blowers' support scheme to include such individuals.

The Trust have received no requests for assurance or information from NHS England and NHS Improvement relating to any cases.

Recommendation 3

The Advisory Group recommends that investigation and disciplinary processes should be open to improved scrutiny through sharing of appropriate information and proactive reporting of progress, as follows:

3(a) Using latest research; sharing relevant information with other NHS organisations via appropriate communications routes; and collating and reporting data for board scrutiny

i. Culture-change and leadership development interventions associated with the NHS People Plan should be informed by contemporary research and insight relating to the impact of investigation and disciplinary procedures on the welfare of staff and the workplace environment (there is a requirement for further research and insight in this area, which could be commissioned from independent expert organisations such as the Health Foundation).

This recommendation does not require action from provider Trusts.

ii. Via the appropriate People Plan workstream(s), NHS England and NHS Improvement should capture and promulgate initiatives, interventions and improvements relating to the conduct of investigation and disciplinary procedures that either have been implemented, or are being progressed, at local employer level. In doing so, there should be an emphasis on highlighting practices which aim to resolve issues and concerns without recourse to formal procedures.

This recommendation does not require action from provider Trusts.

iii. Employers should establish mechanisms by which comprehensive data relating to investigation and disciplinary procedures is collated, recorded, and regularly and openly reported at board level. Data collation and reporting should include: numbers of procedures; reasons for those procedures; adherence to process; justification for any suspensions; decision-making relating to outcomes; impact on patient care and staff; and lessons learnt, all of which the CQC should consider including in its assessment of the 'Well-led' domain.

The Strategic People Committee receives a monthly report on behalf of Trust Board, on the

employee relations activity across the Trust. It is recommended that from April 2021, the report is expanded to include the above on a quarterly basis.

Recommendation 4
The Advisory Group recommends that guidance relating to investigation and disciplinary processes is up to date and fit for purpose, as follows:

4(a) Reviewing current guidance issued by regulatory bodies
Healthcare regulatory bodies should consider reviewing their respective guidance and standards issued to their registrants, which relate to the management and conduct of local investigations and disciplinary procedures, to ensure consistency and alignment.

This recommendation does not require action from provider Trusts.

Recommendation 5

Pending the acceptance and implementation of these recommendations, the Advisory Group recommends the following action is taken: ***Interim guidance is developed in partnership with trades union bodies, through the Social Partnership Forum, that sets out NHS England's and NHS Improvement's expectations of employers regarding their conduct in applying and managing local investigation and disciplinary procedures. NHS England and NHS Improvement should further consider how they should provide oversight of adherence to the interim guidance.***

This recommendation does not require action from provider Trusts.

The Committee noted the Improving People Practices report and approved the proposed change to reporting as follows:

iii. Employers should establish mechanisms by which comprehensive data relating to investigation and disciplinary procedures is collated, recorded, and regularly and openly reported at board level. Data collation and reporting should include: numbers of procedures; reasons for those procedures; adherence to process; justification for any suspensions; decision-making relating to outcomes; impact on patient care and staff; and lessons learnt, all of which the CQC should consider including in its assessment of the 'Well-led' domain.

The receives a monthly report on behalf of Trust Board, on the employee relations activity across the Trust. It is recommended that from April 2021, the report is expanded to include the above on a quarterly basis.

3.5.14	Guardian of Safe Working Quarterly Report Q3

The Committee accepted the report for Quarter 3 2020-21, noting 32 Exception Reports were submitted; this was a reduction compared to the normal monthly average. A reduction in Exception Reports was noted during the first wave of COVID, and it appears that this is being reflected again for Q3, with the surge in COVID inpatients at the Trust during this quarter.

The Committee noted that over 84% of Exception Reports relate to excess hours worked - One Exception report was submitted as a missed educational opportunity and one Immediate Safety Concern was reported in a urology trainee which had been addressed.

Since the last report the Committee noted that rotas remain compliant, and the majority of Junior Doctors are happy with their allocations.

3.5.15	**Trust Board Monthly Staffing Report – Key Issues Report October & November 2020**

The Committee noted that sickness absence rates were recorded at 9.04% in October 2020 and 9.03 % in November 2020 for nursing and midwifery staff. In the month of October 2020, it was noted that 10 of the 21 wards were below the 90% target during the day, with a similar position noted in November with 9 of the 20 wards below the 90% target. In order to ensure safe staffing levels, mitigation and responsive plans were implemented daily to ensure that the safe delivery of patient care. CHPPD in October 2020 was 7.6 and 7.7 in November 2020, with a year to date rate 7.9. The Trust have joined Wrightington, Wigan and Leigh NHS Foundation Trust to participate in a regional pilot for recruitment of international nurses. Following a successful business case the Trust have recruited 30 registered nurses to join the Trust between the months of February and April 2021.

3.5.16	**International Nursing Recruitment Programme update report**

The Committee received assurance on the progress of the business case for the recruitment of 30 International Nurses at Warrington and Halton Teaching Hospitals. A team of staff led by the Associate Chief Nurse have commenced the recruitment process. The Trust is working in partnership with Wrightington, Wigan and Leigh (WWL) NHS Foundation Trust to establish a North West Hub for International Nurse Recruitment.

Since the agreement of the funding to support this initiative and recognising the national context highlighted in the Interim NHS People Plan, which states that addressing the urgent workforce shortages in nursing is the highest priority staffing issue at the present time. A substantial amount of funding has been made available to support Trusts with the plans. NHSI/E introduced a bid process for Trusts to access additional funding under the following strands. In total circa 90 Registered Nurses will be recruited to the Trust – all through approved Business cases by Trust Board.

3.5.17	**Investment Plan for Health Education England funding for Nursing, Midwifery, Registered Nursing Associate and Allied Health Professional Continuing Professional Development (CPD) 2020/21.**

The Committee noted that Warrington & Halton Teaching Hospitals NHS Foundation Trust had been allocated £ 472,333 for 2020/2021 to enable the Trust to provide a £1,000 training budget over the next three years for each nurse, midwife and allied health professionals in the organisation.

The Committee received assurance that a consultation had taken place together with an analysis of learning needs and workforce priorities. An investment plan summary was presented to the Committee outlining a suite of education and training activities that had been/will be made accessible to staff in 2020/21.

3.5.18	**Equality Diversity and inclusion (EDI) Sub- Committee** High Level Briefing Paper (January 2021)

Assurance Committees:

- Patient Equality, Diversity and Inclusion - Quality Assurance Committee
- Workforce Equality, Diversity and Inclusion – Strategic People Committee

The Committee received the High Level Briefing on Workforce Equality, Diversity and Inclusion priorities and accepted this report.

3.6	**March 2021 Committee Meeting**

This report was produced prior to the March 2021 Committee meeting however the following key agenda items are included in this annual report due to their significance related to Covid-19 workforce matters.

The Committee met in the context that the North West had experience a Wave 3 of the pandemic, with reduced community prevalence in Warrington and Halton boroughs and a national roadmap to replace lockdown measures.

The Committee received a range of updates to provide assurance on the response to Covid-19, strategic people priorities and workforce health, safety and wellbeing.

3.6.1	**Chief People Officer Report**

The Committee received a Chief People Officer Report on the following key areas:

- COVID-19 Vaccine
- COVID-19 Workforce Risk Assessments
- NHS Pensions Update
- Code of practice for the international recruitment of health and social care personnel

➢ **COVID-19 Vaccine**

NHS England and NHS Improvement (NHSEI) provide a weekly publication report of COVID-19 Vaccination uptake. The latest update was released on 4 March 2021 and includes vaccinations up to and including 28th February 2021. The table below shows WHH Vaccination Rates in comparison to the whole NHS and the North West:

Cohort / Area	Number of NHS Trust Health Care Workers on ESR	Number of NHS Trust Health Care Workers who have received 1st Dose	Percentage of NHS Trust Health Care Workers who have received 1st Dose
NHS	1,364,299	1,078,123	79.0%
NHS North West	204,824	164,269	80.2%
WHH	**4,487**	**3,907**	**87.1%**

*(WHH data up to and including 4th March 2021. NHS and North West data up to and including **28th February 2021**)*

Key Metrics – WHH Staff Vaccination Rates

The following statistics are based on a match between the National Immunisation Management System ('NIMS') and WHH's Electronic Staff Record.

- Overall staff vaccination rate: 87.07%
- 3,487 vaccinated
- 580 not vaccinated (549 Substantive, 31 Bank)
- BAME substantive staff vaccinated: 87.53%

- Clinically Extremely Vulnerable, those aged 56+, those with a disability vaccinated: all >90%
- All 20 CBUs and all main staff groups have vaccination rates of >80%.
- 5 cohort categories <80%
- Gender difference of c.2.5%. Potentially due to concerns around fertility, pregnancy and / or breastfeeding.

Cohort	Percentage Vaccinated
Clinically Extremely Vulnerable	94.83%
Those aged 56-60	94.66%
Those aged 61-65	93.57%
Those aged 51-55	91.90%
Those aged 66+	91.73%
Those with a disability	91.58%
Religious belief: Hinduism	91.23%
Those aged 46-50	90.13%
Male	89.11%
Those aged 41-45	87.98%
BAME (Substantive Staff)	87.53%
Religious belief: Sikhism	87.50%
WHH Staff Vaccinated (Substantive Staff)	87.30%
Christianity	87.21%
WHH Staff Vaccinated (Overall)	87.07%
Female	86.55%
LGB / Other	86.32%
Those aged 21-25	85.22%
Religious belief: Atheism	85.21%
BAME (Overall)	84.94%
Those aged 36-40	83.41%
Religious belief: Buddhism	83.33%
WHH Staff (Bank)	80.98%
Religious belief: Islam	78.38%
Those aged 26-30	77.92%
Those aged 31-35	76.32%
BAME (Bank Staff)	76.06%
Those aged 16-20	62.50%

The Committee were asked to note that a number of initiatives are underway to ensure continued uptake of vaccination for specific cohort groups and overall uptake, including individual conversations with staff, contact via Occupational Health and Wellbeing Service and drop in clinics. A full report has been provided to Equality, Diversity and Inclusion Sub-Committee, where assurance was noted and future updates agreed.

In addition, the Committee received assurance on the Trusts response to the setting up of a Covid Vaccination Hub from the Director of Strategy & Partnerships. It noted that a multidisciplinary team of staff from across the workforce, led by the Director of Strategy and Partnerships, have successfully launched a COVID-19 Vaccination Programme. To date over ***23,000 vaccine doses*** have

now been administered. ***Around 90%*** of WHH staff have received their first vaccination (compared to an overall NHS staff rate of 82%) with second doses being administered from 15th March 2021 onwards, alongside a continued first dose service. The team have now given vaccinations to over ***1,000*** Care Home Staff, over ***2,000*** Healthcare Staff from other NHS organisations, over ***7,000*** patients from the JVCI's Priority Groups and over ***3,000*** Social Care Staff. Analysis of vaccination data shows positive uptake rates for WHH staff with protected characteristics.

- **COVID-19 Workforce Risk Assessments**

The Trust COVID-19 Workforce Risk Assessment Tool was developed by the HR and OD Team and launched in July 2020. The electronic tool enables all members of staff to undertake a self-assessment and followed by a risk assessment with their line manager where required. The implementation of the tool was supported by guidance, virtual training and regular reporting. The Trust was required to produce a return on compliance to NHSEI on **17 March 2021**.

The table below sets out the Trust compliance as at 12 March 2021

Metric	
Have you offered a Risk Assessment to all staff?	Yes
What % of all your staff have you Risk Assessed?	94.3%
What % of risk assessment have been completed for staff who are known to be "at risk", with mitigating steps agreed where necessary?*	95.7%
What % of risk assessments have been completed for staff who are known to be from a BAME background, with mitigating steps agreed where necessary?	93.5%

Reports of any outstanding self-assessment and risk-assessments are provided to managers on a daily basis and numbers of outstanding assessments by CBU / Department are escalated to Tactical Meeting. In addition, the HR Team proactively make contact with any managers where there are outstanding assessments.

- **NHS Pensions Update: McCloud Judgment**

The Committee were asked to note that in 2015 the government made changes to reform the majority of public service pension schemes. These reforms did not apply to members within 10 years of their normal pension age on the 31 March 2012, who remained in their legacy schemes with 'transitional protection'. The Court of Appeal later found this to be discriminatory against younger members in the judicial and fire fighters' schemes. The government accepted that this discrimination existed in all schemes where transitional protection was introduced, which includes the NHS Pension. This applies to the period from April 2015 to 31 March 2022.

It has been confirmed that the 1995 and 2008 Scheme will close as of 31 March 2022 and all active members of the Scheme as of 01 April 2022, will become/remain as members of the 2015 Scheme. Benefits accrued in the 1995 and 2008 Scheme, will be 'frozen' and payable under the same rules and regulations at the time of retirement. At retirement, members of the scheme who transitioned into the 2015 Scheme as from 01 April 2015, will be given the opportunity to move those years of membership back into their respective 1995 or 2008 Scheme.

Employers are advised that that presently there is no action to be taken and further updates are expected. It is the intention of the Payroll Team to deliver presentations and drop in sessions across the Trust when appropriate.

- **Code of practice for the international recruitment of health and social care personnel**

UK Code of Practice (CoP) for international recruitment ensures that ethical recruitment practices operate within the NHS. The Code was updated on 25 February 2021. It includes refreshed guiding principles and benchmarks, new case study examples and a suite of frequently asked questions. The other significant change is the list of developing countries, which is now in line with the 47 as set by the World Health Organisation (WHO).

There are five guiding principles that underpin the Code:

1. International migration of health and social care personnel can make a contribution to the development and strengthening of health and social care systems to both countries of origin and destination countries if recruitment is managed properly.
2. Opportunities exist for individuals, organisations and health and care systems to train and educate and enhance their clinical practice.
3. There must be no active international recruitment from countries on the list, unless there is an explicit government-to-government agreement with the UK to support managed recruitment activities that are undertaken strictly in compliance with the terms of that agreement.
4. Recruitment of international health and social care personnel is closely monitored and reported on to the Cross Whitehall International Recruitment Steering Group.
5. International health and social care personnel will have the same legal rights and responsibilities as domestically trained staff in all terms of employment and conditions of work. They will also have the same access to further education and training and continuous professional development

The Committee were asked to note that the Trust was currently undertaking a significant programme of international nurse recruitment and is working in line with the Code.

4.	Risk Management

The Committee received an update of strategic risks on the Board Assurance Framework (BAF) throughout the reporting period (2020/21). It has been agreed that the Board receives an update on all strategic risks and any changes that have been made to the strategic risk register, following review at Quality Assurance Committee. A Risk Review Group has been established reporting to Quality Assurance Committee, for oversight and scrutiny of strategic risks and for a rolling programme of review of CBU risks, to ensure risks are being managed and escalated appropriately.

The Committee receives any notable updates on those risks linked to Strategic Objective 2:

We will … be the best place to work with a diverse, engaged workforce that is fit for the future

4.1.1	May 2020 Committee - New Risks

In response to the COVID-19 global pandemic, the Trust had established a specific COVID-19 risk register. The COVID-19 risk register includes all those risks related to the pandemic including those on (or proposed to the added to) the BAF and Corporate risk register.

As a result of the COVID-19 pandemic, the following risks were added to the BAF following approval by the Quality Assurance Committee on 5 May 2020.

Risk 1124

Risk Description:	Failure to provide adequate PPE caused by failures within the national supply chain and distribution routes resulting in lack of PPE for staff	Initial:	25 (5x5)
		Current:	25 (5x5)
		Target:	8 (4x2)

Risk 1134

Risk Description:	Failure to provide adequate staffing caused by absence relating to COVID-19 resulting in resource challenges and an increase within the temporary staffing domain	Initial:	20 (4x5)
		Current:	20 (4x5)
		Target:	8 (4x2)

4.1.2 July 2020 Committee - New Risks

- **New Risk**

In response to a letter to all Trusts from the Chief Operating Officer for NHS England and NHS Improvement requesting board-level scrutiny and oversight, the following risk was added to the BAF following approval by the Quality Assurance Committee in 7 July 2020.

Risk 1207

Risk Description:	Failure to complete workplace risk assessments for all staff in at-risk groups, within the timeframes set out by NHSI/E. This will be caused by a lack of engagement in the set process by line managers, resulting in a failure to comply with our legal duty to protect the health, safety and welfare of our own staff, for which the completion of a risk assessment for at-risk members of staff is a vital component.	Initial:	16 (4x4)
		Current:	16 (4x4)
		Target:	8 (2x4)

4.1.3 September 2020 Committee - New Risks

- **Amendments to risk ratings**

Following approval at the Quality Assurance Committee on 1 November 2020, the rating of the following risk has been reduced from 20 to 15.

Risk 1134 - *Failure to provide adequate staffing caused by absence relating to COVID-19 resulting in resource challenges and an increase within the temporary staffing domain*

It was agreed that the risk rating should be reduced following a reduction in sickness rates in June and July 2020 to 5.55%.

4.1.4 November 2020 Committee - New Risks

- **Amendments to risk ratings**

Since the last meeting, there have been amendments to the ratings of one of the risks on the BAF Following approval at the Quality Assurance Committee on 6th October 2020, the rating of the following risk has been increased from 15 to 20 as a result of increased COVID-related sickness absence evidenced in the daily SITREP and the Trusts compliance with the national track and trace system.

Risk 1134 - *Failure to provide adequate staffing caused by absence relating to COVID-19 resulting in resource challenges and an increase within the temporary staffing domain*

4.1.5	January 2021 Committee - New Risks

- **Amendments to risk ratings**

Since the last meeting, there has been an amendment to the rating of one of the risks on the BAF Following approval at the Quality Assurance Committee on 12 January 2021, the rating of the following risk has been decreases from 25 to 15 as a result of the significant mitigations now in place.

Risk 1124 - *Failure to provide adequate PPE caused by failures within the national supply chain and distribution routes resulting in lack of PPE for staff.*

5.	CQC – Getting to Good, Moving to Outstanding - Staff

The Committee noted that for the reporting period the Moving to Outstanding – Well Led Group was paused.

6.	Policies and Procedure Approved

All changes and introductions to new policies were approved by the Strategic Executive Oversight Group (SEOG).

6.1	May 2020 Committee – policy and procedures

- Media and Social Media Policy (May 2020)

The following policies were temporarily amended in relation to the COVID-19 pandemic:

Policy	Summary of Changes
Attendance Management Policy	Any COVID-19 related absence will not be counted toward sickness absence for the purposes of sick pay or triggers under the policy. This is in line with national guidance.
Special Leave Policy	Special Leave extended from 3 days in a 12 month rolling period to 7 days. The rolling 12 month period was 'reset' for all employees on 23rd March 2020.
Retirement Policy	• Staff can retire and return to a permanent contract where a permanent position exists. • Staff can retire and return to work within 24 hours. • The number of weekly hours worked by individuals who have retried and returned are no longer limited. This is in line with national guidance.
Recruitment and Selection Policy	Amendments to the pre-employment check process have supported speedier recruitment as set out in section 2.1.9 above.
Annual Leave Policy	National changes mean that: • Staff must take 4 weeks/20 days of annual leave each year.

	• Staff can carry forward any untaken annual leave above 20 days into the next leave year. • All leave carried forward under this provision must be taken by 31 March 2022. In addition, a local scheme has been introduced to allow substantive staff to sell annual leave back to the Trust during the period 26th March 2020 to 30th June 2020. Lead Employer (LE) doctors are not within the scope of the Trust Annual Leave Policy however, in the absence of a LE decision about carry-over of leave, the Trust has made a decision to pay LE doctors for any untaken leave at the end of the rotation. This applies where the doctor has been unable to take leave due to COVID-19.
Overtime Policy	Under normal circumstances, agenda for change conditions do not provide overtime pay for anyone in band 8a or above. However, in recognition of the current exceptional circumstances, a decision was made for these members of staff to receive overtime at flat rate. Prospective manager approval is required. This is in line with regional practice.
Appraisal Policy	Due dates have been extended for 3 months for all appraisals due from 1 March 2020 to 1 July 2020. Due dates have been extended until 1 July 2020 for all outstanding appraisals due before 1 March 2020.
Training and Development Policy	• Corporate Induction Day One now virtual • Clinical Induction condensed • Role Specific and Mandatory Training has paused for existing staff who have not changed role as per NHS Employers guidance, where staff are working in a frontline patient facing role and do not have capacity/opportunity to complete the training. For those who are able to continue to complete the training this should continue via ESR • Local management decision on training requirements to be made for staff who have changed role. National guidance for specific area such as critical care will continue to be monitored and implement locally.

Arrangement relating to the following processes were temporarily amended in relation to the COVID-19 pandemic:

Process	Summary of Changes
Expenses	Under normal circumstances, the claiming of telephone expenses is limited to certain staff groups via local agreement. A provision has been introduced whereby those individuals can claim for any telecommunications expenses incurred as a direct result of this where communication via email, Microsoft Teams, Cisco and/or

	Zoom or any other digital options made available by the Trust cannot be used.
Re-banding (Temporary Acting-Up)	Where acting up in a higher band is required due to COVID-19 related roles and this uplift will be time bound for the duration of the crisis /whilst the role is required the following process should be followed: • A brief role profile is to be completed by the requesting manager - see template below. • The request is to be agreed by the relevant Executive Director and the Director of HR and OD • The ECF should then be completed and once agreed, the member of staff will commence on their new acting up banding.
Unpaid Leave	Where a member of staff requests unpaid leave because they do not want to attend work during the pandemic, the manager must handle this situation sensitively and exploring all concerns and potential solutions. Where absolutely all alternatives have been exhausted, unpaid leave can be granted with the approval of the relevant Executive lead.
Pay Protection	Where staff are working differently to their substantive role or intended rotation (Junior Doctors) directly due to COVID-19 and where these changes result in a reduction in pay, pay protection will apply.
Maternity Leave	A maternity compensation scheme (MCS) has been introduced to support staff who chose to return from maternity leave early due to the COVID-19 pandemic. The scheme allows for a compensatory period of time off, in lieu of the maternity leave and pay that they employee would have received, at a later date within 12 months. The payment made under this scheme will only be at the same rate as that which the employee would have received whilst on maternity leave. Maternity leave, pay and all associated statutory and contractual benefits and protections will cease and cannot be reinstated a later date.
Bank and Agency Workers Sick Pay	All bank and directly engaged agency workers will receive full pay for any shifts that they had already booked but were then unable to work due any absence related to COVID-19; sickness, self-isolation or shielding. This is in line with national guidance.
Additional Hours Rates Medical Staff	Under normal circumstances, there are two additional hours and bank rates of pay for Medical Staff, Standard and Enhanced. To support COIVD-19 related activity, all additional hours and bank shifts worked between 7th April 2020 and 31st May 2020, will be paid at the enhanced rates.
Death in Service	The Trust Death in Service SOP has been updated for COVID-19 to include Executive contact with the next of kin, a letter of condolence, appropriate consent and reporting. The process also includes the identification of support for

	teams and colleagues. The process is in line with national guidance.
Employee Relations	The Trust is working within the framework agreed by the Social Partnership Forum which states: *Employers will pause disciplinary and other employment procedures (for example, sickness and capability triggers) while the crisis lasts, except where the employee requests proceeding as it would otherwise cause additional anxiety, or where they are very serious or urgent. Where an issue is less serious or not urgent then pragmatic outcomes, with agreement of the employee, and after consultation with union representatives, should always be considered. Where outcomes cannot be agreed in this way then processes may resume at a future date, without detriment or criticism of either side.*
Accommodation	Under normal circumstances, the Trust has a number of Accommodation rooms at both Halton and Warrington chargeable at £10 per night. Accommodation for those supporting the COVID-19 response is currently free where the individual is impacted by the travel restrictions in place or because of a vulnerable household member. Initially this was administered locally. There is now a National Accommodation Line in place to support this.

6.2	**July 2020 Committee – policy and procedures**

Further decisions have been made by SEOG in June 2020 relating to these temporary policy amendments and these are set out below.

Policy Title	**Key Amendments**	**Decision**
Annual Leave	A) staff may carry over annual leave over and above 20 days into the 20/21 and 21/22 leave year - this is a national decision B) staff may sell annual leave back to the trust from 26/3/20 to 30/6/20	A- Maintain B- Cease
Appraisals	3 months extension to deadline if due before July 2020	Cease
Untaken Annual Leave for LE doctors	Lead Employer trainees to receive pay in lieu of annual leave outstanding, for C-19 related reasons, at the end of their rotation.	To be maintained as per guidance from the Lead Employer
Maternity leave Provisions	Early return from mat leave temporarily facilitated by:- • compensatory period of time in lieu of mat leave given to be taken at a later date (within 12 months) • payment at the rate that would have been received whilst on mat leave • compensatory leave does not attract	Cease

	the statutory protections applicable to maternity leave	
Overtime Provision	C-19 related overtime for bands 8a and above to be paid at flat rate • C-19 related overtime for bands 1 - 7 to be paid as normal • 8a and above overtime to be identified in e-roster or on ESVL as C19 related.	Cease - with the exception of those working within the Control room, only whilst this remains a 7 days service.
Pay Protection	Pay protection applied where staff are working differently to their substantive role or intended rotation (Junior Doctors) directly due COVID-19 and where this has resulted in a reduction in pay.	Maintain until all temporary adjustments have ceased.
Re-banding (temporary acting up)	required due to COVID-19 related roles and this uplift will be time bound for the duration of the crisis /whilst the role is required the following process applies: • A brief role profile is to be completed by the requesting manager - see template below. • The request is to be agreed by the relevant Executive Director and the Chief People Officer • The ECF should then be completed and once agreed, the member of staff will commence on their new acting up banding. Where the decision is made for a member of staff to act up into a higher band and this is not related to COVID-19 specific role the usual procedure as per the Job Matching SOP should be followed.	Maintain until Job Matching is resumed in Mid-July 2020
Retire & Return	Retire & Return provision temporarily changed so that: • there need only be a 24 hr break in service • individuals may be offered a return to an indefinite position, if one exists, rather than being limited to a fixed term. • the number of weekly hours are not limited	Extend to 30 September 2020
Special Leave	Temporarily enhanced provision for carers during the C-19 period: • 7 days provision in a rolling 12 month period instead of the usual 3 • the 12 month period was reset for everyone on 23 March 2020	N/A

Additional Hours for Medics	Enhanced rates on most junior doctors grades eg:- FY1 from £30 to £35 ph etc	Ceased

In addition, the following measures remain in place as per national guidance:

- Increased provision of pay during C-19 related absences for bank workers:
  - bank workers to receive full pay if unable to fulfil booked shifts for C-19 reasons (sickness, self-isolation or shielding)
  - where a bank worker has no booked shifts s/he may be eligible to receive SSP from day 1 of absence (sickness or self-isolation)

Sick pay during C-19 related absences for substantive staff:-

- absence due to illness, self-isolation or shielding will attract sick pay based on a 12 month average earnings
- individuals need to make clear to their manager that the absence is C-19 related

6.3	**November 2020 Committee – policy and procedures**

- **<u>Temporary Policy Amendments During COVID-19</u>**

In order to support the workforce during the second wave COVID-19 response, a number of temporary policy amendments have been reintroduced, following agreement via Strategic Executive Oversight Group in October 2020. All amendments have an agreed review date in place.

Policy Title	Amendment
Overtime Provision	• COVID-19 related overtime for bands 8a and above to be paid at flat rate • COVID-19 related overtime for bands 1 - 7 to be paid as normal
Annual Leave	• Staff may carry over annual leave into the 20/21 and 21/22 leave year - this is a national decision • Introduction of an annual leave 'sell-back' scheme
Retire and Return	Retire and Return provision temporarily changed: • 24 hour break in service • Return to a permanent position, if one exists • Weekly working hours are not limited
Re-banding (temporary acting up)	Where temporary acting up in a higher band is required due to COVID-19 related reasons the following process will be followed: • A brief role profile is to be completed by the requesting manager • The request is to be agreed by the relevant Executive Director and the Chief People Officer • The ECF should then be completed and once agreed, the member of staff will commence on their new acting up banding. Where the decision is made for a member of staff to act up into a higher band and this is not related to COVID-19 specific role the usual procedure as per the Job Matching SOP should be followed.
Maternity leave Provisions	Early return from mat leave temporarily facilitated by: • Compensatory period of time in lieu of mat leave given to be taken at a later date (within 12 months) • Payment at the rate that would have been received whilst on mat leave compensatory leave does not attract the statutory protections applicable to maternity leave

Pay Protection	Pay protection applies where staff members are working differently to their substantive role or intended rotation directly due COVID-19 and where this has resulted in a reduction in pay.
Special Leave	Increase the carer's leave provision from 7 to 10 days in a rolling 12 month period.

6.4	**January 2021 Committee – policy and procedures**

Policy Title	**Amendment**
Overtime Provision	• COVID-19 related overtime for bands 8a and above to be paid at flat rate • COVID-19 related overtime for bands 1 - 7 to be paid as normal
Annual Leave	• Staff may carry over annual leave into the 20/21 and 21/22 leave year - this is a national decision • Introduction of an annual leave 'sell-back' scheme
Retire and Return	Retire and Return provision temporarily changed: • 24 hour break in service • Return to a permanent position, if one exists • Weekly working hours are not limited
Re-banding (temporary acting up)	Where temporary acting up in a higher band is required due to COVID-19 related reasons the following process will be followed: • A brief role profile is to be completed by the requesting manager • The request is to be agreed by the relevant Executive Director and the Chief People Officer • The ECF should then be completed and once agreed, the member of staff will commence on their new acting up banding. Where the decision is made for a member of staff to act up into a higher band and this is not related to COVID-19 specific role the usual procedure as per the Job Matching SOP should be followed.
Maternity leave Provisions	Early return from mat leave temporarily facilitated by: • Compensatory period of time in lieu of mat leave given to be taken at a later date (within 12 months) • Payment at the rate that would have been received whilst on mat leave compensatory leave does not attract the statutory protections applicable to maternity leave
Pay Protection	Pay protection applies where staff members are working differently to their substantive role or intended rotation directly due COVID-19 and where this has resulted in a reduction in pay.
Special Leave	Increase the carer's leave provision from 7 to 10 days in a rolling 12 month period.

- **Job Planning Policy – formal ratification**

The Job Planning Policy had been reviewed and updated. Chair's action taken to ratify the policy on behalf of the Strategic People Committee was taken in early December 2020. Following additional feedback from the BMA, some small amendments were made and therefore the policy was submitted to the Committee for formal ratification.

7.	**Regulatory and Statutory monitoring**

Committee continued to monitor the statutory and regulatory requirements relating to workforce throughout the year. This included monitoring national surveys, employment law updates, people KPIs, Equality and Diversity etc.

The Committee received assurance and / or approved the submission of:

- Workforce Race Equality Standards (WRES)
- Workforce Disability Equality Standard (WDES)
- Facilities Time off Annual Report
- Guardian Quarterly Report, Safe Working Hours – Junior Doctors in Training
- Freedom to Speak Up – Workforce Update
- Monthly Nursing Staffing Report
- HENW/GMC Annual Reports
- GMC Revalidation Annual Report (Medical Appraisal)

The following regulatory reports were paused nationally in 2020:

- Equality Duty Assurance Report (EDAR) PSED Standard
- Workforce Equality Assurance Report (WEAR) PSED Standard
- Equality Delivery System 2 (EDS2) – March 2020
- Gender Pay Gap Report – March 2020

8.	**Issues Carried Forward**

There are a number of issues which the Committee will carry forward into 2021/22:

- Implementation of the People and Equality, Diversity and People Priorities for the year
- Refreshed People Strategy
- Delivery of NHS People Plan
- Planning, scoping and delivery of the NW BAME Assembly Vision for all NHS organisations in the NW to be Anti Racist
- eRostering for Medical Staff within the organisation
- National Staff Survey – You Said We Did
- Deep Dive and recommendations – Sickness Absence
- Improving People Practices principles /assurance
- Workforce Recovery – Introduction of the Steering group as a subgroup of the Committee.

9.	**Summary**

The Committee has evolved in year, in response to the pandemic and the impact this has had on the workforce and the associated assurance Committee members required throughout the reporting period.

There was a significant review of terms of reference and remit, to reflect the oversight required of Equality, Diversity and Inclusion. The chair of Committee encouraged honest and open discussion, so that areas of success can be celebrated and areas of improvement escalated and actioned. Escalation has been to Trust Board or to other assurance Committees as appropriate to the matter.

Michelle Cloney
Chief People Officer

Approved by Strategic People Committee – 24 March 2020
Anita Wainwright, Chair (SPC)

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/21/03/49**			
SUBJECT:	**Learning from Experience Report - Q3 2020/21**			
DATE OF MEETING:	31 March 2021			
AUTHOR(S):	Layla Alani, Deputy Director Governance			
EXECUTIVE DIRECTOR SPONSOR:	Kimberley Salmon-Jamieson, Chief Nurse			
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	SO1 We will.. Always put our patients first through high quality, safe care and an excellent patient experience. SO2 We will.. Be the best place to work with a diverse, engaged workforce that is fit for the future. SO3 We will ..Work in partnership to design and provide high quality, financially sustainable services.			X
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): **(*Please DELETE as appropriate)***	None			
EXECUTIVE SUMMARY *(KEY ISSUES):*	The following report provides an overview of the Learning from Experience Report. The information within the Learning from Experience report is extracted from the Datix system and other Clinical Governance reports for Incidents, Complaints, Claims, Health & Safety, Mortality and Clinical Audit related to Quarter 3, 2020/21.			
PURPOSE: *(please select as appropriate)*	Information	Approval	To note X	Decision
RECOMMENDATION:	The Board of Directors are asked to: • Discuss and note the contents of the report			
PREVIOUSLY CONSIDERED BY:	**Committee**	Quality Assurance Committee		
	Agenda Ref.	QAC/21/03/68		
	Date of meeting	02.03.2021		
	Summary of Outcome	Noted		
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: *(if relevant)*	None			

REPORT TO BOARD OF DIRECTORS

SUBJECT	Learning from Experience Report 2020/21 Q3	AGENDA REF:	BM/21/03/49

1. BACKGROUND/CONTEXT

This report relates to the period October – December 2020 (2020/21 Q3). It contains a quantitative and qualitative analysis (using information obtained from the Datix risk management system) including Incidents, Complaints, Claims, Health & Safety, Mortality and Clinical Audit. The report includes a summary of the key findings identified in Quarter 3 with specific recommendations.

The purpose of the report is to identify themes and trends, make recommendations and provide a formal summary following a review of Incidents, Complaints, Claims, Health & Safety, Mortality and Clinical Audit.

2. KEY ELEMENTS

2.1 Items for Assurance from 2020/21 Q3

2.1.1. Incident Reporting

There was a 13% further increase in incident reporting in 2020/21 Q3 (2447 in 2020/21 Q2 vs 2766 in Q3). The number of no harm incidents reported increased further by 11% in Q3 following incident reporting returning to normal levels. There was a 42% **decrease** in incidents causing Moderate to Catastrophic harm in Q3 (33 in Q2 vs 19 in Q3). This reduction in harm levels has potentially been influenced by a reduced number of surgical patients.

Incident reporting has returned to expected levels. This has been supported by the 'Report to Improve' campaign.

2.1.2. Learning and Actions from Incidents

a) **Medication –** An incident occurred where a patient was prescribed a stat dose of Midazolam IV 1-2mg. One dose of 1mg was administered then a further dose of 1mg was given a little after, equating to the maximum 2mg prescribed.
Further doses were then administered over the next few hours (2 x 1mg and 2 x 2mg) without a prescription - all signed against the initial stat dose.
In total 8mg was administered against a prescription for 1-2mg.

A Rapid Incident Review was held to identify contributory factors, learning and actions from the incident:

- A review of the medicines management policy. The policy is due to be amended via the Medicines Governance and Policy Group.
- Pharmacy issued a Safety alert to remind staff Controlled Drugs can never be given on a verbal order and they must always be prescribed and signed for by 2 individuals.
- Reflective practice was undertaken by the individuals involved.
- The prescription was completed to reflect the medications that had been administered

b) Medication - A patient was discharged to a new care home and not all medicines were provided at discharge. This included levetiracetam for epilepsy and morphine which the patient was prescribed for pain.

A Rapid Incident Review was held to identify contributory factors, learning and actions from the incident:

- The incident was taken to the Trust Safety Huddle with key learning provided in a single point lesson on Discharge Medication.
- Informing the ward pharmacist/pharmacy of the patient's discharge destination when asking them to process the discharge prescription.
- At the time of discharge ensuring that all necessary checks are undertaken to ensure that medication is supplied appropriately to facilitate a safe discharge.

c) Medication - In Quarter 3, 10 incidents occurred across the Trust where medicines were administered to the wrong patient. Actions and learning are detailed below:

- A Safety Alert was taken to the Trust Safety Huddle with learning from these incidents.
- The process for inpatients/outpatients whereby the patient's identity is confirmed prior to administering medication, in accordance with the medicines policy.
- A red tabard when completing the medication round, to inform other staff not to disturb the administration of medicines.
- Incidents are regularly monitored and reviewed by the Pharmacy management team

d) Women's Health Incidents:

Learning from a concise RCA investigation when a woman was transferred from birth suite to intensive care unit following IV fluid overload:

- Accurate completion of HDU charts is essential when caring for an HDU patient.
- Mobilising is important to minimise risk of dependent oedema developing

- When the acuity in birth suite is high, experienced staff should be allocated to patients with the most complex clinical care needs.
- Request daily Critical Care Outreach review for women requiring HDU care
- Request a MET call for an unwell woman if there is a delay in anaesthetic or obstetric review due to acuity of birth suite
- The admitting obstetrician to document a clear plan of care for the woman and that this plan is referred to at all subsequent obstetric reviews, in line with the recommendations of the Ockenden report (2020)
- Obstetric and anaesthetic team to consider earlier transfer to ICU when woman requiring on-going HDU care and multi-organ support.

e) Pressure Ulcer incidents, actions from learning:

- Due to an increase in pressure ulcers related to anti-embolism (TED) stockings, a survey monkey was produced to identify any gaps in knowledge/training needs. The company have been providing training to the high incidence wards. The Datix incident reporting form will accurately capture anti-embolism (TED) stockings related pressure ulcers from 2020/21 Q4.
- Accurate documentation including care and comfort charts, body maps, risk assessments and pressure ulcer care plans to be reinforced. Spot checks and audits by Ward Managers/Matrons.
- **ICU** - Increase in pressure ulcers related to proning in ICU. Dolphin (fluid immersion therapy) mattress now on standby in ICU for patients requiring proning. Silicone gel strips used under ET tube tapes to reduce the risk of pressure damage to the mouth/face.
- Delays in upgrading airflow mattress from alternating pressure to continuous low pressure identified as a factor in pressure ulcer development. The new mattress contract commenced on 1/12/20. The Uno mattress provides either alternating pressure, pulsation or continuous low-pressure therapies by selecting the required therapy on the control panel.

f) Information Governance:

A paediatric result letter was sent to an incorrect recipient (biological parent of a foster child) in error. This resulted in external reporting to the ICO and a claim against the Trust as the child's location should not have been revealed.

The following actions were taken:

- A standardised procedure for patient communication administration was developed within the Paediatric department and communicated to all administration staff.
- The CBU management team will review the number of administration staff to identify vacancies and consider further posts/employment following the investigation

findings around continuity of staff responsible for the correct administration of patient letters.
- Process of external reporting to the ICO followed and data subjects kept fully informed.

g) Radiology Incidents

There was a total of **102** incidents reported in Radiology in the period 1st October 2020 to 31st December 2020. Of these, 18 incidents were for images acquired under the incorrect patient name and 13 related to a delay in imaging.

The following actions have been taken in 2020/21 Q3:
- Radiographers are regularly reminded about incidents through safety huddles and safety briefs.
- Radiographers are reminded to be careful to check they have the correct patient particularly at busy times, when there are patients with similar details, when working in pairs or handing over.
- Departmental SOPs are in place detailing individuals' responsibility for both minimising and rectifying errors of this type.
- The PACS team are able to reconcile images to the correct patient and have developed an admin form to record actions taken.
- Where there are consequences as a result of incidents, Radiographers are encouraged to complete a reflection on their practice. The Radiology team have produced a form to facilitate this.

2.1.3. Complaints and PALS

- Over the 2019/20 financial year, all Clinical Business Units made significant improvements in responding to complaints on time. A number of complaints breached during 2020/21 Q3 (n=5%), however at the time of reporting all complaints are being responded to within timeframe.
- The Trust had a target to respond to 90% of complaints on time and in Q3 the Trust achieved 95%.
- There was a 15.7% reduction in complaints opened Trustwide in Q3 (115 in Q2 versus 97 in Q3).
- Themes identified in complaints mirror those found across PALS and incident reporting; delays in treatment, appointments issues and communication issues.
- Actions from complaints are monitored through specialty governance meetings, CBU meetings and the Clinical Governance Department, reporting to the Complaints Quality Assurance Group. Complaints action reports are also made available Trustwide on a weekly basis.

2.1.4. Mortality

- The Summary Hospital Mortality Indicator (SHMI) and Hospital Standardised Mortality Ratios (HSMR) remained within expected range.
- The Mortality Review Group continues to be held as a virtual meeting during the period of Covid-19 to ensure assurance and oversight. Deaths are being reviewed and discussed at the group which continues to have external representation from our Commissioning bodies.
- MRG 'Case of the Month' continues.

2.1.5. Clinical Audit

There are a number of audits ongoing across the Trust. For Q3, this briefing makes reference to the NHS cataract surgery procedures audit. This audit concluded significant assurance.

2.2 Items for Escalation from 2020/21 Q3

2.2.1. Clinical Incidents

- Radiology - 102 incidents reported for Q3 - this increase in trend (by 19%) has been monitored and lesson learning shared.
- Note the medication incident cluster and actions taken.

2.2.2. Complaints and PALS

- Staff attitude and behaviour complaints increased further by 53% in Q3. 'First impressions' work to be recommenced.
- Communication concerns received via PALS increased by 68% in Q3.
- 6 concerns received via PALS were referred to complaints, an increase of 4 compared to the previous quarter.

2.2.3. Claims

- Payments for clinical claims settled with damages totalled £398,730.90 (excluding costs)
- 3 employer Liability Claims closed with damages (totalling £14,525.00 (excluding costs)
- Learning continues to be shared regarding claims at the claims monthly meeting.

2.2.4. Clinical Audit

Mersey Internal Audit Agency (MIAA) reported in January 2020 on a review of the Trust's Diagnostic Policy in accordance with the requirements of the 2019/20 Internal Audit plan as approved by the Audit Committee. The overall objective of the review was to assess the effectiveness of the implementation of the Diagnostic Policy in place at the Trust. The review completed in Q3 found that the policy was not applied consistently on a sample of 26 patients reviewed – results were not being viewed, communicated to patients or filed on ICE. The MIAA report made a recommendation that Clinical Business Units (CBU's) should

undertake an audit to check compliance with the Diagnostic Policy. The action plan is due for completion by March 2021 with work underway.

3. IMPACT ON QPS?

In relation to quality we aim to provide high quality, safe care and an excellent patient experience. By providing a Learning from Experience report, we are ensuring quarterly key Trustwide learning from incidents, complaints, claims, mortality and clinical audits. Through this reflective analysis from the previous quarter, we are able to capture learning and generate improvements which will support the aims concerning quality.

4. MONITORING/REPORTING ROUTES

The information within this Learning from Experience report is provided and overseen by the Clinical Governance Team and Clinical Audit Department.
Learning from investigations is provided monthly at each Specialty and CBU governance meeting through monthly learning newsletters. Learning from SI investigations is also reported to the Patient Safety and Clinical Effectiveness Sub-Committee on a monthly basis.

Key learning from governance information at a Trustwide level is captured and analysed on a quarterly basis, and is submitted to the Quality Assurance Committee – contained within this report and the accompanying slides.

5. TIMELINES

Trustwide learning was captured and analysed from the period October 2020 to December 2020 (2020/21 Q3).

6. ASSURANCE COMMITTEE

A quarterly report will be submitted to the Quality Assurance Committee, then to the Board of Directors.

7. RECOMMENDATIONS

The Board of Directors are asked to discuss and note this highlight report and accompanying slides.

HIGH QUALITY, SAFE HEALTHCARE
QUALITY PEOPLE SUSTAINABILITY

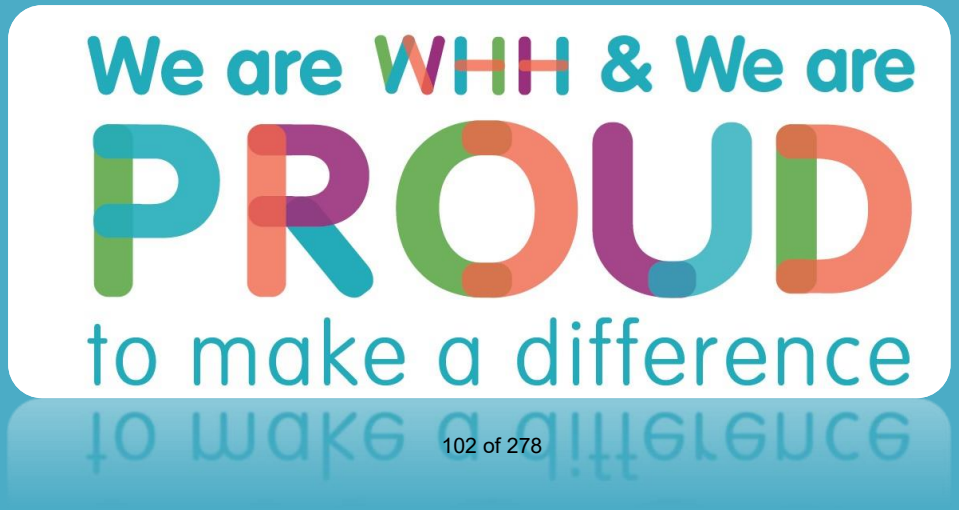
NHS
Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Learning From Experience Q3 Report

Layla Alani

Deputy Director of Governance

February 2021



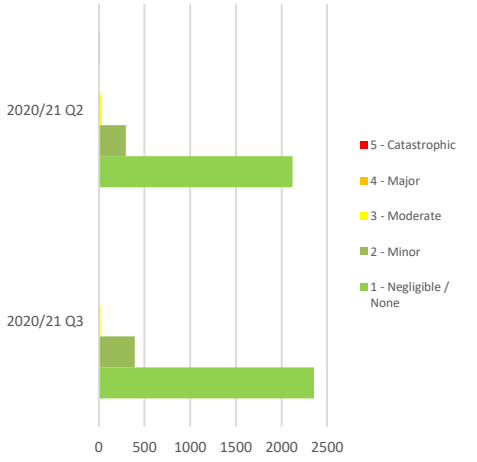
Overview

The following slides provide an overview of the information extracted from the Datix system and other clinical governance reports for Incidents, Complaints, Claims, Health & Safety, Mortality and Clinical Audit related to Quarter 3, 2020/21. They should be viewed in conjunction with the High Level Briefing Report.

Incident Headlines Q2 vs Q3

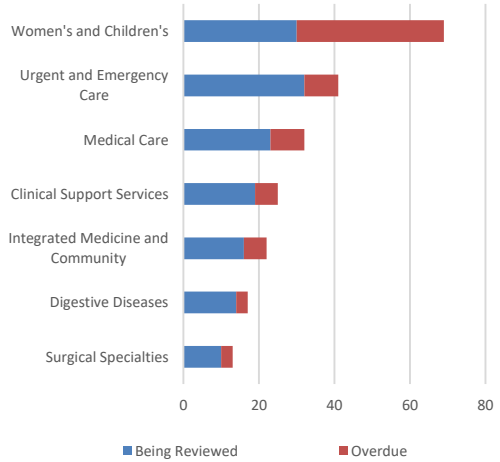
How many staff are raising incidents Q2 vs Q3?

- There was a further 13% increase in incident reporting within the Trust in 2020/21 Q3 (2447 in 2020/21 Q2 vs 2766 in Q3).
- There was a **decrease** in incidents causing Moderate to Catastrophic harm in Q3 (33 in Q2 vs 19 in 19)
- The number of no harm incidents reported increased further by 11% in Q3 following incident reporting returning to normal levels. The 'Report to Improve' campaign was relaunched following the first-wave of the pandemic to enable this.



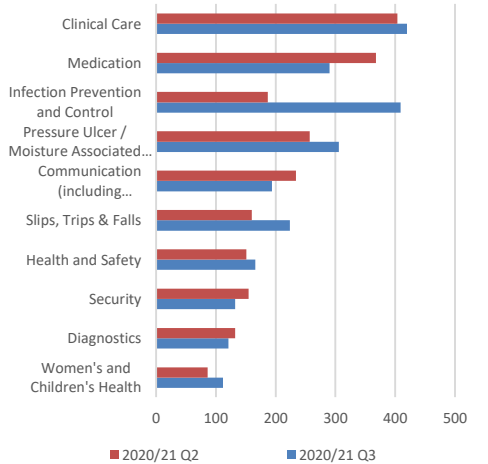
How many incidents are open Q2 vs Q3?

- The Trust reported 440 incidents open in CBUs in the Q2 LFE. To date that has decreased to 219 – a significant improvement in incident management. The graph below shows the 7 CBUs with open incidents and the number of which are overdue.
- Providing feedback and closing incidents in a timely manner remains an important focus and work will continue to ensure that performance continues to improve and CBUs are supported during the Covid-19 pandemic.



What type of incidents are we reporting Q2 vs Q3?

- As stated, there was an increase in the amount of incidents reported. Incidents relating to clinical care, infection prevention and falls increased in Q3 following the overall increase in incident reporting.
- Incidents relating to medication errors and communication issues decreased in Q3.



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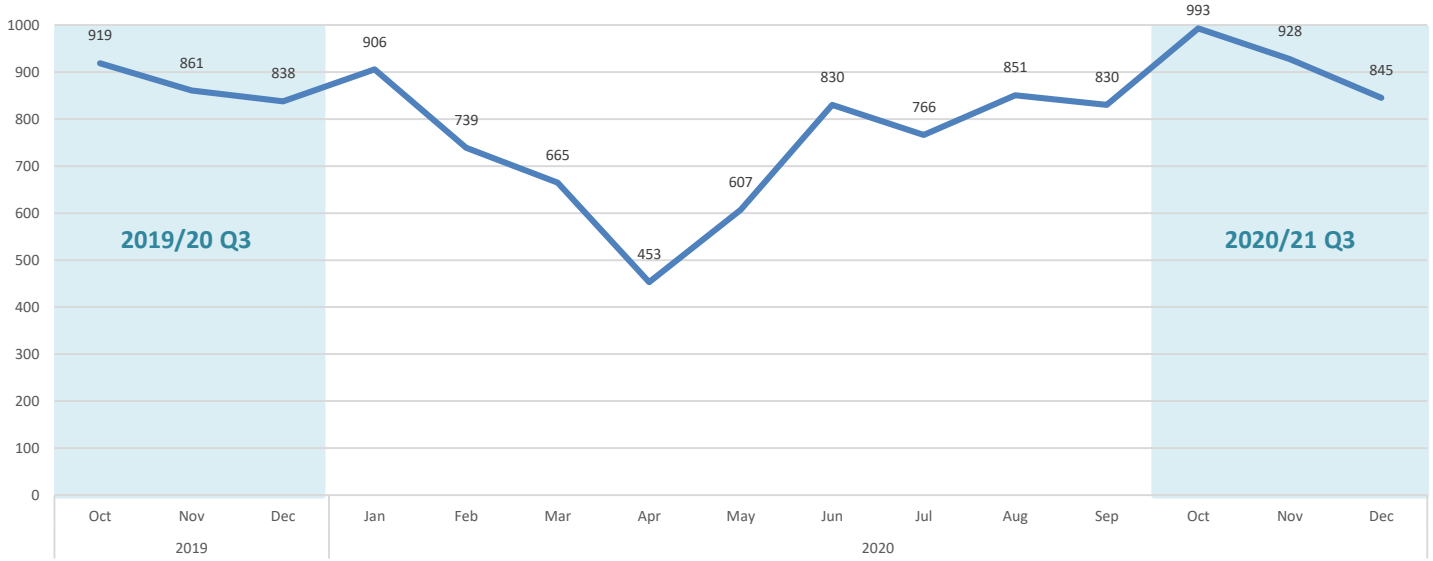
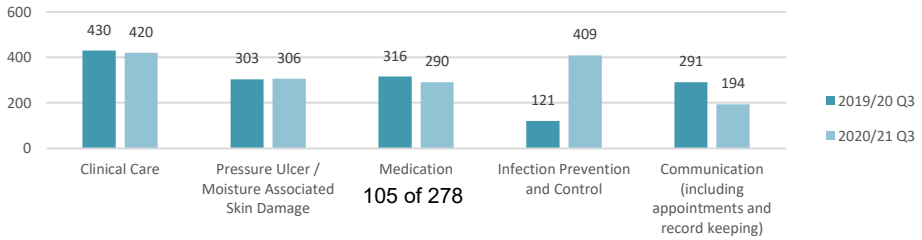
Incident Reporting 2020/21 Q3 vs 2019/20 Q3



In 2020/21 Q3 there was a 6% increase in incident reporting when compared to 2019/20 Q3.

Comparison of Top 5 Incidents Reported



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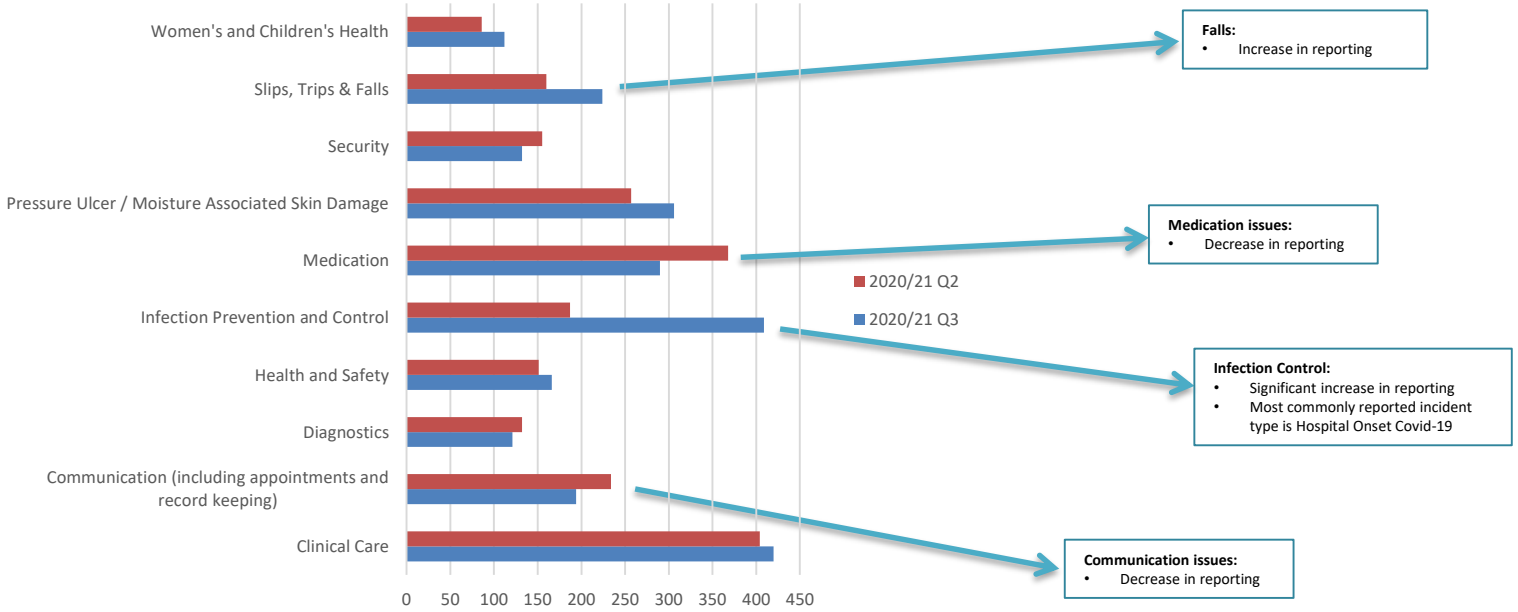
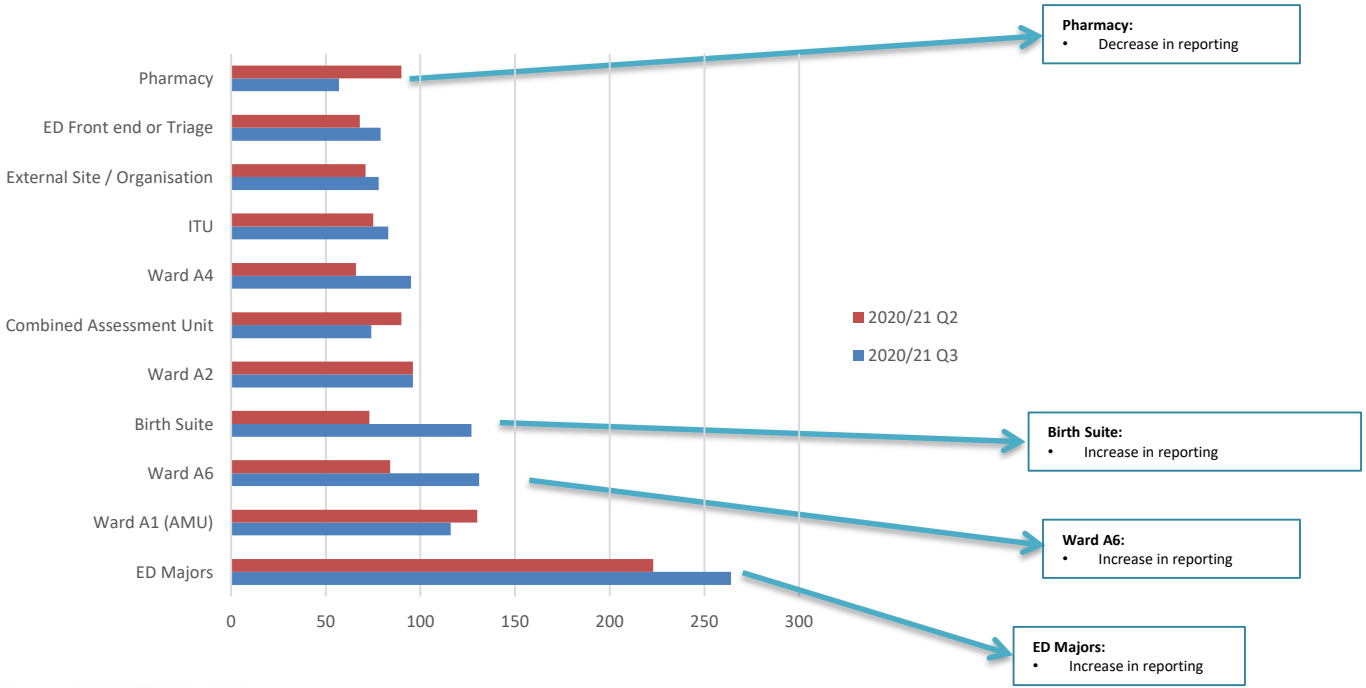
Incident Category Analysis Q2 vs Q3

The information shows the top categories reported incidents how they differ between the 2 quarters.



Incident Location Analysis Q2 vs Q3

The information shows the top reporting locations and how they differ between the 2 quarters.



Pharmacy:
- Decrease in reporting

Birth Suite:
- Increase in reporting

Ward A6:
- Increase in reporting

ED Majors:
- Increase in reporting

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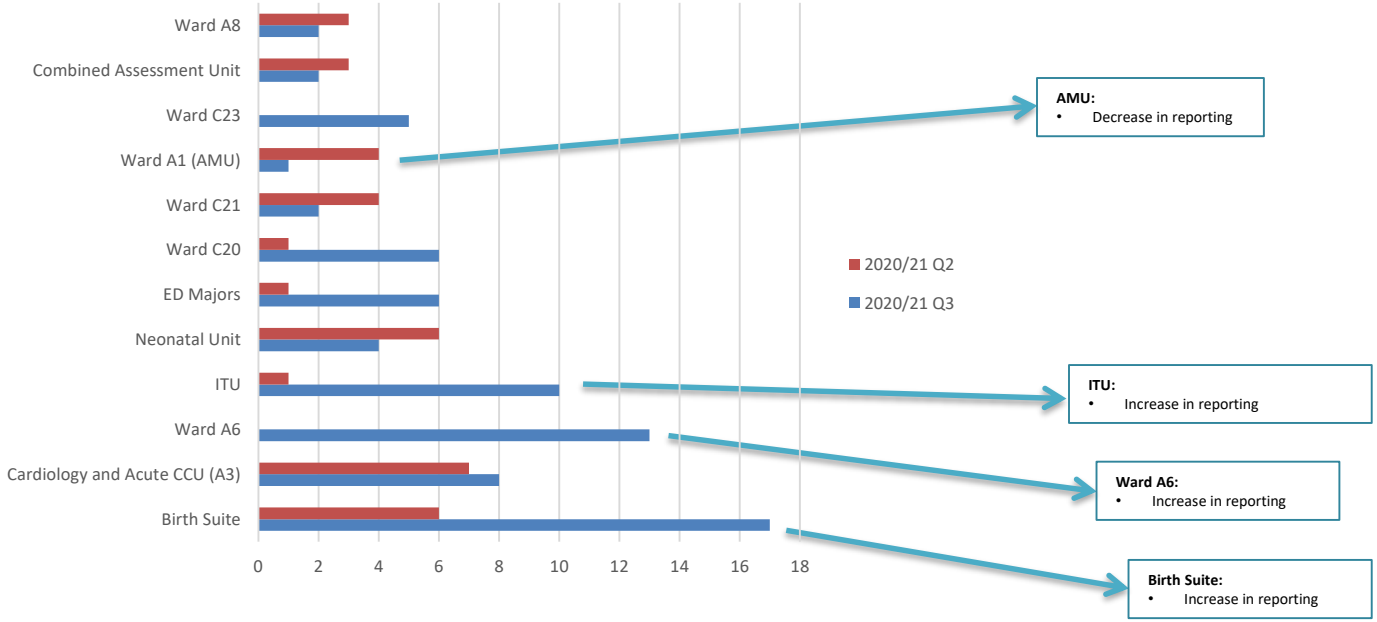
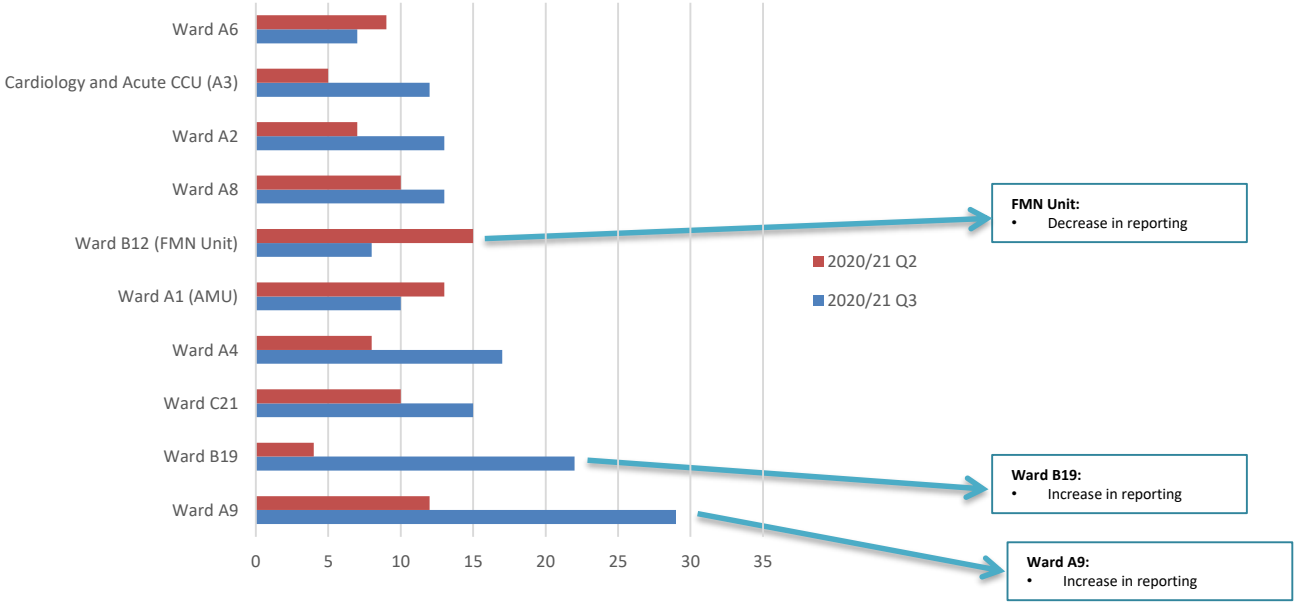
Staffing Incidents Location Analysis Q2 vs Q3

The information shows the top reporting locations in relation to staffing incidents and how they differ between the 2 quarters.



Patient Falls Location Analysis Q2 vs Q3

The information shows the top reporting locations in relation to patient falls and how they differ between the 2 quarters.



Serious Incident (SI) Reporting

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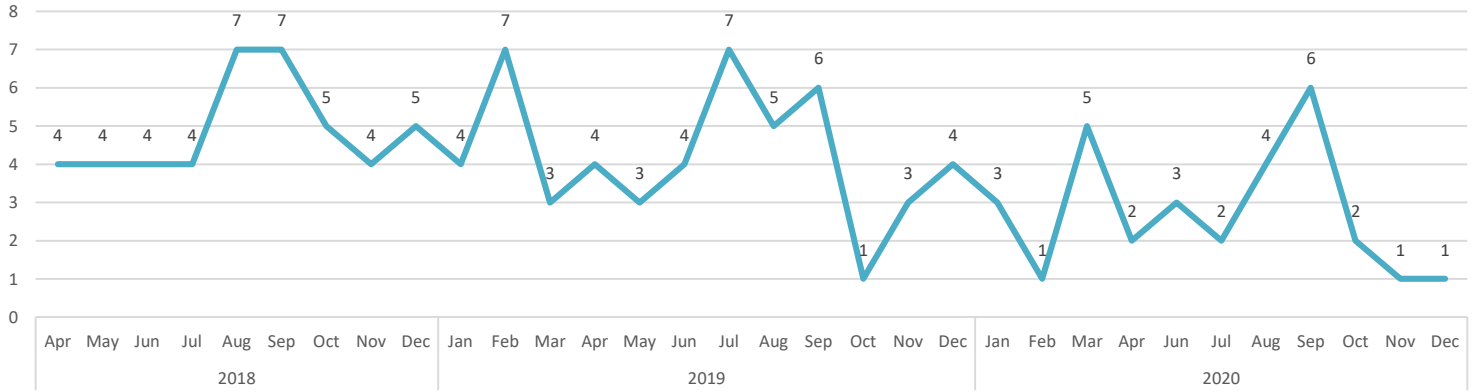
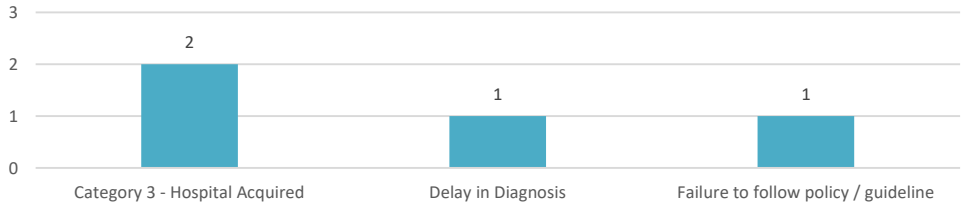
SIs reported by Month



SI Cause Groups Q3



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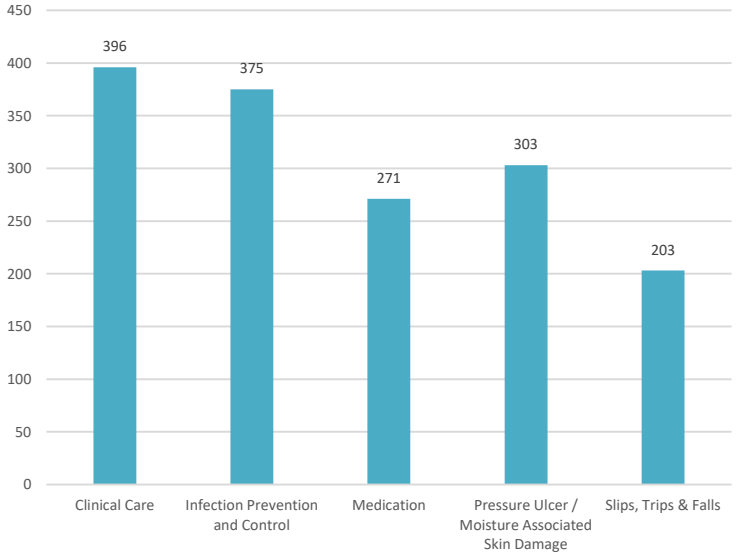
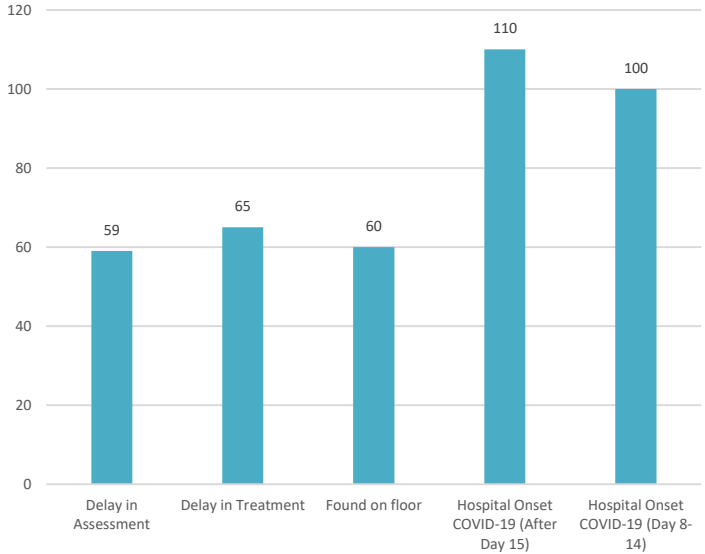
Across the 7 CBUs in Q3

A total of 2434 incidents were reported across the 7 CBUs in Q3, this has increased from 2264 from Q2.

The top 5 categories and subcategories in Q3 were reported as follows:





Learning from Incidents – Medical Care

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We found….

A patient was prescribed a stat dose of Midazolam IV 1-2mg. One dose of 1mg was administered then a further dose of 1mg was given a little after = the maximum 2mg prescribed. Further doses were administered over the next few hours 2 x 1mg, and 2 x 2 mg without a prescription - all signed against the initial stat dose.
In total 8mg was administered against a prescription for 1-2mg. Additionally, all administrations only had 1 signature on the drugs chart (paper copy used)
This was an emergency situation, but Controlled Drugs can never be given on a verbal order even in an emergency. The medication was given in this way to prevent having to intubate the patient due to comorbidities. Midazolam needs to be given in lower doses due to liver problems but should have been prescribed and signed for prior to administration.

We Acted….

- A review of the medicines management policy to see if a section required adding or any amendments made
- Pharmacy issued a Safety alert to remind staff Controlled Drugs can never be given on a verbal order even in an emergency and they must always be prescribed and signed for by 2 individuals.
- A reflective practice was undertaken by the individuals involved.
- The prescription was completed to reflect the medications that had been administered
- The governance lead sent a reminder to the speciality medics regarding the correct process for drugs prescribed and administered in an emergency situation

We found….

Patient admitted and discharged multiple times with UTI, new confusion, aggression, Covid positive, suicidal ideation, and domestic violence. During admission verbally aggressive and making threats to his wife on the phone. Assessed as lacking capacity and DOLS in situ. Seen by consultant psychiatrist diagnosed as suffering from delirium - fluctuating capacity, prescribed antipsychotic and antidepressants. Discharged from psychiatric services with advice to remain on the ward to review delirium and aggression. Reassessed as having capacity, DoLS removed and Medically fit for discharge – no grounds to retain or refuse discharge discussed with the psychiatric services prior to discharge. On returning home the patient assaulted his wife.

We Acted….

- Prior to discharge contact was made with adult safeguarding prior to discharge, DASH completed and an IDVA arranged. Wife reported she would not be at the home address and had arranged to stay with family.
- The ward manager telephoned the mental health team to update them of the intended discharge to make arrangements for follow up in the community with LAMHS.
- Since this incident and the readmission there is clear advice to prevent the patient from leaving to include “If he attempts to leave section 5(2) of MHA can be used”. In hindsight a clear pathway such as this would have been useful prior to the first discharge but at the time the patient had been discharged from the psychiatric service.
- The medical and nursing staff on the ward had done all that was possible to ensure the safety of the patient and family before discharge.

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Learning from Incidents – Integrated Medicine and Community

1. We found….

A gentleman, living in sheltered accommodation with numerous comorbidities including T2DM, peripheral vascular disease, AF (PPM 2018), recurrent DVT, COPD, HTN, gout and recently diagnosed with dementia / Alzheimer's, attended ED feeling unwell. On admission it was noted that the patient brought a blister pack of medications not provided on previous discharge 7 days earlier. This leaves Four possibilities: 1. No medications were taken. 2. just the blister pack medications were taken 3. Just the discharge medications were taken 4. both medications were taken.

We Acted….

- The Deputy Chief Pharmacist made enquires with the sheltered accommodation had they assisted with the taking of medications and if not if they can check the discharge medications to see if any had been taken.
- The Deputy Chief Pharmacist discussed the concerns with the patient's son who reported that he assisted with medications and confirmed that only the medications in the blister pack were taken. No excess of medications was taken, and none were missed.
- Apologies were expressed and the correct medications were provided in a blister pack on discharge.

2. We found….

A patient's records were erroneously sent home with another patient resulting in a breach of data protection. This was reported to NHS Digital and the Information Commissioners Office (ICO) by the Trust's Information Governance department. The ward had a case note trolley per bay for all medical records and some of the case note trolley locks were broken which had been reported. Loose paperwork was often placed in pigeonholes for filling at a later date and It could not be ruled out that the paperwork was miss-filed by a member of staff. There was not a rigorous check of the discharge paperwork before discharge.

We Acted….

- There was an immediate telephone consultation with the GP who discussed the medications and the plan regarding continuing / discontinuing the medications with the hospital chief pharmacist who advised to reduce the dose of one medication in half and monitor for any withdrawal effects then for the GP to further review.
- Arrangements were made by the pharmacy to collect the medications and provide some information regarding withdrawal symptoms
- The lead Consultant for Mrs. Ralston's care also reviewed the medications provided and any possible side effects:
- There was a full apology to the patient and the family
- The Nurse who performed the discharge completed a reflective practice regarding the incident.
- Staff were reminded that discharge medication must be checked by two nurses with the discharge prescription and discharge summary.

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Learning from Incidents – Clinical Support Services

Warrington and Halton Teaching Hospitals NHS Foundation Trust

We Found…

A Rapid Covid Swab was sent to microbiology from the emergency department overnight. The out of hours BMS was not contacted therefore the swab was not processed immediately. ED enquiry 1 hour and 20 minutes later highlighted that the swab result was required urgently as the patient required ITU care and the result would determine where that care would be delivered. The on-call BMS was alerted by switchboard and attended the department. The swab result was not available until nearly 3 hours after it was sent for analysis.

We Acted….

- ✓ The correct process for urgent out of hour's samples for Microbiology was not followed.
- ✓ The process is the same as that used by AE for other urgent out of hours Microbiology samples however this was not clearly stated in the lab handbook.
- ✓ The Covid section of the current version of the lab handbook has been updated to state that rapid swabs are available out of hours and must follow the same process as all out of hours microbiology swabs

We Found…

The MR1 added Zomorph 30mg BD, buprenorphine 15microgram/hr patch once a week on a Monday to the MST Continuous 10mg BD, morphine sulphate 10mg/5ml solution 2.5ml TDS PRN and co-codamol 30/500 1-2 tablets QDS PRN. The pharmacy technician did not question the number of opioids prescribed. During the MR2 check the Pharmacist mistakenly advised consideration of buprenorphine patch to the clinician regarding the wrong patient as they were in the process of reviewing two separate patients' medications. This error was realised but did not appear to be rectified. The Pharmacist also did not sense check the MR1 which would have raised concern. It was the palliative care nurse who raised concerns regarding the volume of opioid's the following day before any excess medications was taken.

We Acted….

- ✓ Reflection for Pharmacy Technician involved in incident
- ✓ Reflection for Pharmacist involved
- ✓ Lessons learned to be shared with full Pharmacy Department
- ✓ Palliative Care Consultant to feedback to individual prescribing doctor

Learning from Incidents – Radiology

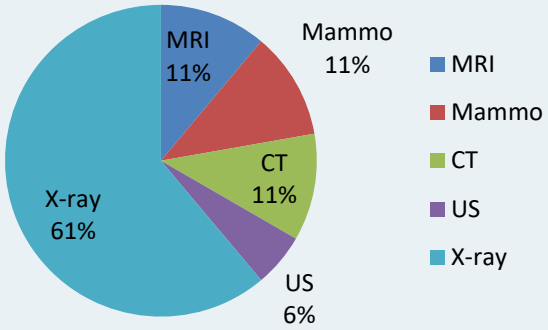
Warrington and Halton Teaching Hospitals NHS Foundation Trust

We Found….

There were a total of **102** incidents reported in Radiology in the period 1st October 2020 to 31st December 2020.

Of these **18** incidents (18%) were for images acquired under the incorrect patient name.

To image a patient the operator has to manually select a patient's name from a list and this is subject to human error.
Incidents were spread across the modalities:



Contributory factors are pressure of work, communication and team working.

In the majority of cases the error is identified immediately but problems can occur if the error is not identified until the reporting stage as there is a risk of incorrect diagnosis; or if the images are 'lost' in another patients folder and the patient needs to be recalled with radiation safety implications and poor patient experience.

We Acted….

Radiographers are regularly reminded about incidents of this type through safety huddles and safety briefs.

Radiographers are reminded to be careful to check they have the correct patient particularly at busy times, when there are patients with similar details, when working in pairs or handing over.

Radiographers are expected to check PACS after each exam which will highlight the error at the earliest possible stage. All staff are made aware of this at induction and when problems occur.

Where there are consequences as a result of the incident Radiographers are encouraged to complete a reflection on their practice and we have produced a form to facilitate this.

The PACS team are able to reconcile images to the correct patient and have developed an admin form to record actions taken.

Departmental SOPs are in place detailing individuals' responsibility for both minimising and rectifying errors of this type.

Learning from Incidents – Urgent & Emergency Care

What staff told us…….	Learning
A patient was admitted following high impact fall . Lower limbs were not examined. The patient also had a chest infection and admission was to treat the chest infection. The following day the patient complained of hip pain and analgesia was administered. There was no escalation of the hip pain. Three days following admission hip x-ray confirmed fractured neck of femur.	• Assessing power of the lower limb is not an adequate hip examination. Full hip examination should be conducted for patients falling a fall. • Unexpected changes to patients' clinical status should be escalated for medical review.
A patient had four episodes of attendance with abdominal pain and was reviewed and discharged; as observations, blood and other investigations were within range. On the 4th attendance the liver function test was deranged and the patient was admitted for further management.	The patient was diagnosed with a rare congenital liver condition and was transferred to specialist organisation for care. The incident was shared with the Emergency Team staff for learning and awareness. Such a condition will not be identified in an emergency setting. The appropriate action was taken to admit for further test when the liver function test result was abnormal.

Learning from Incidents - Surgical Specialities

What Happened?	Learning action points
Patient was recently in hospital due to lithium toxicity and had been discharge with a reduced dose of lithium. Patient was readmitted within a few days again with lithium toxicity. Patient did not get discharged with discharge summary and was unaware of reduction of medication. Patient noted to be confused during inpatient stay.	• All medications must be discussed by the nurse with patients immediately prior to discharge and establish that patient has fully understood medication instructions. • All patients must be discharged home with a copy of the discharge summary so they can refer to this for further information.
Cardiac arrest call put out. Patient was having chemotherapy and had an anaphylactic shock. RMO didn't arrive on scene had to be fast bleeped via 2222. ECG technician's bleep didn't go off so delay in ECG.	• Any emergency bleeps to be responded to in a timely manner

Learning from Incidents - Digestive Diseases

What happened…	Learning action points
Patient had received a Covid swabbed through the day and the swab had returned back around 20:30 hrs as a positive result. The patient was then transferred to a covid-19 cohort ward. It was later identified that the swab had been performed on a different patient but had the wrong patient label attached therefore identifying the wrong patient as Covid-19 positive.	• All staff to have an understanding of all COVID processes. • All staff to be aware that any samples must be taken and labelled at the bedside and confirmation of patient identifiable information must be confirmed with the patient.
Patient had become unwell. Doctors asked advice from the ACT stating the patient had a tension pneumothorax and they did not know who to contact. They had left a message with another ward for a respiratory doctor to call them back. Patient had GCS 4 with clear tracheal shift There was no sense of urgency or that this was a reversible cause. Correct escalation process was not used to notify the appropriate staff members of an emergency situation.	• The junior staff member should have been aware of the correct escalation process to ensure appropriate teams attendance and timely treatment of the patient.

Learning from Incidents – Children's Health

What happened…	Learning action points
A patient's father has emailed stating that his son was discharged from the children's ward with no medication and no follow up. The patient was at home still unwell with no further support.	The Paediatric Matron has liaised with ward team regarding the importance of contacting relatives to collect medication. Learning has been discussed by the paediatric governance lead and matron to nurses and doctors that they are to provide clear safety net advice to parents as to when to return to ED if on-going or worsening symptoms.
Patient's cannula removed, indentation observed where hub of cannula sat, no broken down skin, duoderm not used.	Nursing staff have been asked to reiterate to the paediatric doctors the importance surrounding safe practice when they are inserting a cannula to apply duoderm under the hub of the cannula. The cannula drawer has duoderm as a prompt for staff/medics therefore incidents like this should not happen. Both the paediatric matron and paediatric governance lead have discussed this incident with the nursing and medical staff.
13 year old female on Parvolex treatment for Paracetamol overdose. 3rd bag of Parvolex commenced by night staff. Paracetamol poisoning pathway states that 3rd bag of Parvolex should be administered by adding 23mls of medication into 1000mls of 5% Dextrose and then run over 16 hours at 64ml/hr. 3rd bag was made up correctly, however run at an incorrect rate of 23ml/hr, therefore patient was not getting the correct dose.	Appropriate actions taken. Correct rate commenced. Patient and mother were informed as per Duty of candour. There was no harm to patient. All fluid handover checks were carried out at change of shift which highlighted the error. Learning discussed with all staff that 2 staff to check pump rate at bedside prior to commencing medication.

Learning from Incidents – Women's Health

What happened…	Learning action points
Learning from PMRT: A woman had suspected ruptured membranes at 24/40. She was commenced on antibiotics. Other treatment plans of steroids and intra-uterine transfer to LWH did not occur due to doubt of PPROM.	• Learning shared that if PPROM suspected, then the whole treatment plan should be completed. It would not have made a difference to the pregnancy outcome but was a care issue identified as part of the review.
Learning from Rapid Incident Review. A rare heart condition was not picked up antenatally, as not all heart views were seen at anomaly scan, despite further attempt to complete the scan.	• If not all heart views have been achieved at the anomaly scan, mothers and babies are asked and encouraged to remain in hospital for at least 24 hours post birth. This allows time for the Newborn and Infant Physical Examination (NIPE) to take place at this time when changes with fetal circulation have occurred.
Learning from a concise RCA investigation when a woman was transferred from birth suite to intensive care unit following IV fluid overload	Accurate completion of HDU charts is essential when caring for an HDU patient. Mobilising is important to minimise risk of dependent oedema developing When the acuity in birth suite is high, experienced staff should be allocated to patients with the most complex clinical care needs. Request daily Critical Care Outreach review for women requiring HDU care Request a MET call for an unwell woman if there is a delay in anaesthetic or obstetric review due to acuity of birth suite The admitting obstetrician to document a clear plan of care for the woman and that this plan is referred to at all subsequent obstetric reviews, in line with the recommendations of the Ockenden report (2020) Obstetric and anaesthetic team to consider earlier transfer to ICU when woman requiring on-going HDU care and multi-organ support.

Learning from Medication Incidents

We found…..	We acted…..

A patient was discharged to a new care home and not all of his medicines were provided at discharge. This included levetiracetam which he was prescribed for epilepsy and morphine which he was prescribed for pain.	• A Rapid Incident Review was held to identify contributory factors, learning and actions from the incident.
	• The incident was taken to the Trust Safety Huddle with key learning provided in a single point lesson on Discharge Medication. This included:
	  ○ Informing the ward pharmacist/pharmacy of the patient's discharge destination when asking them to process the discharge prescription.
	  ○ At time of discharge ensuring appropriate medication has been supplied for the patient's discharge destination.

In Quarter 3, there was a cluster of 10 medicine incidents where medicines were administered to the wrong patient.	A Safety Alert was taken to the Trust Safety Huddle with learning from these incidents which included: • The process which must be used for inpatients/outpatients to confirm the patient's identity prior to administering medication. • Wearing a red tabard when completing the medication round, to inform other staff not to disturb you whilst you are administering medicines.
A patient was discharged without his discharge medication and he was left for 2 days without a supply of the critical medicine clindamycin which he was taking to treat an infection.	• A Rapid Incident Review was held to identify contributory factors, learning and actions from the incident. • Learning from the incident was taken to the Pharmacy Safety Huddle about what action should be taken when a medicine on a discharge prescription is not available in pharmacy to ensure the patient is safely discharged with appropriate medication. • Learning from the incident was provided on the ward about assessing the safety of the discharge, if a patient is to be discharged without their discharge medication and if concerned to escalate to the bed manager.

Learning from Incidents – Pressure Ulcers

- Due to an increase in pressure ulcers related to anti-embolism stockings a survey monkey was produced to identify any gaps in knowledge/training needs. The company have been providing training to the high incidence wards.
- Accurate documentation including care and comfort charts, body maps, risk assessments and pressure ulcer care plans to be reinforced. Spot checks and audits by Ward Managers/Matrons.
- Increase in pressure ulcers related to proning in ICU. Dolphin (fluid immersion therapy) mattress now on standby in ICU for patients requiring proning.
- Silicone gel strips used under ET tube tapes to reduce the risk of pressure damage to the mouth/face.

- There is now ED representation at monthly category 2 RCA meetings to feedback and share learning/actions from pressure ulcer incidents to the ED team.
- Delays in upgrading airflow mattress from alternating pressure to continuous low pressure identified as a factor in pressure ulcer development. The new mattress contract commenced on 1/12/20. The Uno mattress provides either alternating pressure, pulsation or continuous low pressure therapies by selecting the required therapy on the control panel.
- Focus by Ward Managers on pressure ulcer prevention e-learning to improve compliance.

Learning from Incidents – Information Governance

We Found	We Acted….
A results was letter was sent to an incorrect recipient (biological parent of a foster child) in error. This resulted in external reporting to the ICO and a claim against the Trust as the child's location should not have been revealed.	• A standardised procedure for patient communication administration was developed within the department and communicated to all administration staff. • The CBU management team will review the number of administration staff to identify vacancies and consider further posts/employment. • Process of external reporting to the ICO followed and data subjects kept fully informed.
Interfacing issues between CRIS (Radiology system) and Lorenzo (PAS system) has resulted in incidents of patient's letters being sent to their previous addresses.	• Issue identified as a HL7 interfacing message issue between systems. This is now being addressed so that addresses within the Lorenzo system are mapped correctly to address fields in the CRIS Radiology system. This will result in prevention of reoccurrence. • Data subjects have been informed where this error has occurred.

Complaints Headlines Q2 vs Q3

How many people are raising complaints Q2 vs Q3?

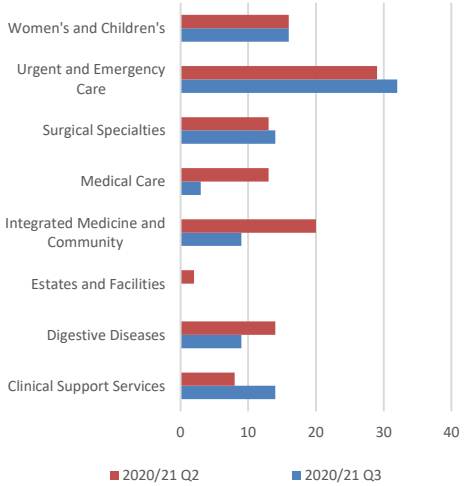
- There was a 15.7% reduction in complaints opened Trustwide in Q3 (115 in Q2 versus 97 in Q3).
- Estates and facilities, Digestive Diseases and Medical Care saw reduction in the complaints received.
- Urgent and Emergency Care, Surgical Specialities and Clinical Support Services saw increases in their complaints.

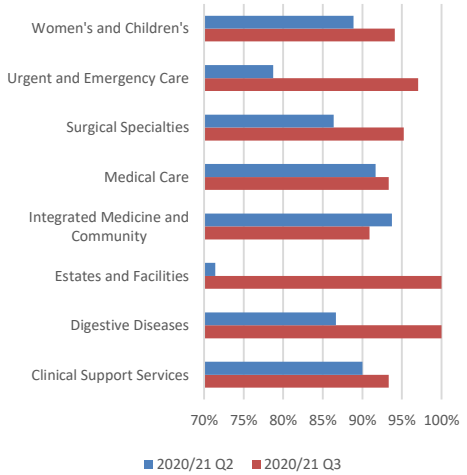
Are we Responsive Q2 vs Q3?

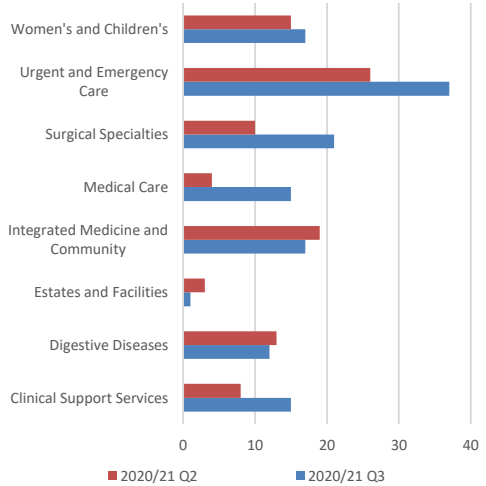
- There was an increase in the number of complaints meeting timescales during Q3.
- Surgical Specialties, Women's and Children's, Urgent and Emergency Care, Medical Care, Estates and Facilities, Digestive Diseases and Clinical Support Services have improved the number of complaints closed on time
- The Trust had a target to respond to 90% of complaint on time and in Q3 the Trust achieved 95%.
- The Trust currently has 0 breached complaints and there are no complaints over 6 months old.

How many complaints has the Trust closed Q2 vs Q3?

- There was an increase in the number of complaints closed in the Trust in Q3 (102 in Q2 versus 135 in Q3).
- Women's and Children's, Urgent and Emergency Care, Surgical Specialties, Medical Care and Clinical Support Services have increased in the number of complaints closed in Q3. Integrated Medicine and Community have seen the highest decrease.

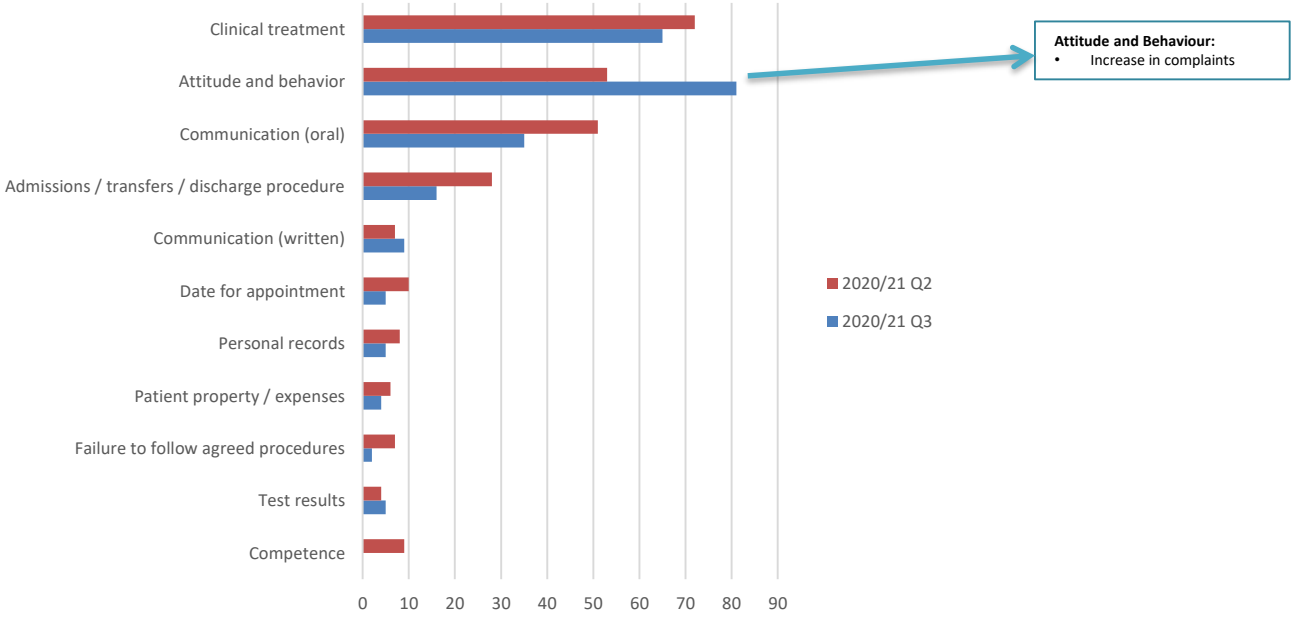






Complaints Analysis Q2 vs Q3

The information shows the top subjects in complaints in Q2 vs Q3.
Note: Complaints can have more than one subject.

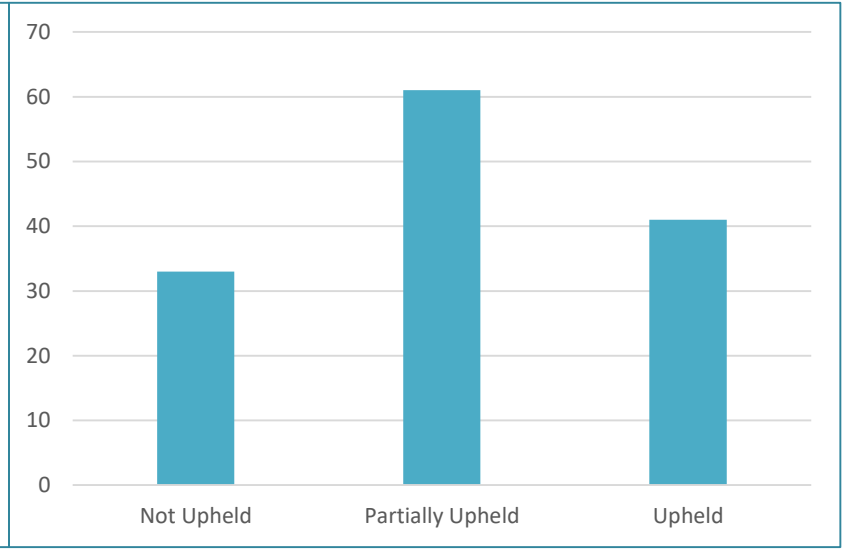


Attitude and Behaviour:
- Increase in complaints

Complaints Outcomes Q3

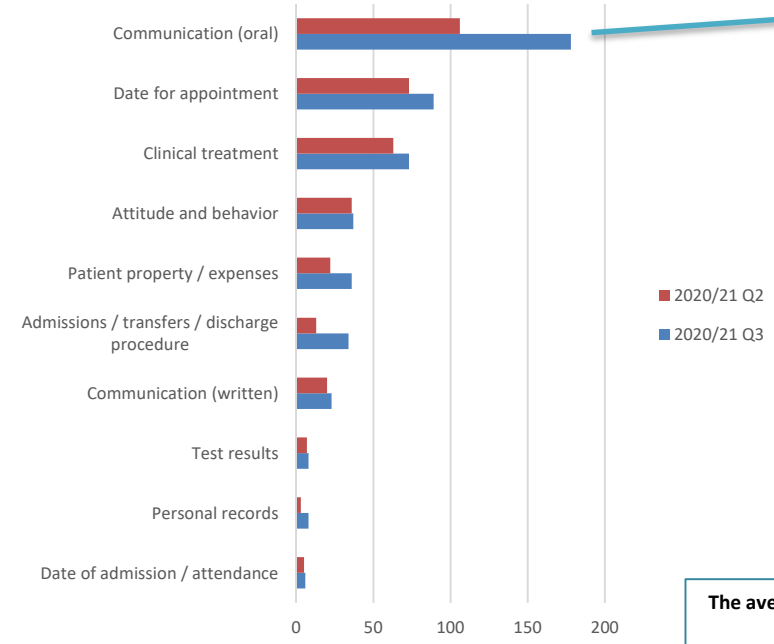
Once a complaint has concluded (either following a local resolution meeting or once a formal written response has been sent) the outcome will be recorded in line with the findings of the investigation.

A complaint will be “upheld”, “upheld in part” or “not upheld”.



PALS Analysis Q2 vs Q3

The information shows the top subjects in PALS.
Note: PALS can have more than one subject.



Communication issues:
- Increase in concerns

The average response time for a PALS concern of those closed:

Q2	Q3
6 days	7 days

PALS to Complaints:

Q2	Q3
2	6

Learning from Complaints

You Said….	We Did….
A complainant's mother (the patient) was transferred to the wrong hospital	We introduced an ambulance booking form to ensure patients were transferred to the correct location. This helps to ensure the correct booking details are handed over to the ambulance service.
A patient complained that during their seven hour visit to the Emergency Department they were not offered a drink. The patient ended up drinking water from a sink tap.	We recognised that prior to the pandemic there had been a self-service area within ED with water jugs and cups. However, this had been removed to infection control concerns and a replacement offer hadn't been put in place. The ED team ordered a water fountain and put signs up throughout the department explaining to patients if they needed a drink then they could approach ED staff to request this. We apologised to the patient for their experience. All staff were also reminded of the importance of ensuring drinks and sandwiches were offered during care and comfort rounds.
A patient complained that the consultant has not contacted her on all available numbers at the time of her telephone appointment. This resulted in her missing her appointment.	We reminded all staff of the importance of trying all contact numbers for patients when undertaking telephone appointments. A further appointment was also arranged for the complainant.

Complaints Headlines

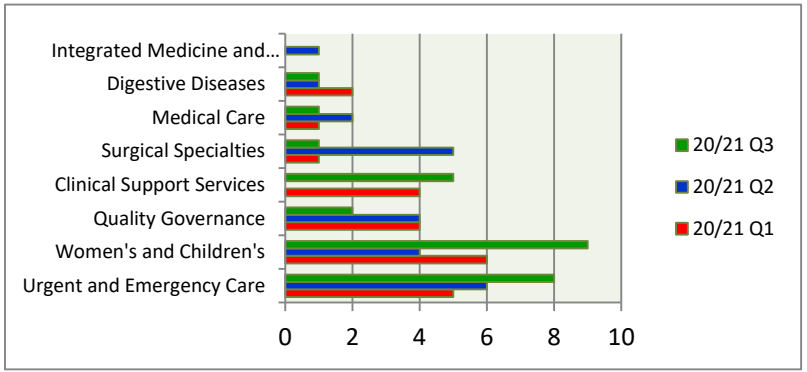
- 97 complaints were opened during Q3 2020/21, which is a decrease of 15.7% compared to Q2 (115). The decrease reflects our usual complaints activity for the same period of time in the previous financial year.
- In Q3, the number of complaints relating to attitude and behaviour have increased compared to Q2.
- There has also been a decrease in the number of clinical treatment complaints in Q3 compared to Q2.
- 471 PALS concerns were received during Q3 2020/21, which is a 39.3% increase compared to Q2
- There has been an increase in the number of PALS concerns received oral communication. There has also been an increase in concerns regarding a date for an appointment where unacceptable time to wait for an appointment, an appointment date continues to be rescheduled and cancellation of appointments has been raised.
- The Trust received 14 dissatisfied complaints in Q3 2020/21; which is a decrease of 17.6% compared to Q2 where there was 17.
- In Q3, 5 complaints were closed and deemed to require an SI investigation.

Analysis of Claims Received Q3 2020-2021

NHS
Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Clinical Claims Received 2020/2021

Q1: 23 Received
Q2: 23 Received
Q3: 27 Received



27 Claims received via:
- 2 Incident (ERS)
- 3 Letter of Claim
- 1 Request for extension to limitation
- 21 Requests for notes

There has been 397 request for notes via Medico-Legal Services (444 previous qtr)

Non-Clinical Claims Received 2020/21

There were 6 Non-Clinical Claims received this quarter:
Q1: 0
Q2: 5
Q3: 6

Clinical Support Services	1
Consent, Confidentiality or Communication	1
Estates and Facilities	2
Patient Information (records, documents, test results, scans)	1
Accident that may resultin in Injury/harm	1
Medical Care	1
Consent, Confidentiality or Communication	1
Urgent and Emergency Care	1
Accident that may resultin in Injury/harm	1
Women's and Children's	1
Consent, Confidentiality or Communication	1

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Analysis of Claims Closed 2020/2021 Q3

Clinical Claims Closed Q3 2020/2021

6 Claims closed with damages (totalling £398,730.90 (excluding costs))

Clinical Business Unit	Repudiated	Settled with damages	Withdrawn	Grand Total
Clinical Support Services	1	2		4
Digestive Diseases	1	1	1	3
Integrated Medicine and Community		1	1	2
Surgical Specialties	2		6	8
Urgent and Emergency Care		1	6	7
Women's and Children's		1	3	4
Grand Total	**4**	**6**	**17**	**27**

Non-Clinical Claims Closed Q3 2020/21

3 employer Liability Claims closed with damages (totalling £14,525.00 (excluding costs)) 1 claim was struck out

Specialty	Details
Medical Records 2	Slipped on floor
Urgent and Emergency Care 1	Assaulted by Patient

1 Public Liability Claims closed with damages (totalling £5,500.00 (excluding costs))

Specialty	Details
Urgent and Emergency Care	Slipped on floor

Action taken on Clinical Claims

Radiology

Negligently failed to diagnose a navicular fracture	• The x-ray and subsequent MRI reviewed via the discrepancy meeting. Whilst the fracture was easily missed on x-ray this will be used for reflective practice across the team
Delay in diagnosing lung cancer	• 'The Radiology team must designate two reporting rooms within the Radiology department to minimise interruption and allow appropriate dedicated time to report all scans. • An immediate action that has been taken is to amend the original Radiology Discrepancy policy regarding escalation of errors leading to potential harm and ensuring early corporate involvement in the investigation of these errors. • Therefore scan reporting times should continue to abide by the timeframe mentioned in the external radiologist's opinion and Trust reporting times of 3-4 per hour dependant on complexity.

General Surgery

Negligent Jejunostomy	• Following the complaint it was advised that historically jejunostomy management has been allocated to one consultant, which created a issue whilst he was on annual leave. To alleviate this problem jejunostomy management was discussed at the surgery directorate meeting and two colleagues have agreed to shard the workload of this service. • The case was also discussed with the individual concerned

Action taken on Clinical Claims

Care of the Elderly

Pressure care assessment and prevent fell below the expected standards	• Revisit the single point lessons for tissue viability. Contact to deliver training to the ward areas • Pressure area care to be included onto mandatory training for all staff. • Patients who are frail and high risk of developing a deep tissue injury or a pressure ulcer should be places on a repose trolley toper until it is appropriate to move them onto a bed with the • Audit notes and feedback to nursing staff if documentation not correctly filled in in AED and the ward areas. • Review the pressure ulcer risk assessment tool that is used within the organisation • Increased Random Audits on nursing documentation. Nurses who fail to document correctly or accurately to be dealt with in line with HR policies. • Pressure ulcer training sessions to be arranged. • Nursing staff on AED, AMU and A3 to reread all pressure ulcer single point lessons. • Education on 'Moisture or 'Pressure' tool to assist with differentiation between pressure ulcer and moisture lesions. • Qualified nurses to direct the care that is needed for the patient. And Increase spot checking on patient documentation. • Visual prompts on wards for when patients are due to be turned • Introduce new care and comfort round documentation across the organization • Trust wide action plan to incorporate all the above actions

Action taken on Clinical Claims

Emergency Medicine

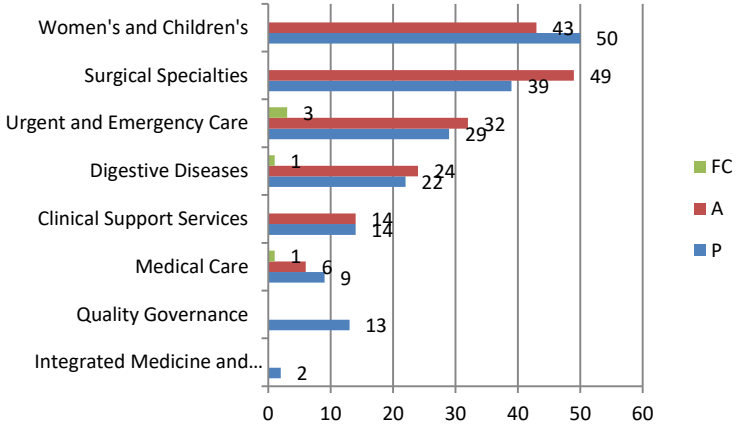
Failure to diagnose wrist fracture	• The clinician involved has been fed back to regarding the unusual initial x-ray, the ED consultants and other senior clinicians will receive communication around the unusual nature of this bony injury, but also of the importance of soft tissue injuries associated with these. The importance of verbal and written advice given out to patients, especially those with unusual X-rays will be shared through twice daily safety briefs and governance updates within the monthly departmental meeting. • Clinical scenario added to the 'missed fractures in ED' power-point presentation that is given to the ENPs and junior doctors, and will also share with Nurse Specialist and the ENP clinicians.

Gynaecology

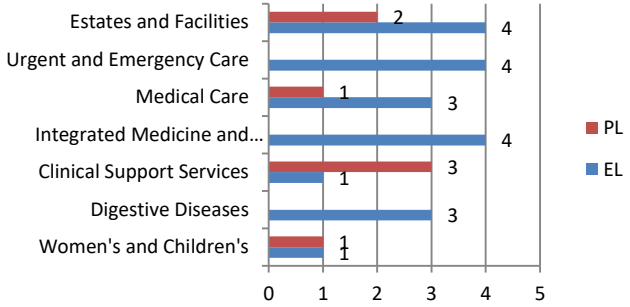
Delay in identifying damage to ureter during hysterectomy resulting in loss of kidney	1. Perform a review of the discharge process to prevent appointments failing to be generated and ensure follow up from ward discharges. 2. Review access Policy to include a Consultant to Consultant referral pathway. 3. Explore alternatives to the current appointments system: consider outsourcing to a system which is digitalised as opposed to continuing in house. 4. Consideration of an IT solution to provide a full audit trail of the printing of letters. 5. Consideration of an IT solution for automated discharge appointments. 6. Clear communication between CBU management and clinical teams following weekly outpatient's escalation reports. 7. Reflective learning by the clinicians involved in the provision of care to be completed

Claims Position – End of Q3

351 **Clinical Claims** open
168 Actual (Formal Claim) | 178 Potential (Request for notes) | 5 Coroners Funding



27 **Non-Clinical Claims** open
20 Employer Liability |7 Public Liability



Key:
FC – Coroners Funding P – Potential = Request for notes A – Actual = (Formal Claim, Letter of Claim / Proceedings) PL – Public Liability EL – Employer Liability

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Headlines of Learning from Deaths Q3

- The Mortality Review Group (MRG) has successfully moved to virtual meetings. Deaths are being reviewed and discussed at the group which continues to have external representation from our Commissioning bodies.
- SHMI and HSMR, are within the expected range at present.
- There is a key focus on reviewing COVID-19 deaths.
- MRG 'Case of the Month' is actively disseminated to ensure learning is filtered across the Trust.
- The electronic system has been launched for reviewers to undertake their SJR reviews and to ensure a triangulation of governance.
- The Medical Examiners actively feed any themes and learning into MRG.

Learning from National Audits

The ROYAL COLLEGE of OPHTHALMOLOGISTS

NATIONAL OPHTHALMOLOGY DATABASE AUDIT

NHS Warrington and Halton Teaching Hospitals NHS Foundation Trust

Summary:

In the 2018-2019 audit year, around 452,000 NHS cataract surgery procedures were undertaken in England. Cataract surgery is the most frequently performed surgical procedure in the UK. A widely accepted indicator of surgical quality is the frequency of significant breach of the lens-zonule
barrier through posterior capsule rupture with or without vitreous prolapse, or zonule rupture with vitreous prolapse, events abbreviated here as PCR.

			The percentage (%) of operations performed by:			
Number of eligible operations	Estimate of cases submitted to the audit (%)	Number of surgeons	Consultant surgeons	Career grade non-consultant surgeons	More experienced trainee surgeons	Less experienced trainee surgeons
1,075	89.4	15	79.3	5.3	14.5	0.8

Posterior Capsular Rupture (PCR) Overall Consultant Surgeon rate= **1.1%**			
No of Operations	Unadjusted PCR Rate	Case Complexity Index	Adjusted PCR Rate
1,075	0.65	1.50	0.48
Visual Acuity loss Overall Consultant Surgeon VA Loss rate= **0.9%**			
No of Operations	Unadjusted VA Loss rate	Case Complexity index	Adjusted VA Loss rate
627	0.64	1.14	0.50

National Recommendations:

- Providers should submit complete data including all relevant risk factors for outcomes to ensure case complexity can be taken into account and results appropriately interpreted
- In line with the NHS Digital Agenda, providers should use electronic data collection to improve data completeness
- Providers should review patient pathways to maximise the recording of both preoperative and postoperative VA data for every operation
- Providers should consider including Patient Reported Outcome Measures (PROMs) before and after surgery to quantify and validate patient benefit from surgery
- Electronic Medical Record (EMR) enabled providers should review the settings on their EMR regarding mandatory data collection. Specifying mandatory collection for specific data items aids in improving data collection

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Assurance Rating:	Significant	There is a good system of internal control designed to meet the system objectives, and that controls are generally being consistently applied.

Learning from Local Audits

WHH Diagnostic Policy

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Mersey Internal Audit Agency (MIAA) reported in January 2020 on a review of the Trust's Diagnostic Policy in accordance with the requirements of the 2019/20 Internal Audit plan as approved by the Audit Committee. The overall objective of the review was to assess the effectiveness of the implementation of the Diagnostic Policy in place at the Trust. The review completed in Q3 found that the policy was not applied consistently on a sample of 26 patients reviewed – results were not being viewed, communicated to patients or filed on ICE. The MIAA report made a recommendation that Clinical Business Units (CBU's) should undertake an audit to check compliance with the Diagnostic Policy.

Learning points:

1. The audit methodology did not allow for auditing other evidence of alerting high risk results to a clinician apart from documentation in the EPR.
2. Each diagnostic department should have a process in place to alert a high risk result to a clinician; this process is not available in the Diagnostic Policy.
3. The Diagnostic Policy does not make allowance for occasions when a clinician has viewed a result on ICE but not documented this result by replicating it in the EPR. For some diagnostic tests, documentation of a resultant management plan or diagnosis may be sufficient.
4. A small percentage of results on ICE were not viewed. It is possible that these results were viewed on paper reports issued by the diagnostic department. An SOP for each specialty/CBU defining the process for review/receipt of results would add clarity to the Diagnostic Policy. This SOP template is available as an appendix in the Diagnostic Policy.
5. The vast majority of results viewed on ICE were not filed. This is likely to be a training issue for clinicians viewing results on ICE – lack of awareness of the requirement to file results as an acknowledgement that results have been noted and appropriate action taken on results.
6. The audit tool used may not have allowed for collecting evidence of communication of results to patients by communicating a diagnosis/treatment plan rather than communicating every test result.

Recommendations:

1. Diagnostic departments to define process for alerting clinicians; include this process in the Diagnostic Policy.
2. Amend Diagnostic Policy to reflect that viewed and filed results are an acknowledgement that results have been noted by a clinician as all test results do not have to be documented in the medical records.
3. Disseminate training to clinicians on "filing" results on ICE.
4. Fill out SOP template for each specialty/CBU to define process for requesting and receiving results.
5. Re-audit with modified audit tool for communication of results to patients.

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Moderate Assurance	There is an adequate system of internal control, however, in some areas weaknesses in design and/or inconsistent application of controls puts the achievement of some aspects of the system objectives at risk.

Learning from Local Audits - continued

Standard	Actions required
1.Immediately life-threatening and high risk results should be alerted to a clinician	Process for each diagnostic department to alert a clinician on immediately life-threatening and high-risk results to be included in the Diagnostic Policy
2. Review Diagnostic Policy to include viewing and/or filing of results as acknowledgement that results have been noted by a clinician.	Review Diagnostic Policy
3. Training of clinicians on the requirement to file results on ICE	Disseminate safety message to clinicians at clinical handover meetings; include in doctors' induction training
4. Complete SOP template for each specialty/CBU	Specialty leads of each CBU to complete SOP template for diagnostic testing and review process
5. Re-audit in 6 months	Modify audit tool as per recommendations and re-audit in 6 months

Non-Clinical Incidents Q3

From 1st October to 31st December 2020, there were 326 non-clinical incidents reported. The top 2 categories were:

Security incidents = 55

The top sub-categories were:

- Aggressive behaviour by patients/relatives
- Loss
- Abuse – verbal
- Doors not locked

Health and Safety incidents = 125

The top sub-categories were:

- Injury to staff
- Needlestick Injury
- Poor temperature control/issue

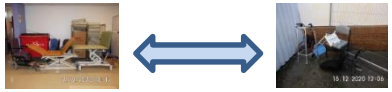
Environmental Health and Safety Inspections

At the beginning of November 2020, the Health and Safety Department were asked to complete environmental health and safety inspections of wards and departments, carry out regular corridor inspections and undertaken weekly observational tasks.

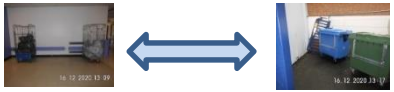
The environmental health and safety inspections are based on the Risk Assessments for the Reduction of Nosocomial Infection and the request for 2 meter bed spacing. This is to ensure control measures are being adhered to and action plans addressed. An 8 week programme was produced which covers 5-7 wards and departments each week. The Patient Safety Improvement Nurses are also in attendance to assist and review clinical practices.

Weekly unannounced observational checks are also randomly carried out whereby the Health and Safety Advisers attend a department or clinical area and observe practices to ensure hand sanitisers are being used, face masks worn, social distancing in waiting areas being adhered to, staff are wearing appropriate PPE, segregation and distancing is in place etc.

Ad hoc corridor inspections are undertaken several times a week and these are to ensure the corridors are safe, hazardous free and control measures being adhered to. The one way system is observed, PPE stations reviewed, ensure signage is relevant, face masks are being worn, social distancing is taking place, and the environment safe. Actions addressed, if found, as below.



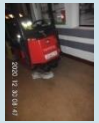
From this to this



Each Friday, detailed reports of the findings are forwarded to the Deputy Chief Nurse. These are shared with the Chief Nurse at the following Monday Silver Command meetings

Stay Alert – Don't get hurt

Learning from Non-Clinical Incidents

We found….	We Acted….
Due to the inclement weather during Quarter 3, re: rain, snow and ice, it was noted the external tugs and trailers were bringing in water along the ground floor corridors and leaving a trail of puddles. Several incidents were being raised on Datix. The Health and Safety Department contacted Facilities and asked that additional control measures were required as a preventative measure	Additional wet floor signs were ordered. Waste Operatives were asked to wipe down their tugs. Paper rolls, towels and mops were provided for each driver to ensure any excess water was cleared up. Domestic Supervisors were also asked to increase their corridor checks during inclement weather. Evidence that signage and towelling was being used  

Risk Assessments

The Health and Safety Department have been supporting various wards and departments to ensure each area has the appropriate risk assessments in place relating to COVID 19.

The 3 main risk assessments were:

- Risk Assessment for Offices, Rest Rooms and Meeting Rooms – A total of 271 individual risk assessments have been completed
- Risk Assessment for the inability to maintain 2 meter social distancing in patients bays – A total of 36 risk assessments have been completed
- Risk Assessment for the Reduction of Nosocomial Infection and the Request for 2 meter bed spacing – A total of 52 risk assessments have been completed

The Health and Safety Department have also assisted by completing a number of ad hoc risk assessments relating to COVID 19 such as:

- Risk assessment for the use of the Marquee, Conservatory Area and other Communal and Rest Areas
- Risk assessment for corridors, stair cases and entrances
- Risk assessment for the vaccination programme in the Outpatients Department
- Risk assessment for the Thank You Awards and collection of badges, cakes and bingo cards

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REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/21/03/50**	
SUBJECT:	**Infection Prevention and Control Q3 report**	
DATE OF MEETING:	31 March 2021	
AUTHOR(S):	Lesley McKay, Associate Chief Nurse, Infection Prevention + Control	
EXECUTIVE DIRECTOR SPONSOR:	Kimberley Salmon-Jamieson, Chief Nurse + Deputy Chief Executive	
LINK TO STRATEGIC OBJECTIVE: ***(Please select as appropriate)***	SO1 We will.. Always put our patients first through high quality, safe care and an excellent patient experience.	√
	SO2 We will.. Be the best place to work with a diverse, engaged workforce that is fit for the future.	√
	SO3 We will ..Work in partnership to design and provide high quality, financially sustainable services.	√
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): ***(Please DELETE as appropriate)***	#1124 Failure to provide adequate PPE caused by failures within the national supply chain and distribution routes resulting in lack of PPE for staff. #1134 Failure to provide adequate staffing caused by absence relating to COVID-19 resulting in resource challenges and an increase within the temporary staffing domain. #125 Failure to maintain an old estate caused by restriction, reduction or unavailability of resources resulting in staff and patient safety issues, increased estates costs and unsuitable accommodation.	
EXECUTIVE SUMMARY (KEY ISSUES):	This report provides a summary of infection prevention and control activity for Quarter 3 (Q3) of the 2020/21 financial year and highlights the Trust's progress against infection prevention and control key performance indicators. In Q3 the Trust reported: - • 10 Clostridium difficile cases • Nil MRSA bacteraemia cases • 8 MSSA bacteraemia cases • 13 E. coli bacteraemia cases • 5 Klebsiella spp. cases • 2 P. aeruginosa cases National healthcare associated infection reduction targets have not been set for 2020/21. An increase in the local incidence of Covid-19 was observed with cases detected: • 562 (0-2 days) • 115 (3-7 days) • 91 (8-14 days – probable healthcare associated) • 126 (15+ days – definite healthcare associated) 17 Covid-19 outbreaks occurred: - • 10 staff outbreaks • 7 combined staff/patient outbreaks Outbreak Control Groups were established to manage the Covid-19 outbreaks and learning has been shared Trust wide.	

PURPOSE: (please select as appropriate)	Information	Approval	To note √	Decision
RECOMMENDATION:	The Board is asked to receive the report.			
PREVIOUSLY CONSIDERED BY:	**Committee**	Quality Assurance Committee		
	Agenda Ref.	QAC/21/03/71		
	Date of meeting	02/03/2021		
	Summary of Outcome	Noted		
NEXT STEPS: ***State whether this report needs to be referred to at another meeting or requires additional monitoring***	**Submit to Trust Board**			
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None			

SUBJECT	Infection Prevention and Control Q3 report 2020/21	Agenda Ref:	BM/21/03/50

1. BACKGROUND/CONTEXT

This report provides an overview of infection prevention and control activity for Quarter 3 (Q3) of the 2020/21 financial year (FY). The report highlights the Trust's progress against Healthcare Associated Infection (HCAI) reduction targets and the response to the Covid-19 Pandemic.

NHSE/I use Clostridium difficile infection rates as one of a number of metrics to assess Trust performance. Both avoidable and unavoidable cases are taken into account for regulatory purposes. The Trust is assessed for breaches of the Clostridium difficile objective using a cumulative year to date (YTD) trajectory.

The zero-tolerance threshold for avoidable cases of Meticillin resistant *Staphylococcus aureus* (MRSA) bacteraemia remains in place.

There is a national ambition to halve Gram-negative bloodstream infections (GNBSIs). The Antimicrobial resistance 5 year plan provided a revised timescale to meet this objective and advises a systematic approach is required to deliver a 25% reduction by 2021-2022 with the full 50% by 2023-2024.

From the start of Q2 apportionment of bacteraemia cases (Gram positive and Gram negative) changed to include community onset healthcare associated cases (patients discharged within 28 days of positive sample being taken). Data from Q2 (onwards) has been amended to include these cases.

NHSE/I published Covid-19 case definitions as follows:

- Community-Onset – First positive specimen date ≤ 2 days after admission to Trust
- Hospital-Onset Indeterminate Healthcare-Associated - First positive specimen date 3-7 days after admission to Trust
- Hospital-Onset Probable Healthcare-Associated - First positive specimen date 8-14 days after admission to Trust
- Hospital-Onset Definite Healthcare-Associated - First positive specimen date 15 or more days after admission to Trust

A cluster of cases is defined as 2 cases arising within the same ward/department over a 14 day period. Further investigation assesses if the cases are linked and if linked this is considered an outbreak.

2. KEY ELEMENTS

HCAI data

RAG rating of Trust performance for HCAIs by month is shown in Table 1. Breakdown by ward is included at appendix 1.

Table 1: HCAI data by month

Indicator	Target	Position	A	M	J	J	A	S	O	N	D	Total
C. difficile	Local <44	Over trajectory	5	4	2	6	5	4	6	2	2	36
MRSA bacteraemia	Zero tolerance	Over trajectory	0	0	0	0	0	1	0	0	0	1
MSSA bacteraemia	No target	No target	1	2	0	6	1	2	2	3	3	20
E. coli bacteraemia	TBC	On trajectory	2	2	5	1	7	6	4	4	5	36
Klebsiella spp. bacteraemia	TBC	On trajectory	0	0	1	2	2	1	2	2	1	11
P. aeruginosa bacteraemia	TBC	On trajectory	0	0	1	0	0	0	1	1	0	3

HCAI data for Q3

Clostridium difficile

- 10 cases reported (7 hospital onset/ healthcare associated: 3 community onset/ healthcare associated)
- All hospital apportioned cases undergo post infection review
- Internal review panel meetings were suspended to focus activity on Covid-19. Review meetings have been scheduled to recommence in Q4
- The CCG have offered to host extraordinary meeting for any cases considered unavoidable by the Trust
- Ribotyping of all hospital onset/healthcare associated and community onset/ healthcare associated cases has not identified any links between the toxin positive cases

Bacteraemia Cases

From the start of Q2 apportionment of bacteraemia cases changed to include community onset/healthcare associated cases (patients with a prior hospital admission and positive sample taken within 28 days).

Gram positive bacteraemia

Meticillin resistant Staphylococcus aureus (MRSA) bacteraemia

- Nil cases reported in Q3. 1 case reported year to date

Meticillin sensitive Staphylococcus aureus MSSA bacteraemia

- 8 hospital onset cases (no national reduction target/threshold)
    - 5 hospital onset/healthcare associated
    - 3 Community onset/healthcare associated

Review of the cases year to date has identified the following primary sources: -

- 6 unknown
- 5 skin and soft tissue infection
- 3 pneumonia
- 3 peripheral cannula associated
- 2 urinary tract infection
- 1 septic arthritis

Supportive training has been provided to wards where cannula associated infections occurred and wider sharing of learning taken to Trust-wide safety brief.

Gram negative bacteraemia (GNBSI)

E coli bacteraemia

- 13 cases

Klebsiella Spp.

- 5 hospital onset cases

Pseudomonas aeruginosa

- 2 hospital onset case

Due to Covid-19 demand across the Trust, there is a reduced focus on activity for GNBSI reduction. Work is taking place in the background to refocus the reduction action plan and meetings with Quality Academy support will recommence as soon as possible.

Comparative data on HCAI cases and rates across the Northwest is included in appendix 2. Appropriate comparison with similar organisations shows:

- Similar case numbers to Local Delivery System (LDS) partners for Clostridium difficile
- Several Trusts have seen a rise in MRSA bacteraemia cases in Q3 which may relate to a reduction in hand hygiene with Covid-19 PPE use. The Trust submitted a nil return in Q3
- Similar number of MSSA bacteraemia cases for one LDS partner
- Significantly lower numbers of E. coli bacteraemia cases than both LDS partners
- Lower numbers of Klebsiella and Pseudomonas bacteraemia cases than one LDS partner and comparable case numbers with the other partner

Outbreaks/Incidents

Viral Gastroenteritis

There were no reports of viral gastroenteritis outbreaks in Q3.

Influenza

Three paediatric Patients were admitted with influenza (community acquired). This compares to national reports of low numbers of influenza cases.

Covid-19

Nosocomial cases

An increase in the local incidence of Covid-19 was observed from September. Cases detected in Q3 were identified as detailed below: -

- 562 (0-2 days)
- 115 (3-7 days)
- 91 (8-14 days – probable healthcare associated)
- 126 (15+ days – definite healthcare associated)

Cases from April 2020 are shown in Appendix 3. All cases detected ≥ day 8 of admission undergo root cause analysis. A schedule of meetings has been set up to review Nosocomial Covid-19 cases. Learning from the cases has identified several themes including: -

- Length of stay
- Missed swabbing opportunities
- Clinically Covid-19 but negative swab result
- Multiple ward moves
- Wander some patients
- Decrease in nursing cleaning score
- Occasional PPE noncompliance

Learning from Trust Outbreaks

Outbreak Control Groups are set up to investigate clusters of Covid-19 cases. During Q3, 17 Covid-19 outbreaks were reported: -

- 10 outbreaks affecting staff
- 7 outbreaks affecting both staff and patient

Themes emerging from investigation of outbreaks include: -

- Possible missed opportunity to test – hospital acquired pneumonia (HAP)
- Lack of 2 negative tests before moving patients from ED
- Multiple ward moves
- Having positive and negative patients on the same ward
- Missed day 3 and day 5 swab
- Occasional concerns with compliance with PPE
- Length of stay
- Staff car sharing
- Breaks not socially distanced
- Bed spacing < 2 metres

Challenges include: -

- Old estate – limited side / break rooms / offices
- Less clearly defined pathways (in-patients high/low risk areas)
- Patients and staff movements from /to high risk areas
- Test with possible sub-optimal performance
- Areas with lack of compliance with PPE/social distancing
- Poorly ventilated bays /wards
- Environmental hygiene – some areas of concern
- 'Presenteeism' – coming to work despite having symptoms

Next steps include: -

- Introduce point of care admission screening to meet 2 negative screens prior to moving guidance
- Further review use of physical barriers pods where inpatient beds are < 2 metres apart
- Increase uptake of Lateral Flow Testing
- Continue to provide and reinforce updates on Covid-19 IPC precautions
- Continue review and thematic analysis of RCAs from nosocomial cases
- Staff vaccination programme completion
- Streaming of patients to Covid/non-Covid wards timely to avoid both cohorts being on the same ward as far as reasonably practicable
- SJR for patients who die following nosocomial Covid

The additional hydrogen peroxide vapour machines for environmental decontamination have been put in to use to ensure appropriate levels of decontamination are achieved.

The Infection Prevention and Control Team members continued to provide education and road shows where staff raised concerns about PPE guidance. The programme of Fit Testing of FFP3 respirators has continued.

The risk assessment to support the re-introduction of visiting has been recirculated in preparation for lockdown restrictions being lifted. Compassionate visiting arrangements remain in place and visitors are supported with training on use of PPE.

The procurement team continue to provide an extended service and have maintained availability of personal protective equipment throughout the pandemic. PPE stock levels remains under constant review. Mutual aid from other Trust is in place. Scrub Suits continue to be offered as an alternative to home laundering of uniforms. A national managed inventory has been implemented to ensure Trusts have a 7 -14 day supply (dependant on storage capacity). Additional steps with quality control have been taken at national level.

The Environmental Action Plan produced jointly with Infection Prevention and Control, the Associate Director of Estates and Facilities and the Deputy Chief Nurse for Patient Safety has been updated. This action plan incorporates a number of other actions including: reduction of entrances/exits, signage promoting social distancing, Perspex barriers at reception desks, ensuring high standards of cleanliness and risk assessments to create Covid secure areas for staff. A risk assessment tool has been implemented across the Trust.

NHSE/I have published an update to the Board Assurance Framework linked to the Code of Practice on prevention of Healthcare Associated Infections. The Trust compliance has been reassessed and a paper submitted to the Quality Assurance Committee and Trust Board. An action plan has been developed to support minor gaps in assurance.

Infection Prevention and Control Training

Overall compliance with Mandatory training was 84% in December 2020.

Table 3 Infection Control Training compliance

Infection Control Training	A	M	J	J	A	S	O	N	D
Overall % of staff trained	-	84%	-	-	85%	-	-	-	84

Level 2 (clinical training) is 75%. Face to Face mandatory infection control training was halted due to the pandemic and will recommence as part of the recovery schedule. All Clinical Business Units have been requested to set an improvement trajectory. The Infection Prevention and Control Nurses will be providing additional training during Q3 to drive improved compliance.

Infection Prevention and Control Audits

The IPCN audits were halted due to the Covid-19 pandemic and will recommence as part of the recovery schedule. Auditing of hand hygiene and Personal Protective Equipment (PPE) compliance for both aerosol generating and non-aerosol generating procedures is in place across the Trust with nil significant issues highlighted.

Environmental Hygiene

The frequency of cleanliness monitoring has been increased in areas where outbreaks of Covid-19 have been reported. Activity in place pre pandemic to implement the recommendations of the draft National Standards of Healthcare Cleanliness document will recommence as part of the recovery schedule. Hydrogen peroxide vapour has been used to support terminal cleaning of vacant wards and enhanced following the purchase of additional equipment.

Infection Control Sub-Committee

The Sub-Committee meetings met once during Q3.

Awareness raising events

The Infection Prevention and Control Team have focussed awareness raising activity throughout Q3 on Covid-19.

3. ACTIONS REQUIRED/RESPONSIBLE OFFICER

- Develop the Infection Prevention and Control Service recovery plan
- Publish the Infection Prevention and Control Strategy
- Continue to provide expert advice throughout the pandemic
- Update the healthcare associated reduction action plans into healthcare associated infection prevention plans

4. IMPACT ON QPS

- Q: A reduction in HCAIs will demonstrate a positive impact on patient outcomes
- P: Improved attendance at training assists staff in fulfilling mandatory training requirements
- S: Reduction in HCAIs supports sustainability by avoidance of contractual financial penalties

5. MEASUREMENTS/EVALUATIONS

- Mandatory reporting of healthcare associated infection (HCAI) to Public Health England
- Surveillance of hospital onset Covid-19 cases
- The Infection Prevention and Control Team meet to monitor cases of HCAI. Action is implemented in response to increased incidences of HCAIs and infection control related incidents
- The Infection Control Sub-Committee will aim to meet monthly (12 times per annum) and discusses HCAI surveillance data and learning from HCAI incidents
- Meetings will take place weekly to review HCAI incident investigation reports and agree actions to support care improvements
- Healthcare Associated Infection data is included in the Ward Dashboard data

6. TRAJECTORIES/OBJECTIVES AGREED

- The Clostridium difficile threshold for 2020/2021 has been set locally at ≤ 44 cases
- There is a national GNBSI target of 25% reduction by 2021/2022 and the full 50% reduction by 2024. A 5% GNBSI reduction target has been set as a priority within the Quality Strategy
- The zero tolerance to avoidable MRSA bacteraemia cases remains in place

Work streams will continue to:-

- Progress GNBSI reduction
- Launch the revised Urinary Catheter Passport – which has been adapted across Cheshire and Merseyside
- Reduce the incidence of Clostridium difficile infection and implement learning from incidents
- Promote Antimicrobial Stewardship and challenge inappropriate prescribing
- Partnership working with Urgent and Emergency Care CBU to support timely blood culture sampling
- Implement Covid-19 screening competency assessments
- Monitor invasive device management/bacteraemia reduction
- Recommence ANTT competency assessor training
- Implement an infection control surveillance systems including Catheter Associated UTI

- Support staff training in Infection Prevention and Control where CBU compliance is lower than 85%
- Promote excellent standards in uniform/workwear and the Bare Below the Elbows campaign
- Promote excellence in adherence to Covid-19 PPE guidance
- Support assessment of decontamination standards
- Enhance the surgical site infection surveillance programme
- Implement a recovery plan to review overdue policies

7. MONITORING/REPORTING ROUTES

High level briefing papers from the Infection Control Sub-Committee are submitted to:-

- Quality and Assurance Committee
- Health and Safety Sub-Committee
- Patient Safety and Clinical Effectiveness Committee

DIPC reports are submitted quarterly to the Quality and Assurance Committee and Trust Board.

Verbal updates are provided to Trust Board monthly as part of the Integrated Performance Report.

A Director of Infection Prevention and Control Report is submitted to Trust Board annually.

Exception reports will be submitted to the Quality and Assurance Committee when increased incidences of infection are identified.

Daily monitoring by the Senior Executive Oversight Group during the pandemic

8. TIMELINES

2020/21 Financial Year

9. ASSURANCE COMMITTEE

- Infection Control Sub-Committee

10. RECOMMENDATIONS

The Quality Assurance Committee is asked to: note the content of the report; the exceptions reported and the progress made.

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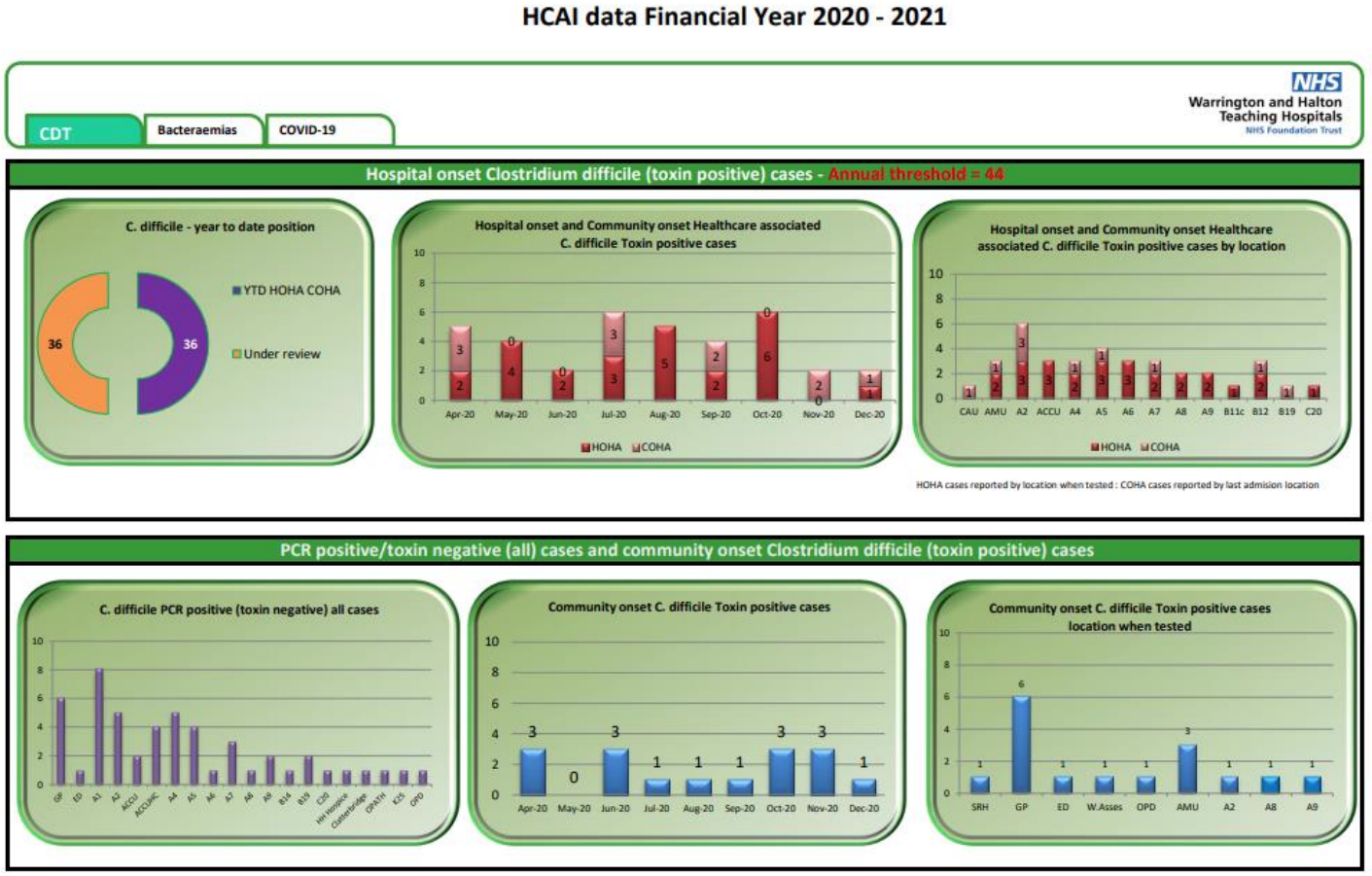
APPENDIX 1 Healthcare Associated Infection Data April – December 2020

Clostridium difficile Cases



Hospital onset/Healthcare associated = HOHA
Community onset/Healthcare assocaiated = COHA
Community onset/Healthcare associated cases are linked to the ward the patient was most recently discharged from

April - December 2020

Gram Positive Bacteraemia Cases

HCAI data Financial Year 2020 - 2021

Hospital onset/Healthcare associated = HOHA
Community onset/Healthcare assocaiated = COHA
Community onset/Healthcare associated cases are linked to the ward the patient was most recently discharged from

April - December 2020

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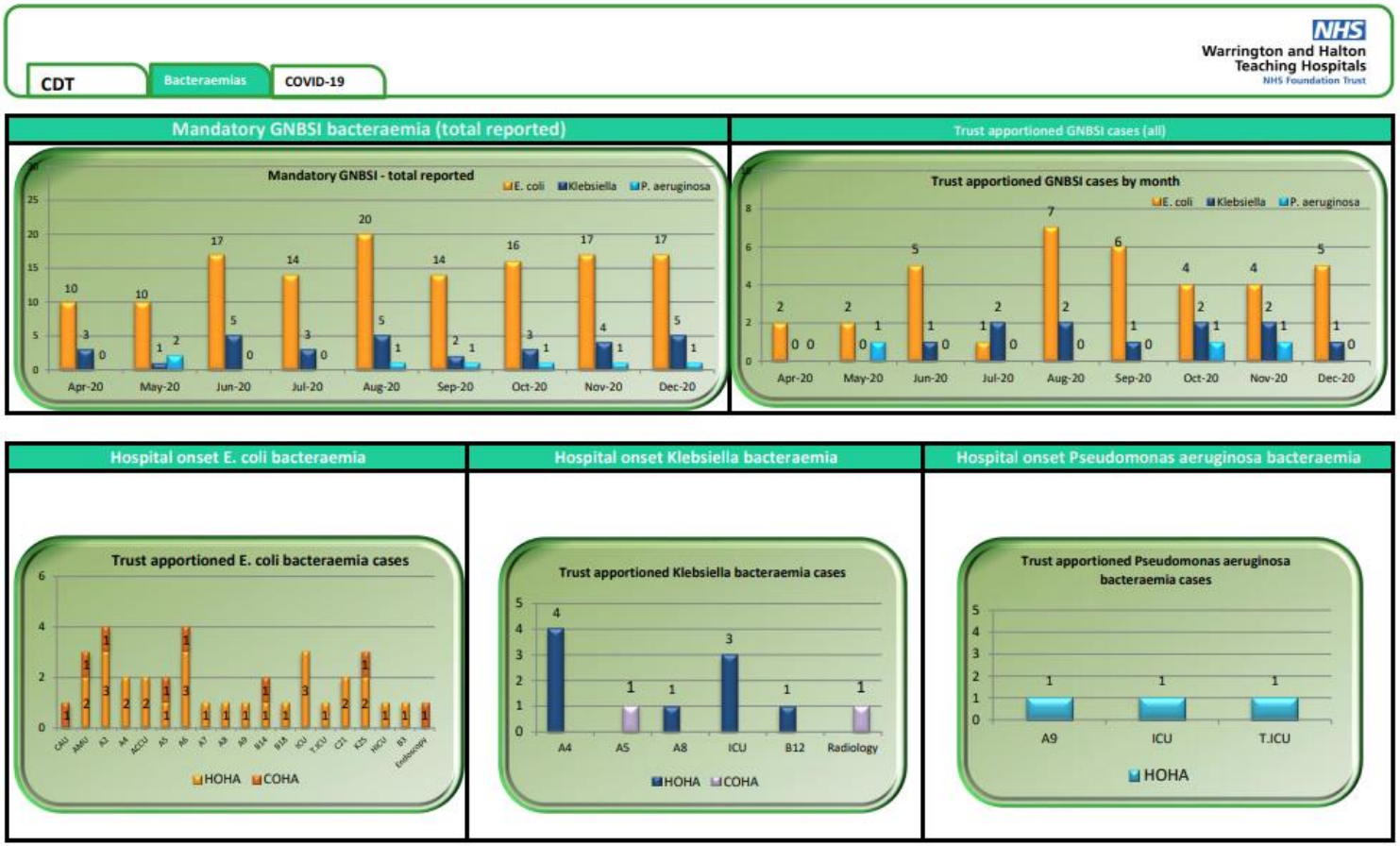
Gram Negative Bacteraemia Cases

HCAI data Financial Year 2020 - 2021



Hospital onset/Healthcare associated = HOHA
Community onset/Healthcare assocaiated = COHA
Community onset/Healthcare associated cases are linked to the ward the patient was most recently discharged from

April - December 2020

APPENDIX 2 COMPARISION OF HEALTHCARE ASSOCIATED INFECTION DATA ACROSS THE NORTHWEST

Clostridium difficile (January to December 2020)

Public Health England

C. difficile annual tables: healthcare associated cases & rates by Trust (hospital onset & community onset)

Organisation Name	January to December 2020	Rate per 100,000 bed days	Significance
ALDER HEY CHILDREN'S NHS FOUNDATION TRUST	6	11.7	Low (0.001)
BLACKPOOL TEACHING HOSPITALS NHS FOUNDATION TRUST	98	50.6	High (0.001)
BOLTON NHS FOUNDATION TRUST	51	27.9	
COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST	40	26.5	
EAST CHESHIRE NHS TRUST	12	13.7	Low (0.001)
EAST LANCASHIRE HOSPITALS NHS TRUST	74	29.2	
LANCASHIRE TEACHING HOSPITALS NHS FOUNDATION TRUST	109	49.2	High (0.001)
LIVERPOOL HEART AND CHEST HOSPITAL NHS FOUNDATION TRUST	5	14.3	Low (0.025)
LIVERPOOL WOMEN'S NHS FOUNDATION TRUST	0	0.0	
LIVERPOOL UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	117	26.7	
MANCHESTER UNIVERSITY NHS FOUNDATION TRUST	174	34.2	
MID CHESHIRE HOSPITALS NHS FOUNDATION TRUST	23	14.9	Low (0.001)
NORTH CUMBRIA INTEGRATED CARE NHS FOUNDATION TRUST	81	48.0	High (0.001)
PENNINE ACUTE HOSPITALS NHS TRUST	93	28.5	
SALFORD ROYAL NHS FOUNDATION TRUST	47	22.5	Low (0.025)
SOUTHPORT AND ORMSKIRK HOSPITAL NHS TRUST	36	30.4	
ST HELENS AND KNOWSLEY TEACHING HOSPITALS NHS TRUST	48	22.3	Low (0.025)
STOCKPORT NHS FOUNDATION TRUST	32	19.3	Low (0.025)
TAMESIDE AND GLOSSOP INTEGRATED CARE NHS FOUNDATION TRUST	34	30.6	
THE CHRISTIE NHS FOUNDATION TRUST	32	71.5	High (0.001)
THE CLATTERBRIDGE CANCER CENTRE NHS FOUNDATION TRUST	4	20.5	
THE WALTON CENTRE NHS FOUNDATION TRUST	3	8.1	Low (0.001)
UNIVERSITY HOSPITALS OF MORECAMBE BAY NHS FOUNDATION TRUST	60	31.7	
WARRINGTON AND HALTON TEACHING HOSPITALS NHS FOUNDATION TRUST	49	31.7	
WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FOUNDATION TRUST	56	28.7	
WRIGHTINGTON, WIGAN AND LEIGH NHS FOUNDATION TRUST	42	30.7	
North West	1326	30.2	

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MRSA – Annual rolling rate (October – December 2020)

Public Health England

MRSA quarterly tables: Trust cases & rates

Organisation Name	October to December 2020	Rate per 100,000 bed days	Significance
ALDER HEY CHILDREN'S NHS FOUNDATION TRUST	0	0.0	
BLACKPOOL TEACHING HOSPITALS NHS FOUNDATION TRUST	0	0.0	
BOLTON NHS FOUNDATION TRUST	0	0.0	
COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST	0	0.0	
EAST CHESHIRE NHS TRUST	0	0.0	
EAST LANCASHIRE HOSPITALS NHS TRUST	2	3.2	
LANCASHIRE TEACHING HOSPITALS NHS FOUNDATION TRUST	0	0.0	
LIVERPOOL HEART AND CHEST HOSPITAL NHS FOUNDATION TRUST	0	0.0	
LIVERPOOL WOMEN'S NHS FOUNDATION TRUST	1	17.0	
LIVERPOOL UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	0	0.0	
MANCHESTER UNIVERSITY NHS FOUNDATION TRUST	6	5.0	
MID CHESHIRE HOSPITALS NHS FOUNDATION TRUST	0	0.0	
NORTH CUMBRIA UNIVERSITY HOSPITALS NHS TRUST	0	0.0	
PENNINE ACUTE HOSPITALS NHS TRUST	0	0.0	
SALFORD ROYAL NHS FOUNDATION TRUST	2	4.0	
SOUTHPORT AND ORMSKIRK HOSPITAL NHS TRUST	0	0.0	
ST HELENS AND KNOWSLEY TEACHING HOSPITALS NHS TRUST	1	1.8	
STOCKPORT NHS FOUNDATION TRUST	0	0.0	
TAMESIDE AND GLOSSOP INTEGRATED CARE NHS FOUNDATION TRUST	0	0.0	
THE CHRISTIE NHS FOUNDATION TRUST	0	0.0	
THE CLATTERBRIDGE CANCER CENTRE NHS FOUNDATION TRUST	0	0.0	
THE WALTON CENTRE NHS FOUNDATION TRUST	0	0.0	
UNIVERSITY HOSPITALS OF MORECAMBE BAY NHS FOUNDATION TRUST	1	2.1	
WARRINGTON AND HALTON TEACHING HOSPITALS NHS FOUNDATION TRUST	0	0.0	
WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FOUNDATION TRUST	0	0.0	
WRIGHTINGTON, WIGAN AND LEIGH NHS FOUNDATION TRUST	1	2.8	
North West	14	1.3	

MSSA – Annual rolling rate (October – December 2020)

Public Health England

MSSA quarterly tables: Trust cases & rates

Organisation Name	October to December 2020	Rate per 100,000 bed days	Significance
ALDER HEY CHILDREN'S NHS FOUNDATION TRUST	4	30.0	
BLACKPOOL TEACHING HOSPITALS NHS FOUNDATION TRUST	7	13.9	
BOLTON NHS FOUNDATION TRUST	5	12.2	
COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST	4	11.0	
EAST CHESHIRE NHS TRUST	0	0.0	
EAST LANCASHIRE HOSPITALS NHS TRUST	20	31.6	
LANCASHIRE TEACHING HOSPITALS NHS FOUNDATION TRUST	7	13.2	
LIVERPOOL HEART AND CHEST HOSPITAL NHS FOUNDATION TRUST	7	76.9	
LIVERPOOL WOMEN'S NHS FOUNDATION TRUST	0	0.0	
LIVERPOOL UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	16	14.8	
MANCHESTER UNIVERSITY NHS FOUNDATION TRUST	30	24.8	
MID CHESHIRE HOSPITALS NHS FOUNDATION TRUST	4	10.6	
NORTH CUMBRIA INTEGRATED CARE NHS FOUNDATION TRUST	8	18.8	
PENNINE ACUTE HOSPITALS NHS TRUST	14	17.7	
SALFORD ROYAL NHS FOUNDATION TRUST	12	24.0	
SOUTHPORT AND ORMSKIRK HOSPITAL NHS TRUST	3	9.9	
ST HELENS AND KNOWSLEY TEACHING HOSPITALS NHS TRUST	8	14.6	
STOCKPORT NHS FOUNDATION TRUST	0	0.0	
TAMESIDE AND GLOSSOP INTEGRATED CARE NHS FOUNDATION TRUST	3	11.3	
THE CHRISTIE NHS FOUNDATION TRUST	3	27.9	
THE CLATTERBRIDGE CANCER CENTRE NHS FOUNDATION TRUST	2	37.5	
THE WALTON CENTRE NHS FOUNDATION TRUST	4	44.4	
UNIVERSITY HOSPITALS OF MORECAMBE BAY NHS FOUNDATION TRUST	6	12.9	
WARRINGTON AND HALTON TEACHING HOSPITALS NHS FOUNDATION TRUST	8	20.9	
WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FOUNDATION TRUST	9	18.8	
WRIGHTINGTON, WIGAN AND LEIGH NHS FOUNDATION TRUST	5	13.9	
North West	189	17.5	

E. coli bacteraemia – Quarterly data (October – December 2020)

Public Health England

E. coli quarterly tables: Trust cases & rates

Organisation Name	October to December 2020	Rate per 100,000 bed days	Significance
ALDER HEY CHILDREN'S NHS FOUNDATION TRUST	1	7.5	Low (0.025)
BLACKPOOL TEACHING HOSPITALS NHS FOUNDATION TRUST	29	57.7	
BOLTON NHS FOUNDATION TRUST	9	21.9	Low (0.025)
COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST	18	49.3	
EAST CHESHIRE NHS TRUST	6	29.2	
EAST LANCASHIRE HOSPITALS NHS TRUST	30	47.5	
LANCASHIRE TEACHING HOSPITALS NHS FOUNDATION TRUST	21	39.6	
LIVERPOOL HEART AND CHEST HOSPITAL NHS FOUNDATION TRUST	4	43.9	
LIVERPOOL WOMEN'S NHS FOUNDATION TRUST	1	17.0	
LIVERPOOL UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	37	34.2	
MANCHESTER UNIVERSITY NHS FOUNDATION TRUST	52	42.9	
MID CHESHIRE HOSPITALS NHS FOUNDATION TRUST	8	21.2	Low (0.025)
NORTH CUMBRIA INTEGRATED CARE NHS FOUNDATION TRUST	26	61.2	
PENNINE ACUTE HOSPITALS NHS TRUST	33	41.8	
SALFORD ROYAL NHS FOUNDATION TRUST	16	32.0	
SOUTHPORT AND ORMSKIRK HOSPITAL NHS TRUST	16	53.0	
ST HELENS AND KNOWSLEY TEACHING HOSPITALS NHS TRUST	22	40.3	
STOCKPORT NHS FOUNDATION TRUST	16	39.8	
TAMESIDE AND GLOSSOP INTEGRATED CARE NHS FOUNDATION TRUST	9	34.0	
THE CHRISTIE NHS FOUNDATION TRUST	11	102.2	
THE CLATTERBRIDGE CANCER CENTRE NHS FOUNDATION TRUST	3	56.2	
THE WALTON CENTRE NHS FOUNDATION TRUST	2	22.2	
UNIVERSITY HOSPITALS OF MORECAMBE BAY NHS FOUNDATION TRUST	26	55.7	
WARRINGTON AND HALTON TEACHING HOSPITALS NHS FOUNDATION TRUST	13	33.9	
WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FOUNDATION TRUST	20	41.8	
WRIGHTINGTON, WIGAN AND LEIGH NHS FOUNDATION TRUST	12	33.4	
North West	441	40.9	

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NHS
Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Klebsiella bacteraemia - Annual rolling rate (October – December 2020)

Public Health England

Klebsiella quarterly tables: Trust cases & rates

Organisation Name	October to December 2020	Rate per 100,000 bed days	Significance
ALDER HEY CHILDREN'S NHS FOUNDATION TRUST	2	15.0	
BLACKPOOL TEACHING HOSPITALS NHS FOUNDATION TRUST	9	17.9	
BOLTON NHS FOUNDATION TRUST	4	9.7	
COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST	2	5.5	Low (0.025)
EAST CHESHIRE NHS TRUST	2	9.7	
EAST LANCASHIRE HOSPITALS NHS TRUST	9	14.2	
LANCASHIRE TEACHING HOSPITALS NHS FOUNDATION TRUST	8	15.1	
LIVERPOOL HEART AND CHEST HOSPITAL NHS FOUNDATION TRUST	0	0.0	
LIVERPOOL WOMEN'S NHS FOUNDATION TRUST	1	17.0	
LIVERPOOL UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	13	12.0	
MANCHESTER UNIVERSITY NHS FOUNDATION TRUST	36	29.7	High (0.025)
MID CHESHIRE HOSPITALS NHS FOUNDATION TRUST	3	7.9	
NORTH CUMBRIA INTEGRATED CARE NHS FOUNDATION TRUST	8	18.8	
PENNINE ACUTE HOSPITALS NHS TRUST	11	13.9	
SALFORD ROYAL NHS FOUNDATION TRUST	12	24.0	
SOUTHPORT AND ORMSKIRK HOSPITAL NHS TRUST	4	13.3	
ST HELENS AND KNOWSLEY TEACHING HOSPITALS NHS TRUST	11	20.1	
STOCKPORT NHS FOUNDATION TRUST	6	14.9	
TAMESIDE AND GLOSSOP INTEGRATED CARE NHS FOUNDATION TRUST	7	26.4	
THE CHRISTIE NHS FOUNDATION TRUST	5	46.5	
THE CLATTERBRIDGE CANCER CENTRE NHS FOUNDATION TRUST	3	56.2	
THE WALTON CENTRE NHS FOUNDATION TRUST	2	22.2	
UNIVERSITY HOSPITALS OF MORECAMBE BAY NHS FOUNDATION TRUST	8	17.2	
WARRINGTON AND HALTON TEACHING HOSPITALS NHS FOUNDATION TRUST	5	13.0	
WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FOUNDATION TRUST	7	14.6	
WRIGHTINGTON, WIGAN AND LEIGH NHS FOUNDATION TRUST	3	8.4	
North West	181	16.8	

Pseudomonas aeruginosa - Annual rolling rate (October – December 2020)

Public Health England

Pseudomonas aeruginosa quarterly tables: Trust cases & rates

Organisation Name	October to December 2020	Rate per 100,000 bed days	Significance
ALDER HEY CHILDREN'S NHS FOUNDATION TRUST	3	22.5	
BLACKPOOL TEACHING HOSPITALS NHS FOUNDATION TRUST	3	6.0	
BOLTON NHS FOUNDATION TRUST	2	4.9	
COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST	0	0.0	
EAST CHESHIRE NHS TRUST	1	4.9	
EAST LANCASHIRE HOSPITALS NHS TRUST	4	6.3	
LANCASHIRE TEACHING HOSPITALS NHS FOUNDATION TRUST	1	1.9	
LIVERPOOL HEART AND CHEST HOSPITAL NHS FOUNDATION TRUST	2	22.0	
LIVERPOOL WOMEN'S NHS FOUNDATION TRUST	0	0.0	
LIVERPOOL UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	5	4.6	
MANCHESTER UNIVERSITY NHS FOUNDATION TRUST	9	7.4	
MID CHESHIRE HOSPITALS NHS FOUNDATION TRUST	2	5.3	
NORTH CUMBRIA INTEGRATED CARE NHS FOUNDATION TRUST	2	4.7	
PENNINE ACUTE HOSPITALS NHS TRUST	4	5.1	
SALFORD ROYAL NHS FOUNDATION TRUST	3	6.0	
SOUTHPORT AND ORMSKIRK HOSPITAL NHS TRUST	1	3.3	
ST HELENS AND KNOWSLEY TEACHING HOSPITALS NHS TRUST	6	11.0	
STOCKPORT NHS FOUNDATION TRUST	1	2.5	
TAMESIDE AND GLOSSOP INTEGRATED CARE NHS FOUNDATION TRUST	2	7.5	
THE CHRISTIE NHS FOUNDATION TRUST	5	46.5	
THE CLATTERBRIDGE CANCER CENTRE NHS FOUNDATION TRUST	1	18.7	
THE WALTON CENTRE NHS FOUNDATION TRUST	0	0.0	
UNIVERSITY HOSPITALS OF MORECAMBE BAY NHS FOUNDATION TRUST	5	10.7	
WARRINGTON AND HALTON TEACHING HOSPITALS NHS FOUNDATION TRUST	2	5.2	
WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FOUNDATION TRUST	4	8.4	
WRIGHTINGTON, WIGAN AND LEIGH NHS FOUNDATION TRUST	6	16.7	
North West	74	6.9	

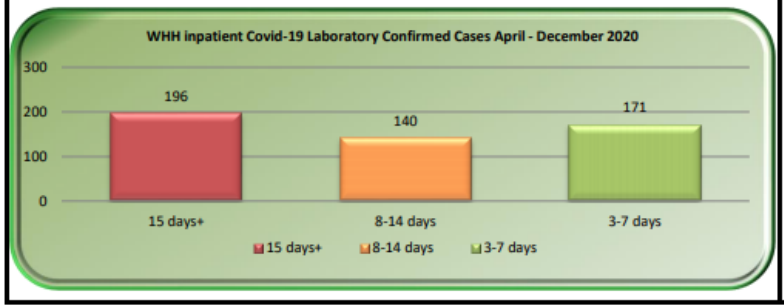
APPENDIX 3 COVID-19 Cases

HCAI data Financial Year 2020 - 2021

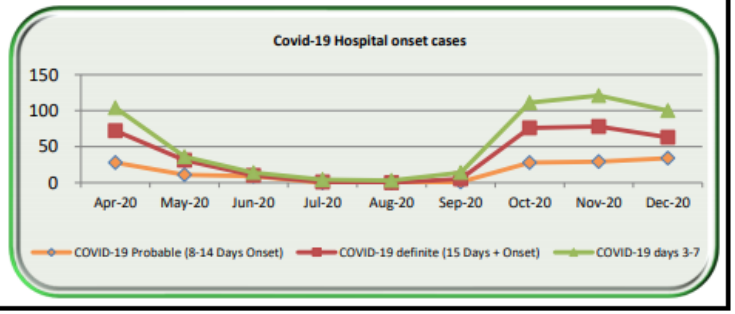
CDT | Bacteraemias | COVID-19

NHS Warrington and Halton Teaching Hospitals NHS Foundation Trust

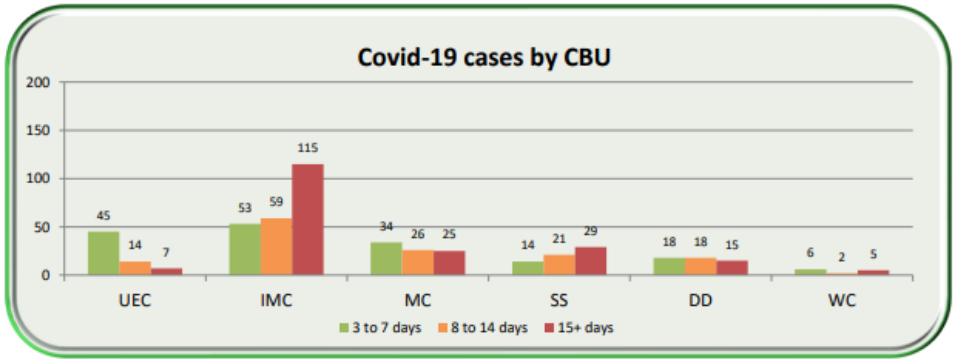
COVID-19 - Total inpatient cases from April - December 2020



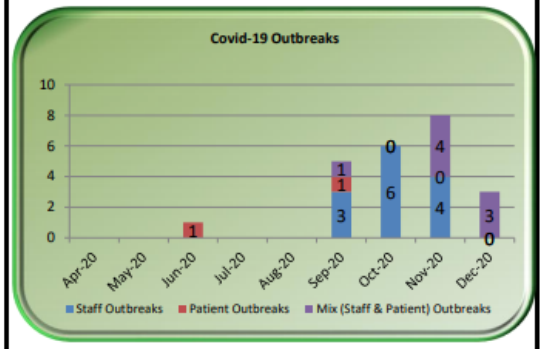
Covid-19 Cases by Month



Day 8-14 and 15+ combined from April - December



Outbreaks



April - December 2020

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/21/03/51**	
SUBJECT:	**Maternity Serious Incident Report**	
DATE OF MEETING:	31st March 2021	
AUTHOR(S):	Layla Alani, Deputy Director Governance	
EXECUTIVE DIRECTOR SPONSOR:	Kimberley Salmon-Jamieson, Chief Nurse & Deputy Chief Executive	
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	SO1 We will.. Always put our patients first through high quality, safe care and an excellent patient experience. SO2 We will.. Be the best place to work with a diverse, engaged workforce that is fit for the future. SO3 We will ..Work in partnership to design and provide high quality, financially sustainable services.	x
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF):	#1108 Failure to maintain staffing levels, caused by high sickness and absence, including those affected by Covid, resulting in inability to fill midwifery shifts. This also currently affects the CBU management team.	
EXECUTIVE SUMMARY *(KEY ISSUES):*	In 2017, following a letter from bereaved families raising concerns regarding the delivery of maternity services at Shrewsbury and Telford Hospital NHS Trust a review was commissioned by the former Secretary of State for Health and Social Care. In December 2020 this review was shared with all Trusts with clear recommendations identified, one of which was the sharing of Serious Incident (SI) information for assurance of learning from ward to board. This information must also be shared with the Local Maternity System (LMS) and the Trust await further guidance upon this process. This report will provide detail on the number of SIs reported and number completed at WHH in February 2021 with learning identified.	

PURPOSE: *(please select as appropriate)*	Information	Approval	To note	Decision
			x	

RECOMMENDATION:	The Board of Directors is asked to receive the report.	
PREVIOUSLY CONSIDERED BY:	**Committee**	Quality Assurance Committee
	Agenda Ref.	
	Date of meeting	
	Summary of Outcome	
FREEDOM OF INFORMATION STATUS (FOIA):		
FOIA EXEMPTIONS APPLIED: ***(if relevant)***		

REPORT TO BOARD OF DIRECTORS

SUBJECT	Maternity Serious Incident Report	AGENDA REF:	BM/21/03/51

1. Background

In 2017, following a letter from bereaved families raising concerns regarding the delivery of maternity services at Shrewsbury and Telford Hospital NHS Trust a review was commissioned by the former Secretary of State for Health and Social Care. In December 2020, this review was shared with all Trusts with clear recommendations identified, one of which was the sharing of Serious Incident (SI) information for assurance of learning from ward to board. This information must also be shared with the Local Maternity System (LMS) and the Trust await further guidance upon this process.

This report will provide detail on the number of SIs reported and number completed at WHH in February 2021 with learning identified.

2. Key Elements and Lessons Learned

2.1 In February 2021 Maternity services at WHH reported 2 new Serious Incidents (SI) for investigation:

2.1.1 StEIS 2021/2749

Description: The woman was 36 weeks and 6 days gestation (tern is 37-42 weeks) at the time of the incident. The Perinatal Mortality Review Tool (PMRT) panel reviewed all aspects of the womans' care from her booking appointment through to her bereavement care. The panel identified that there was a missed opportunity to admit the woman to the maternity ward on 13/10/20 for regular monitoring of maternal and fetal wellbeing. The team said this may have made a difference to the pregnancy outcome. The cause of death of her baby was determined to be placental high grade fetal malperfusion syndrome, which represents a recognisable pattern of injury to the placenta related to altered uterine and intervillous blood flow. The post-mortem also showed congenital anomalies.

Actions following PMRT:

- Individual reflection with ST5 doctor to ensure they realise the importance of discussing complex pregnancy care with a consultant obstetrician.
- As this woman was diagnosed with Intrahepatic cholestasis of pregnancy (ICP) which affects around 5,500 women a year, causing premature birth and, in extreme cases, stillbirth. The ST5 doctor was asked to reflect and prepare a presentation on the Lancet paper regarding the PITCHES study (a research study into ICP published August 2019). to be shared and discussed with all obstetricians and midwives to ensure learning.

2.1.2 StEIS 2021/4551

Description: A 31-year-old woman at 27 weeks and 2 days gestation presented to maternity triage with a first episode of reduced fetal movements. The woman had a computerised Cardiotocograph (CTG) (Dawse Redman Criteria) recording to check fetal wellbeing. The computerised programme used is commonly known as the 'Dawes Redman criteria[1]'and looks at a set of markers. The Dawes Redman criteria was not met and so did not confirm fetal wellbeing. The CTG was repeated as appropriate. The second and third CTG also did not meet the Dawes Redman criteria. The fourth CTG met the Dawes Redman. The woman received a medical review from a junior obstetrician who discharged her home with safety net advice to return if further concerns. The woman came back to triage 2 days later with reduced fetal movements and the baby had sadly died.

A PMRT review took place on 26/02/2021 and the PMRT panel decided that different antenatal care may or would have a made a difference to the outcome (D Grade on PMRT), up to the point that the baby was confirmed as having died. The panel identified that there was a missed opportunity for the junior obstetrician to discuss the womans' care and the CTGs with a consultant obstetrician (as outlined in the Trust fetal monitoring policy) and to organise an ultrasound scan because the Dawes Redman criteria had not previously

[1] Dawes/Redman criteria are evaluated at the end of the process. To check against the criteria the program detects fetal heart rate accelerations and decelerations. It also estimates the fetal heart baseline, short-term variation (STV), long-term variation (LTV), the basal heart rate and evaluates if there is a possible sinusoidal pattern.

met. The PMRT panel also identified that a partogram should have been started earlier when the woman was in labour.

Actions following PMRT:

- The two midwives and the doctor involved in the incident will complete fetal monitoring and reflective learning pathway. Training for the maternity team was instigated regarding the: -
    - Use of Dawes Redman criteria
    - Computerised fetal monitoring guideline
    - Reduced fetal movements guideline
- Lessons learned have been shared with the maternity team and midwives and Birth Suite shift leaders have been reminded to ensure a partogram is completed.

2.2 At the time of this report, there are five on-going Serious Incident (SI) investigations relating to WHH Maternity services, findings will be shared upon completion of the investigations. There were no Maternity related SIs completed in February 2021.

3.0 MONITORING/REPORTING ROUTES

The SI action plans are monitored within the Clinical Business Unit with the support of the Governance Manager. All concise reviews and SI's are discussed at the weekly meeting of harm when the investigation is complete. This ensures executive sign off all incidents involving care graded as moderate harm or above. All maternity SIs are reported via the Quality Assurance Committee monthly and updates are provided weekly to the Strategic Oversight Group (this includes maternity).

4.0 RECOMMENDATIONS

The Board of Directors is asked to receive the report.

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Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/21/03/52**			
SUBJECT:	**Volunteer Annual Report 2020**			
DATE OF MEETING:	24 March 2021			
AUTHOR(S):	John Goodenough, Deputy Chief Nurse			
EXECUTIVE DIRECTOR SPONSOR:	Kimberley Salmon-Jamieson, Chief Nurse & Deputy Chief Executive			
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	SO1 We will.. Always put our patients first through high quality, safe care and an excellent patient experience.	*		
	SO2 We will.. Be the best place to work with a diverse, engaged workforce that is fit for the future.			
	SO3 We will ..Work in partnership to design and provide high quality, financially sustainable services.			
EXECUTIVE SUMMARY ***(KEY ISSUES):***	The annual review for WHH Volunteers covers the year April 2019 to March 2020. The report outlines key statistics on recruitment and highlights the many programmes and opportunities where Volunteers have impacted the work of staff in both clinical and non-clinical settings. Through engaging volunteers we have supported improvements in patient experience, complimented health care and enhanced the quality at Warrington and Halton Teaching Hospitals (WHTH).			
PURPOSE: ***(please select as appropriate)***	Information *	Approval	To note *	Decision
RECOMMENDATION:	The Board of Directors is recommended to receive and note the contents of this report.			
PREVIOUSLY CONSIDERED BY:	**Committee**	Strategic People Committee		
	Agenda Ref.	SPC/21/01/07		
	Date of meeting	02.03.2021		
	Summary of Outcome	Notes		
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None			

VOLUNTEERING

Making a difference at WHH

INTRODUCTION

This year has seen a marked increase in visibility and engagement of volunteers across the many departments at all our hospital sites. There have been some exciting pilot projects and new services developing that have potential to impact our patient's health and wellbeing and have a more positive experience when visiting our sites and services.

We also supported our staff to test out innovative projects and ideas to improve your own wellbeing; raise awareness of issues that could affect you and promote ways to improve your mental health.

WHAT HAVE WE DONE?

Now a well-established service, we have continued to recruit volunteers throughout the year, working with our WHTH Colleagues to deliver bespoke training for pilot projects; supporting the development of new policies to allow pets as therapy dogs to visit patients amongst others. Here are some highlights:

IN THE PAST YEAR WE HAVE:

- Worked with staff in the Trust on developing a range of new volunteering opportunities that support the overall priorities on patient safety, improving quality, reducing demand and improving patient flow and wellbeing. These include: Volunteer Readers, Dining Companions, Ward Buddies, Discharge Support, Way Finders, Pets as Therapy Volunteers, Breast Clinic Volunteers, Patient Simulation Volunteers, Theatre Volunteers, Front Entrance Meet & Greet Volunteers, Friends and Family test volunteers, Morning Movers.
- Supported staff in understanding the uniqueness of volunteers; their skills, experience and support and how this compliments and adds value to the valuable work of all departments.
- We have continued to work with colleagues to improve the experience of induction for volunteers integrating a specific exercise with our Clinical Skills Educators on understanding a patients area within a ward setting and the communication between patient, volunteer and ward team.
- Improved and adapted our volunteer management portal with key new features, shift rotas and communications for all engaging in its use. Volunteers are now starting to regularly log the hours they have completed and provide feedback on their experience.
- Working with The Reader Organisation, WHH Staff and chosen wards, our volunteers supported a unique programme to test out reading out loud with our patients and the lasting impact on health, wellbeing and recovery. This initiative was submitted for a national award towards the end of this financial year.
- We have introduced a Wellbeing & Social Intervention training module to the volunteer induction, that supports our ambition that the volunteer workforce are implementing evidenced wellbeing approaches and top tips for promoting self care.
- We piloted our Dining Companion Volunteer Role on Ward A1 working alongside our Clinical Skills Educators to put together bespoke training. This gave our volunteers, knowledge and skills in preparation, encouragement and completion of a busy mealtime environment. It provided additional personnel resources to allow clinical staff to focus on those who needed support.
- There's no place like home when a patient knows they can go home and in our Discharge Suite, volunteers were welcomed with open arms by the team, making them feel a part of an important step for our patients. The staff have seen and experienced the benefits of not just an extra pair of hands but the difference having a volunteer involved can make to the patients through their social and friendly interaction.
- Through engaging volunteers to support the Therapist Teams, the Morning Movers Programme could be opened up to other wards allowing more patients to benefit from exercise which led to improved health outcomes. Volunteers would gently encourage patients to join in; supported safety and cleaning of equipment between patients and had a little workout themselves.
- Working alongside Infection Prevention and Control leads we were able to safely bring in Pets As Therapy Dog Coco on her inaugural visit to the Stroke Ward. A whole range of positive emotions were experienced by both patients and staff who were caring for them. That experience was worth the work put into the policy and risk assessments. Further visits followed.
- We delivered a "Be The Change" project that provided small grants and specialist support for staff and volunteers who had ideas that could improve the health and well being of the patients and the workforce. Tropical Shirt Tuesday and funding Staff Sports Teams were two of the many projects supported.

KEY FIGURES

288 NEW VOLUNTEERS

80% FEMALE

30% AGES 16 - 25

21% AGES 26 - 44

20% AGES 45 - 64

29% AGES OVER 65

PER WEEK 300 VOLUNTEER HOURS

88 OPPORTUNITIES LISTED

INCLUDING SOME SHORT TERM, ONE OFF OPPORTUNITIES

FEEDBACK ON THEIR VOLUNTEERING EXPERIENCE

"I had a great few hours helping out in the forget me not garden. Jane the activities coordinator was lovely and I look forward to working with her again. The garden looks great and I will be back again soon."

"Great opportunity to make a difference for patients. The role is to help patients use an automated touch-screen to check in, saving them time and effort as they enter the hospital for an appointment (especially in orthopaedics where some patients may be in pain stood up queuing to speak to a receptionist). Recommended."

"I really enjoyed my time on the ward, felt included, kept busy, very friendly team"

"Started being a ward companion on B1, meeting all the patients was great, offering them tea and coffee really made it easier to talk to some patients. Hearing about their day and trying to bring a smile to them I found fulfilling.".

"Really enjoyable to be a part of the Doctors learning. Lovely team to help you along the way."

FEEDBACK FROM OUR STAFF

"Lauren is an asset to the team and has fitted in well with her new opportunity."

"Margaret is an asset to our PALS Team providing excellent service to our patients and staff. Thank you for your support."

"Hi Albert. Thanks for all the fantastic work you have done for us. We are so delighted with your efforts that we have an even more challenging task that we would like your help with! Are you interested?"

"Amy is a fantastic Volunteer who is always happy to help. She has had some great feedback from visitors and patients including some of our CQC inspectors who returned specifically to thank her for getting her to a meeting place on time."

SUCCESS STORIES...

JULIE

Gained employment as a carer after supporting both our Wayfinder Role and Clinic Meet and Greet..

PAM

Moved into further education after supporting wellbeing activities within a ward buddy role

LIAM

Gained a university place after completing his sports rehab course and volunteering with our rehabilitation clinic

BETH

Gained an NHS Apprenticeship place in Administration after being a Courtesy Caller

NEXT STEPS

We have laid solid foundations, and developed trusted partnerships with staff at all levels of the Hospital Trust to enable the Volunteering Programme to continue to flourish over the coming years. We are looking forward to working with the Trust to further co-design and co-deliver the programme working with staff, patients and local people. These opportunities will include:

ONE:
Expanding the repertoire of volunteering opportunities available within the Trust ensuring that the skills and talents of local people can be harnessed alongside staff to provide wider wellbeing support for patients. These volunteering roles will provide opportunities for patients to learn new skills, meet new people and enhance their physical and mental wellbeing.

TWO:
We will continue to raise the profile of the Trust as a trailblazing volunteering organisation. We will showcase the work of volunteers in the Trust, and celebrate their achievements through awards and showcasing their achievements. We will also enter the programme for regional and national awards.

THREE:
We will support, guide and develop ALL volunteering across the Trust, engaging the long-standing volunteering organisations. Developing a Volunteering Steering Group reporting to the Patient Experience Sub Committee that provides a robust Governance structure for any future volunteering strategy.

FOUR:
We will ensure that the volunteering offer is an integral part of the newly proposed Health Campus and we will work with Trust leaders and clinical staff to ensure that every patient will be able to access the invaluable support provided by trained volunteers.

FIVE:
We will link with the National Volunteering Hub and Helpforce to adapt and improve on our support to volunteers in recruitment training and development - simplifying process whilst maintaining high standards.

IN CONCLUSION

Warrington and Halton Foundation Trust is exemplary in recognising the value that volunteering can bring to enhancing patients' experiences by complementing the work of clinical staff in ward and department settings. By mobilising **'volunteer power'** the Trust has made excellent progress in kick-starting a social movement for wellbeing and in realising its ambitions to become a health promoting Trust.

The report outlines key statistics on recruitment noting 288 new volunteers in the last 12 months. It is also highlights the many programmes and opportunities where volunteers have impacted in both clinical and non-clinical settings. These have included but not limited to:

- Pets as Therapy
- Dining Companions
- Implementation of a Reader Programme
- Morning Movers
- Enhanced Induction programme for staff

The engagement of volunteers has supported improvements in patient experience and complimented the quality of health care provided for patients at Warrington and Halton Teaching Hospitals.

THANK YOU...

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/21/03/53**			
SUBJECT:	Moving to Outstanding			
DATE OF MEETING:	31st March 2021			
AUTHOR(S):	Layla Alani, Deputy Director Governance			
EXECUTIVE DIRECTOR SPONSOR:	Kimberley Salmon-Jamieson, Chief Nurse & Deputy Chief Executive			
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	SO1 We will.. Always put our patients first through high quality, safe care and an excellent patient experience. SO2 We will.. Be the best place to work with a diverse, engaged workforce that is fit for the future. SO3 We will ..Work in partnership to design and provide high quality, financially sustainable services.			X
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): **(*Please DELETE as appropriate)***	None			
EXECUTIVE SUMMARY *(KEY ISSUES):*	This paper provides an update on: • M2O's refreshed focus • Feedback from the Provider Collaboration Review • An update from the latest Insight Report			
PURPOSE: *(please select as appropriate)*	Information	Approval	To note X	Decision
RECOMMENDATION:	The Board of Directors are asked to: • Note the contents of the report			
PREVIOUSLY CONSIDERED BY:	**Committee**	Quality Assurance Committee		
	Agenda Ref.	QAC/21/03/59		
	Date of meeting	2 March 2021		
	Summary of Outcome	Noted		
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: *(if relevant)*	None			

REPORT TO BOARD OF DIRECTORS

SUBJECT	Moving to Outstanding	AGENDA REF:	BM/21/03/53

1. BACKGROUND/CONTEXT

Following completion of the CQC Action plan, Moving to Outstanding has a refreshed focus with underpinning workstreams and a Task and Finish Group.

This Group is focusing on how CQC's changing methodology will impact the Trust, completion of an assessment of our current position before progressing to identify actions required to further progress the Trust's ambition to become an outstanding organisation.

The Trust met with CQC for the Provider Engagement Meeting on 9th February 2021. Confirmation was received that quarterly meetings will continue and the next engagement meeting will be on 12 May 2021. It should be noted that this paper is a different report than the one provided to the Quality Assurance Committee.

2. KEY ELEMENTS

2.1 CQC action plan

The CQC action plan is now closed. This will be replaced by action plans for different areas once governance led assessments have been completed using a combination of CQC's interim and existing frameworks.

2.2 Task and finish group

There have been three meetings of the Task and Finish Group for M2O, which is chaired by the Associate Director of Governance and Compliance. The Group has a core group of staff leading it, with involvement from Patient Experience, Nursing, Quality Academy, Library Services and IT.

In line with the presentation provided by the Chief Nurse to the Board at the recent away day, the M2O Task and Finish Group have agreed:

- some initial assessment frameworks
- an order of approach to different 'core services' within the Trust

The Task and Finish Group are continually reviewing changes within CQC's regulatory approach considering how this will affect the Trust. The first three assessment frameworks have been sent out to 'core services' (Maternity, Urgent and Emergency Care and Outpatients).

The Task and Finish Groups' focus will be maintained on:

- Changes within CQC's methodology
- CQC's Strategic Direction
- How the change in Methodology and Strategic Direction could impact the Trust from a Core Service and Well Led perspective
- Delivery of our internal assessment process
- Key Focus Areas
- Communications
- Supporting Action Planning post review
- Use of Data to improve Services

Updates will continue to be provided to Board via M2O and the Quality Assurance Committee.

2.3 **Provider Collaboration Review**

Following the Trust's Urgent Care Provider Collaboration Review (PCR), CQC have produced an interim report. The Trust were anonymously recognised in this report for our work with 'Core 24', (Mental Health Services Support) which was seen as good practice.

2.4 Enquiries from CQC

The Trust has recently received positive feedback from CQC in relation to care provided by Maternity services. This has been shared with the Maternity Team.

Since 1 February 2021 the Trust have received 1 enquiry from the CQC:

- Enquiry regarding a complaint CQC had received concerning capacity assessments of a patient

The Deputy Director of Governance has fully responded to the CQC enquiry.

2.5 CQC Quarterly Engagement Meetings

The next engagement meeting is on 12 May 2021. The trust received informal positive feedback regarding the last engagement meeting on 9 February 2021.

2.6 CQC Surveys

In order to collate patient feedback to help them assess risk within providers, CQC run a programme of surveys.

In 2020/2021 five surveys will run as part of the Programme:

- 2020 **Urgent & Emergency Care (UEC) Survey (all trusts are currently in field)**
- 2020 **Inpatient Survey**
- 2020 **Children and Young People's Survey**
- 2021 **Community Mental Health Survey**
- 2021 **Maternity Survey**

CQC are improving and future-proofing the survey programme, by encouraging patients and their families to complete questionnaires online wherever possible, rather than only using paper questionnaires. They are trialling new methods for collating information so should increase the number of patients completing them.

CQC has recently confirmed that the 2021 Maternity Survey will run in the spring and will be coordinated by the Coordination Centre for Mixed Methods (Ipsos MORI). Sampling for the survey will begin in March and fieldwork in April, with a webinar for trusts scheduled for early February. A further update will be provided through M2O.

CQC will run mixed-mode pilots for the Community Mental Health Survey and Urgent and Emergency Care Survey next.

2.7 Insight report

The Trust continue to receive the CQC Insight Report. A new process has been established within the Trust where key elements of the Insight Report are shared at M2O meeting to recognise our successes along with details of actions taken to address any areas for improvement.

Key elements of the Insight Report

Overall performance for the Trust is about the same.

Areas Improving

→ Well Led performance

- Areas Declining
  → Responsive Performance
  → Outpatients and Diagnostic Imaging Performance

- Areas Stable
  → Urgent and Emergency Care, Critical Care, Children and Young People, Maternity and Gynaecology, Medical care, Surgery Performance
  → Caring, Effective, Safe Performance

Performance deterioration in relation to the responsive domain and Outpatients largely relates to referral to treatment times, which have been affected by the Covid pandemic and national decisions to pause elective activity.

Outliers trust wide and core service indicators

Outlier

There is one active outlier for maternity currently being monitored by the regional CQC team. There is a re-audit in April following which we aim for this to be closed.

Indicators

Of the 79 trust wide indicators, the following are categorised as:-

→ 8 (10%) better than national average
→ 1 (1%) worse than national average
→ 1 (1%) much worse than national average
→ All other indicators are in line with national averages.

Better

→ Equality, diversity & inclusion
→ Health and Wellbeing
→ Immediate Managers
→ Morale
→ Quality of appraisals
→ Quality of care
→ Safe environment – bullying and harassment
→ Safety Culture
→ Sick days for medical and dental staff

Worse

→ Sick days for other clinical staff

Much Worse

→ Sick days for nursing and midwifery staff – compared nationally

Improved indicators

→ Digital maturity capabilities score (%)
→ Digital maturity infrastructure score (%)
→ Digital maturity readiness score (%)
→ Morale
→ Never Events (total events with rule-based risk assessment)
→ Quality of appraisals
→ Quality of care
→ Safety Culture
→ Staff Engagement

Declined

→ Turnover rate for other clinical staff

In relation to indicators identified as worse or much worse, work has been undertaken to understand them in more detail. For sick days for staff this was largely impacted by our local prevalence of Covid 19 in the community. The turnover rate for other clinical staff included all our students and temporary staff who came to support us during the pandemic, resulting in a higher than average turnover due to the length of their contracts.

CQC have retired the Trust Composite indicator, which has previously been reported in the integrated performance report. Currently no alternative metric is being proposed.

3 RECOMMENDATIONS

The Board of Directors are asked to receive the contents of this report.

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/21/03/54**
SUBJECT:	Safe Staffing Report – 6 monthly review (May 2020 – October 2020)
DATE OF MEETING:	31 March 2021
AUTHOR(S):	Rachael Browning, Assistant Chief Nurse, Clinical Effectiveness
EXECUTIVE DIRECTOR SPONSOR:	Kimberley Salmon-Jamieson, Chief Nurse and Deputy Chief Executive
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	SO2: To have a committed, skilled and highly engaged workforce who feel valued, supported and developed and who work togther to care for our patients
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): **(*Please DELETE as appropriate)***	BAF2.2: Nurse Staffing BAF2.5: Right People, Right Skills in Workforce BAF2.1: Engage Staff, Adopt New Working, New Systems
EXECUTIVE SUMMARY ***(KEY ISSUES):***	This paper details the six monthly review of nurse staffing in line with the commitment requested by the National Quality Board in 2016 and more recently in the Improvement Resource for Adult Inpatient Wards in Acute Hospitals January 2018. The report provides transparency and assurance with regard to the management of the nursing and midwifery staffing response at Warrington and Halton Teaching Hospitals (WHTH) to the COVID-19 pandemic • The report provides an overview of the current nurse staffing workforce data, including numbers of staff in post, turnover of staff, recruitment initiatives such as the international nurse recruitment programme and the COVID-19 pandemic nurse staffing response. • The COVID-19 pandemic waves 1 and 2 presented a number of staffing challenges including increased staff sickness absence and the expansion of critical care and respiratory services which continues to be managed with a robust daily operational staffing process. • The report represents the review of a 4 week sample of census data recorded within the SafeCare acuity and dependency system between 1st to 31st October 2020 • The report demonstrates that our budgeted nurse staffing WTE (whole time equivalent) is comparable to the safe care census data requirements. Improvements have been made in the overall nurse staffing establishments enabling the Trust to meet the SafeCare acuity requirement of 651.41 WTE nurses (RN & HCA). The actual number of staff in post is currently 570.99 leaving a deficit of 80.42 which is an improvement on the previous 6 months review when the deficit was 139.79 WTE. • There has been a gradual reduction in the number of registered nurse vacancies over the last six months. In October 2020 the

	vacancy figure was 82 whole time equivalents which is the lowest registered nurse vacancy number in the previous 12 months • Registered nurse turnover continues to reduce with an Improvement noted from 14.99% in November 2018 to 10.59% in November 2020, which is the lowest figure during the last 2 years. • Care Hours per Patient Day (CHPPD) is the national reporting metric for safe staffing levels. The average CHPPD from June until October 2020 is 7.9. CHPPD continues to increase bringing us in line with the national median rate of 9.1 and peer organisations of 8.3. • The report includes a detailed analysis of the paediatric and maternity staffing review for the last 6 months. • The report demonstrates the progress that continues to be made across the organisation in nursing and midwifery staffing.			
PURPOSE: ***(please select as appropriate)***	Information *	Approval	To note *	Decision
RECOMMENDATION:	It is recommended that the Trust Board review the progress to date and receive the contents of the report.			
PREVIOUSLY CONSIDERED BY:	**Committee**	Quality Assurance Committee		
	Agenda Ref.	QAC/21/03/69		
	Date of meeting	02.03.2021		
	Summary of Outcome	Noted		
FREEDOM OF INFORMATION STATUS (FOIA):	Choose an item.			
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	Choose an item.			

Contents

REPORT TO BOARD OF DIRECTORS

SUBJECT	Safe Staffing Report – 6 monthly review (May 2020 – October 2020)	AGENDA REF:	

1. Introduction

This paper details the six monthly review of nursing and midwifery staffing in line with the commitment requested by the National Quality Board (NQB) document, 'Supporting NHS Providers to deliver the right staff, with the right skills, in the right place at the right time – safe and sustainable staffing ' (2016) in response to the Francis Enquiry (2013). More information on this can be found in Appendix 1. The NQB guidance has been further refreshed, broadened and re issued in January 2018 with the provision of 'An Improvement Resource for Adult In-patient Wards in Acute Hospitals' which recommends that Boards should carry out a strategic staffing review at least annually. At this Trust, the staffing review is carried out twice per year, review meetings are held with the Ward Managers, Chief Nurse and Deputy Chief Executive to discuss and sign off all establishments in addition to the bi –annual staffing reviews.

Due to the COVID-19 pandemic response during wave 1 and 2, a number of services and activities were reviewed with some being paused in order to manage the increase in activity and meet the challenges at that time. As a number of wards changed their establishments and specialities, a pause was made to the 6 monthly staffing reports. During this time robust staffing scrutiny and oversight was in place and a COVID 19 nursing and midwifery safe staffing report was provided.

This report is presented as an expectation of the NQB guidance and represents the outcome of reviewing the acuity and dependency data recorded in the Safe Care system over a four week period between 1st to 31st October 2020 at Warrington and Halton Teaching Hospitals (WHTH).

All ward sisters/charge nurses, matrons, lead nurses and the associate chief nurse for clinical effectiveness participate in the acuity and dependency review process.

2. Workforce Information - Warrington and Halton Teaching Hospitals (WHTH)

There is evidence which shows that nurse staffing levels make a difference to patient outcomes (mortality and adverse events) patient experience, quality of care and the efficiency of care delivery. Short staffing compromises care and recurrent short staffing results in increased stress and reduced staff wellbeing, leading to higher sickness and a higher turnover rate as more staff leave. The COVID-19 pandemic required a nursing and midwifery staffing response to manage the demands in activity and workforce challenges. This was undertaken in a gradual and systematic approach utilising revised staffing models using the evidence based acuity data SNCT in the safe care module of the E-Rostering system. The expansion of critical care services was undertaken using national and local best practice guidance.

2.1. Staff in post

Chart 1 below illustrates the total number of budgeted registered nursing and midwifery staff in post by month from November 2019 to October 2020. Nurse recruitment remains a priority with targeted recruitment events in place with bespoke recruitment events for areas with high number of vacancies supported by enhanced social and local media campaigns. A focused approach for retaining staff includes

options available such as ward and department transfers, flexible contracts and a strengthened continued professional development offer in order to retain staff. Chart 1 indicates the number of staff in post which has shown an increase in the overall whole time equivalent in the last 6 months (May – October 2020) with the highest whole time equivalent of 976 nurses and midwives in post in October 2020.

Chart 1

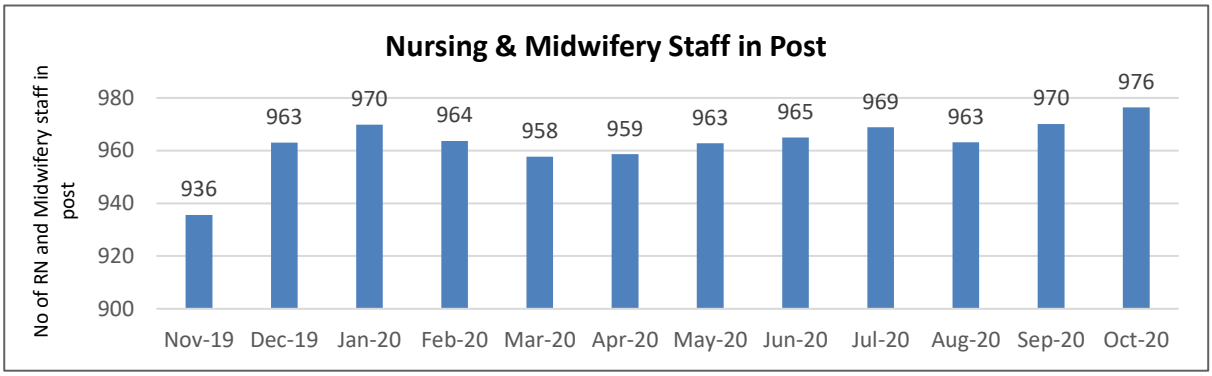
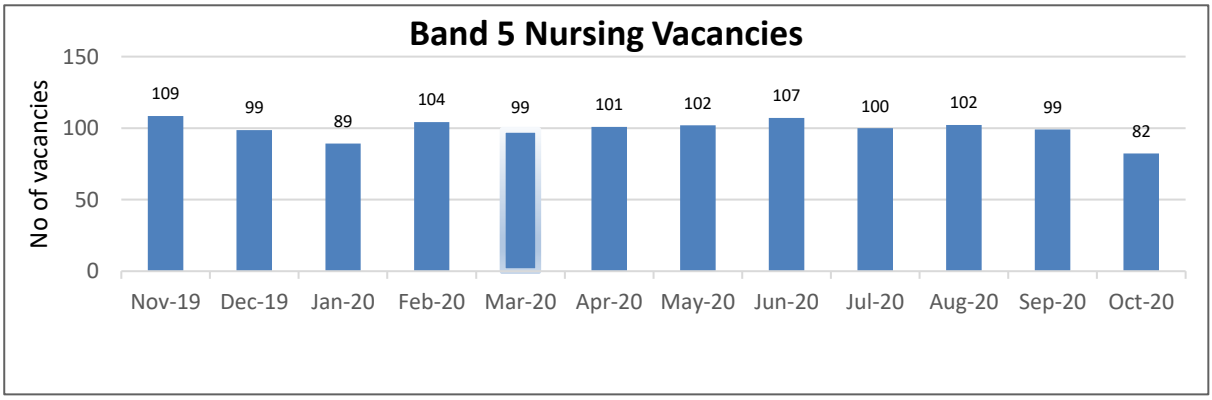


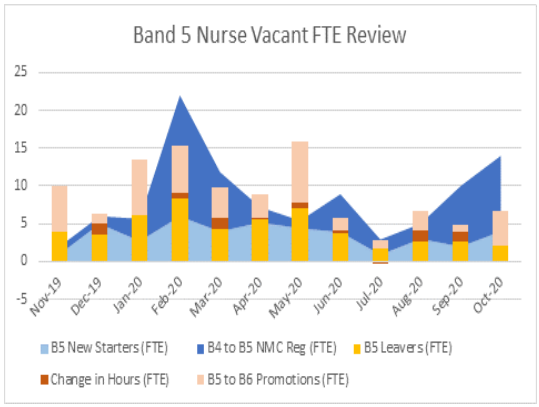
Chart 2 identifies the number of band 5 vacancies based on the funded establishments against the number of staff in post (excluding operating department practitioners in Theatres). We have seen a gradual reduction in the number of nursing vacancies over the last six months. October 2020 reports a vacancy figure of 82 whole time equivalents which is the lowest registered nurse vacancy number in the last 12 months.

Chart 2



Included in this report is a further detailed analysis on band 5 nursing vacancies. In the last 6 months the turnover rate has continued to reduce therefore we are not losing staff from the organisation at the same rate. As demonstrated in chart 3, from May 2020 to October 2020 we had 51 wte band 5 leavers in comparison to the previous 6 months where we had 66 wte band 5 leavers. We continue to see a number of internal promotions within the organisation which is positive for WHTH as we are able to retain experienced staff in the organisation.

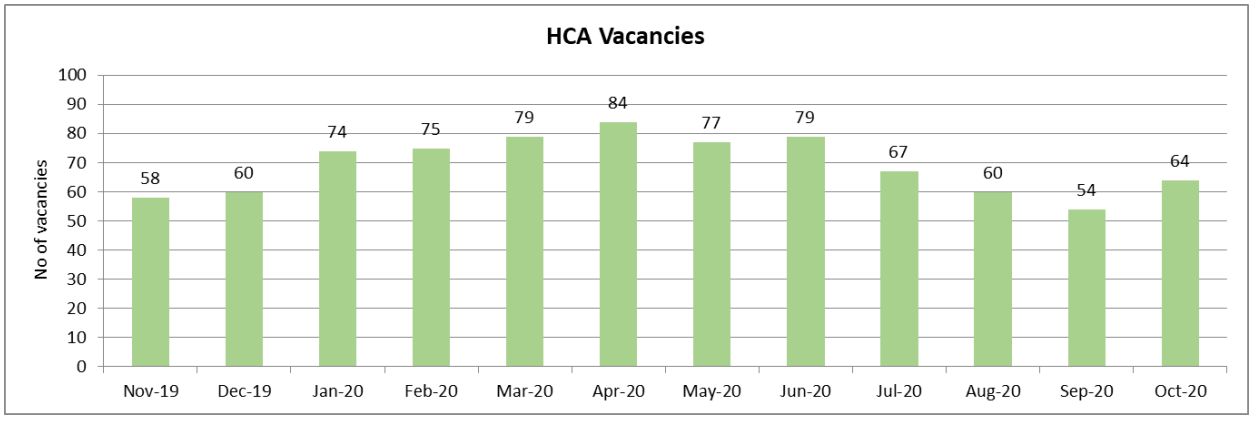
Chart 3



B5 Leavers (FTE)	Change in Hours (FTE)	B5 to B6 Promotions (FTE)
51.64001	7.02	47.53333

Chart 4 identifies the number of HCA vacancies based on the funded establishments against the number of staff in post. Over the last 6 months HCA vacancies have reduced from 84 to 64 whole time equivalents. Recruitment events are now held monthly which has supported a reduction in our overall vacancies however turnover for this group of staff remains high at 24.99%. We currently have 46 newly recruited HCA's. Of this 46, 30 are undergoing pre-employment checks, 8 have started in post in November 2020 and a further 8 have an agreed start date in place. A further initiative to support HCA vacancy reduction is the care support worker development (CSWD) programme with NHSP. This programme offers staff who require the flexibility of working through the bank the opportunity to undertake training and development within the Trust, many of whom go on to secure substantive posts at WHTH on completion of their course. The Trust welcomes 20 CSWD's to the programme in December 2020.

Chart 4



2.2. Staff Turnover

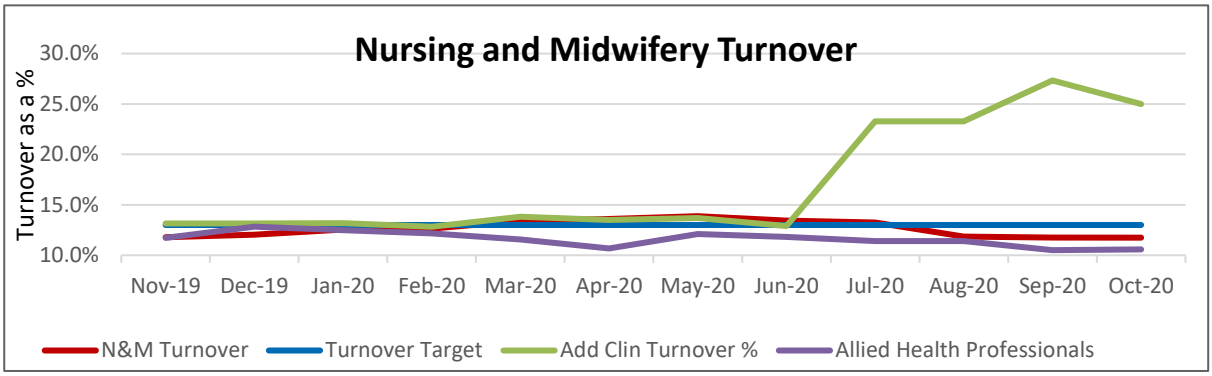
Chart 5 illustrates nursing and midwifery turnover which has seen a gradual improvement from November 2019. The current registered nurse turnover rate in October 2020 is 10.59% which is the lowest turnover rate in the last 12 months; this is against a regional YTD turnover of 13.2% and a national YTD turnover of 12.1%.

Additional clinical services turnover includes health care assistants and is noted to show a significant increase in June 2020 from 12.89% in May 2020 to 23.27% in June 2020. This increase is largly attributed to the 133 student nurses who were recruited into health care assistant posts as part of the COVID-19 pandemic wave 1 staffing expansion plans who left to return to their studies in June 2020. As turnover data is recorded as a 12 month average it will take some months before we see an overall reduction in the

additional clinical services line. When the data is broken down to remove the temporary staff (student nurses) the indicative overall turnover rate in October 2020 is 11.1% which is the lowest rate we have seen in the past 12 months demonstrating an overall reduction of 2.91% since October 2019.

Monthly progress updates on staff turnover reduction continue to be provided to the workforce a review group chaired by the deputy chief nurse.

Chart 5



2.3. Recruitment and Retention

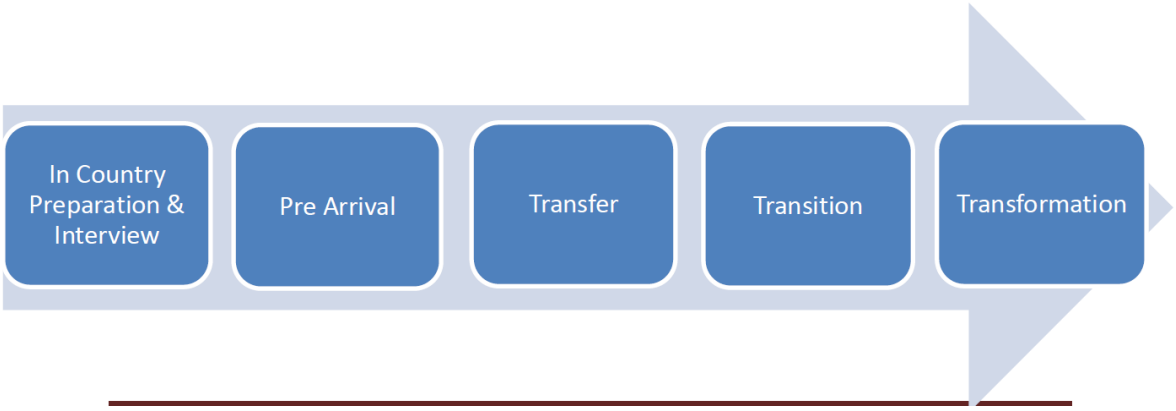
The Nursing Recruitment and Retention Strategy is being delivered alongside a programme for international nurse recruitment. An innovative recruitment campaign continues with flexible working plans as one of the initiatives on offer. A number of new approaches have had to be adopted to support the recruitment campaign as a result of the COVID-19 pandemic, including telephone interviews and a call to arms campaign.

In the last 12 months the Trust has welcomed 60 WTE new starters into the Band 5 Nursing roles and 105 HCA's. It should be noted that our continued focus on recruitment and retention has been maintained during the pandemic and we currently have the lowest number of registered nurse vacancies, 82 WTE in October 2020 which is the lowest number in the past 12 months.

2.4 International Nurse Recruitment

Following the successful business case for the recruitment of 30 international nurses at WHTH a team of staff, led by the associate chief nurse, have commenced the recruitment process. The Trust is working in partnership with Wigan, Wrightington and Leigh and has received NHSI funding of £47,000 to support these nurses as they undertake their OSCE training before joining the Trust. Ten nurses have arrived in the UK in November 2020 and are currently undertaking a training programme in preparation for their OSCE following which they will join the NMC register and be available to work at WHTH in February 2021. A further 20 nurses will be arriving in January 2021 and will be available to join us at the Trust in March 2021.

Process for recruitment of International Nurses



Phase	Timings	Education and Training	Work Experience	Living
Transfer	Weeks: 1 to 8: GTEC	• Arrival in the UK • Induction into GTEC • 4 to 6 week intensive OSCE Training • OSCE Exam	• None	Accommodation based with GTEC (free for up to 3 months). Social Integration support
Transition	Year 1: Host trust	• Trust Induction • Local Preceptorship	• Ward Based	Nurse supported to find accommodation near Host Trust. Social Integration support
Transformation	Years 2 to 3 : Host Trust and GTEC	• GTEC Educational programme • Nurse expresses area of interest	• Ward Based • Experience in area of interest	Maintains living where based Ongoing social support

2.4.1 International Nurse Recruitment Pastoral Support

We have a designated practice educator and a matron who will lead on the WHTH welcome and pastoral support for these new nursing recruits. Pastoral support is recognised as a really important part of the international nurse recruitment process in order to help the nurses settle into the UK and their local Trust / community. As such we are currently working with colleagues across the Trust to ensure that we have everything in place for their arrival which includes some of the following:

- Welcome pack
- Health and Well-being pack
- Local information including accommodation, community groups, transport links and amenities.

The team are organising a treasure hunt around Warrington to help them find key places of interest and bring some light hearted fun on their arrival.
- The BAME network chair is also going to visit the nurses in Crewe and offer the network support on their arrival in the Trust.

Following the success of the first cohort of international nurses WHTH was given an opportunity to collaborate in a Mid Cheshire partnership to further expand our international nurse recruitment programme. Following a successful business case and accessing additional funding from NHSI/E to support the Mid Cheshire Partnership £400,000 has been secured and we have agreed to recruit a further 36 nurses to join the Trust in the Summer of 2021.

2.5 Workforce Development

The Clinical Education Team has supported the up-skilling of nursing and midwifery staff to build competence and confidence in responding to the Covid-19 pandemic. This support has included the provision of a mobile skills trolley and classroom based clinical skills refresher training, in situ simulation, in situ training e.g. theatres.

During waves 1 and 2 of the Covid-19 pandemic flexibility was given to the delivery of the Trust Preceptorship Programme including a reduced programme to focus on clinical skills acquisition. Any additional sessions will be provided through the planned preceptorship development days during the preceptorship year. A preceptor preparation workshop has commenced, preparing preceptors to support preceptees effectively during their programme.

The Trust submitted a bid as lead partner for a consortium of Wirral and Cheshire organisations clinical placement expansion funding for nursing and midwifery. The University of Chester is the lead Higher Education Institution (HEI) involved in the bid. The funding is made available to support organisations to develop plans to grow student placement capacity for the September 2020 intake, and support students in practice. HEE have confirmed our application had been successful. The partnership will receive £350,000 for delivering an increase of 187 student placements from the September 2020 nursing and midwifery cohorts. This programme supports an increase to future workforce supply.

Following the passing of emergency legislation, more than 170 student nurses, midwives and allied health professional students who chose to opt in, commenced extended paid placements to support WHTH's response to the COVID-19 pandemic. By providing paid placements students have been able to continue to undertake learning that contributes to their programme practice hours, mitigating the risk of an interruption to workforce supply. For final placement nursing students, a permanent offer of band 5 employment was made when they commenced their contracts subject to confirmation of their NMC registration.

The Trust has received a full Continuing Professional Development (CPD) allocation from Health Education England (HEE). Our CPD allocation for 20/21 is £472,333 for nurse, midwife and AHP's CPD. The funding was based on staff in post in April 2019 for hospital Trusts. WHTH has engaged with eligible staff through two survey monkey questionnaires. Priority areas identified include: mental health, learning disabilities, safeguarding (non-mandatory), clinical examination and diagnostics, clinical skills development, health promotion, palliative care, long term conditions, patient safety and human factors.

Physiological observations training, removal of cannulas and removal of catheter training have been added to the health care assistant clinical induction programme so that following completion of competencies in practice, our new healthcare assistant workforce can utilise these skills to support the delivery of care at an earlier stage in their employment.

On the 27th October 2020, WHTH received confirmation from Health Education England that we have been allocated training grant funding to support 10 registered nursing degree apprenticeships (RNDA)

commencing in 2020/21. A decision regarding programmes commencing in 2021/22 is yet to be received. We have provisionally indicated that our recruitment campaign would target five internal staff from all departments within the Trust and five external new starters to the Trust. WHTH have indicated that the preferred model for delivery would be a 4 year programme commencing in March 2021. The training grant is £8300 per apprentice per year.

The Trust is waiting for confirmation of whether our expression of interest to support 10 assistant practitioner /nursing associate "top up" RNDA's in 2020/21 and 7 in 2021/22 is successful.

3. Evidence Based Strategic Workforce Planning

There must be sufficient and appropriate staffing capacity and capability on inpatient wards to provide safe, high quality care to patients at all times. Nurse staffing levels are determined by using a range of metrics. Warrington and Halton Foundation Trust use four factors as follows:

- Using systematic evidenced based acuity data utilising the Safer Nursing Care Tool (SNCT)
- Benchmarking with Peers for example Care Hours per Patient Days (CHPPD) through the Model Hospital.
- NICE Guidance and 1:8 minimum staffing: patient ratios
- Professional judgement

Each of the above methodologies are used to ensure that we have consistent evidence based approach to determining the required establishments for each ward.

3.1. Evidence Based Acuity Data

The Trust operationally utilises the SafeCare function within the Allocate E-Rostering system to collect acuity and dependency data twice daily for all wards. SafeCare uses the same dependency scoring as the Safer Nursing Care Tool (SNCT). This is an evidence based tool that enables nurses to assess patient acuity and dependency, incorporating a 'staffing multiplier' to ensure that nursing establishments reflect patient needs in acuity/dependency terms. The data has previously been manually collated for a two week period twice a year; however we are now able to access the information on a daily basis from the SafeCare module in the electronic system. The data is inputted twice daily. The senior nursing team review the data twice daily to ensure appropriate escalation plans are in place to support staffing decisions to meet the needs of the operational demands so that high quality care can be provided on inpatient wards. Any potential care issues associated with staffing are also recorded here using the Red Flag system (See Appendix 2).

3.2. SafeCare Census Results

It should be noted that the SafeCare tool does not differentiate between qualified and unqualified staffing hours and as such requires a very good understanding of the patient groups and nursing requirements. Professional judgment is also an important and essential factor to be considered when making decisions about staffing establishments.

Overall the SafeCare results (summarised in Table 1) demonstrates the acuity of the patients at the time of the survey indicated we required 651.41 WTE against a budgeted nursing staff wte of 669.95. This represents a difference of 18.54 WTE. The survey is an average of the acuity and dependency of the patient group over the month of October 2020. It is important to note that two wards (K25 – 18 beds & B3 – 27

beds at Halton) which were open at the time of the data collection did not have a fully funded establishment for nursing staff. Staffing requirements for ward K25 and B3 were achieved by a combination of transferring substantive nurses from other wards as well as the use of temporary staff from NHS Professionals. Some wards are showing a positive staff position however there are a number of other considerations that impact on staffing which is detailed below.

Table 1 – SafeCare™ Census Results 1st to 31st October 2020

	SafeCare Required WTE Nurses vs Nurses in Post*					
Ward	SafeCare Required WTE	Budgeted Nursing Staff WTE	+/- Budget	Nursing Staff in Post WTE	+/- in-post	Average Daily 1:1s
A1	46.75	59.66	12.91	44.79	-1.96	0.71
A2	39.97	37.17	-2.80	30.49	-9.48	3.84
A4	41.24	38.51	-2.73	35.17	-6.07	0.57
A5	45.85	38.61	-7.24	39.51	-6.34	0.50
A6	65.21	47.14	-18.07	42.55	-22.66	1.68
A7	46.65	43.47	-3.18	33.59	-13.06	0.16
A8	47.88	42.94	-4.94	34.69	-13.19	3.19
C21	31.96	26.76	-5.20	28.81	-3.15	1.80
B3	23.30	16.51	-6.79	0	-23.30	0.00
B4	0.00	23.02	23.02	14.39	14.39	0.00
B12 FMN	35.95	47.12	11.17	38.05	2.10	0.00
B14	37.36	36.48	-0.88	33.02	-4.34	0.10
B18	5.44	40.04	34.60	21.77	16.33	0.00
B19	40.40	39.34	-1.06	41.99	1.59	0.33
C20	12.70	19.24	6.54	17.82	5.12	0.00
ACCU	36.53	48.71	12.18	45.13	8.60	1.23
A9	54.05	32.95	-21.10	44.24	-9.81	2.26
CMTC	14.05	31.28	17.23	22.3	8.25	0.06
K25	26.15	1	-25.15	2.68	-23.47	0.38
Total	651.41	669.95	18.54	570.99	-80.42	16.82

* Nurses in post information taken from e-rostering system

3.2.1 One to One or Enhanced Care

On average during the census period we had 16.82 patients identified each day across all wards that required enhanced care (1:1s). This is not directly included in the SafeCare requirement; however the wards record the number of patients requiring the direct supervision therefore to directly supervise 16.8 patients 24 hours a day would require a significant nursing resource. This requirement is currently accessed via NHSP.

3.2.2 Medical Admissions Ward and Elective / Day Case Surgical Wards

The budgeted nursing staff for A1, B4, B18, ACCU & CMTC shows a positive position however throughout the day the daily responsive staffing planning is in line with NICE guidance and 1:8 minimum staffing: patient ratios. SNCT does not adequately quantify the care hours required on a medical admissions ward like A1, ACCU, and other short stay elective areas that require nurse time for the higher turnover of patients that cannot be captured in the twice daily census.

3.2.3 Additional Demand - A6, A7, A8 & A9

During this census period we noted an additional staffing requirement identified in the SafeCare data. There are a number of factors that need to be taken into account during this reporting period specifically for A7, A8 & A9 as they were the designated as wards to support patients with COVID-19, which will increase the patient acuity at that time. All of these wards are reviewed at the daily staffing meetings and additional staffing are redeployed and accessed via NHSP/Agency to ensure they have the appropriate staffing levels to meet the patient acuity.

A6 experienced an outbreak of COVID-19 during October that affected both patients and staff. Acuity of the patients will have increased during this period. Another factor included the ward manager who was not on the ward during October to support the inputting of the SafeCare acuity data, training is being provided for the other shift leaders on the ward.

3.2.4 SafeCare Requirement Compared to Number of Staff in Post

The SafeCare WTE requirement is 651.41 with 570.99 WTE staff currently in post giving a shortfall of 80.42 WTE which is comparable the total number of RN and HCA vacancies at the time of the report. The figure is offset by significantly reduced activity in the elective wards during October. The October 80.42 WTE is an improvement on the previous reporting period (December 2019) where a shortfall of 139.79WTE was identified, providing assurance that the Trust nursing recruitment and retention strategies are having a positive effect on staffing across the organisation.

3.3 COVID Workforce Expansion

In March 2020 the Trust initiated a command and control response to the COVID-19 pandemic which continued through waves 1 and 2. The Trust received national guidance to support local expansion of the nursing workforce on a number of wards to meet the expected demands and surge of activity and acuity during this time. WHTH used the national guidance to support our local planning, staff deployment to ensure that staffing models were in line with the best practice guidance. Further details can be accessed below:

- Accountability, Delegation and Indemnity for the Corona Virus Adult Critical Care Surge; April 2020 UK Critical Care Nursing Alliance https://www.baccn.org/static/uploads/resources/Accountability_
- Coronavirus: principles for increasing the nursing workforce in response to exceptional increased demand in adult critical care, March 2020 NHSE/I https://www.england.nhs.uk/coronavirus/wp-content/uploads/site
- Deploying the healthcare science workforce to support NHS Clinical Delivery Plan for COVID-19; https://www.england.nhs.uk/coronavirus/wp-content/upload

- Advice on acute sector workforce models during COVID-19 https://www.england.nhs.uk/coronavirus/publication/advice-on-acute-sector-workforce-models-during-covid-19/

For both waves 1 and 2 of the COVID-19 pandemic WHTH reviewed current staffing models in particular the intensive care and respiratory ward using systematic evidenced based acuity data - Safer Nursing Care Tool (SNCT), Care Hours per Patient Day (CHPPD) and reviewed this against national guidance for workforce expansion. This process enabled WHTH to detail revised staffing levels for each of the speciality areas who were receiving patients with COVID-19 to ensure patient and staff safety.

In order to expand our respiratory care provision in critical care, acute and supportive wards revised staffing models were undertaken across the organisation. These staffing models used a systematic evidenced based acuity data (SNCT) model in order for WHTH to meet the needs of our patients on the critical care unit and respiratory wards. This required an overall uplift of 60.5wte registered nurses and 72.78wte health care assistants.

There was an immediate requirement to provide additional registered nurses and health care assistants to support the Trust during the COVID 19 pandemic. A number of initiatives were implemented to support the expansion of the nursing workforce which included staff and student redeployment, local and national call to arms and continued targeted recruitment campaigns. In order to further increase the staffing availability NHSP worked in close collaboration with the senior nursing team to offer alternative options to increase the number of staff available to work at WHTH. This included the introduction of a rapid response recruitment process and the offer of enhanced rates for bank workers. In collaboration with NHSP the Trust have recently been recognised for the COVID-19 temporary staffing response by winning a prestigious Nursing Times Workforce Award for “Best Recruitment Offer 2020”.

During the COVID-19 pandemic WHTH accessed off-framework agencies Thornbury Nursing Services and Greenstaff Medical Agency details of which can be seen in section 6 and a full safe staffing response plan for the COVID-19 surge was presented in May 2020 to the Strategic People Committee and Finance and Sustainability Committee.

4. Monthly Staffing Return

Nursing and Midwifery staffing data is published on a daily basis at entrances to WHTH wards along with submission of data on a monthly basis through the Unify system to NHSE, in addition to publication on the Trusts website and reporting to the Board of Directors. A review of the ‘ward staffing boards’ has been undertaken to ensure that staffing levels are displayed on all ward entrances and to support patient understanding of ward staffing.

The Trust is required to submit a monthly staffing return as part of the Strategic Data Collection Service (SDCS) detailing planned v’s actual staffing fill rates. In line with recommendations from the NQB (2016) the staffing data return is presented to the Board of Directors on a bi monthly basis highlighting areas where fill rates fall below 90%. Although the 90% standard has not been constantly achieved during the day time there have been mitigating actions taken with senior nurse escalation, and an increase in HCA fill rates to support the ward teams. Matrons and lead nurses support the ward managers with ward risk assessments and staffing plans to ensure safety is maintained.

4.1. Comparing staffing levels with peers – Care Hours per Patient Day (CHPPD)

Care Hours per Patient Day (CHPPD) was developed following Lord Carter's review in February 2016, it has been tested and adopted to provide a single, consistent and nationally comparable way of recording and reporting deployment of staff to provide care on inpatients wards. CHPPD monitoring and tracking can be facilitated alongside E-Rostering systems and supports the daily assessment of operational staffing requirements. NHS Improvement (NHSI) Model Hospital portal now makes it possible to compare CHPPD metrics with comparable peer Trusts.

Chart 7 and 8 illustrates the reported CHPPD figures for the Trust from May 2020 to October 2020 which gives us an overall CHPPD for the current financial year of 7.9. This is in comparison to the peer median of 8.3 and the national median figure of 9.1 hours over the same period. The overall rate of 7.9 year to date position represents an overall increase on CHPPD following significant investment in nurse staffing and demonstrates an improvement from the previous 6 months 2019 / 20 with a rate of 7.3.

Chart 7 CHPPD - Model Hospital website

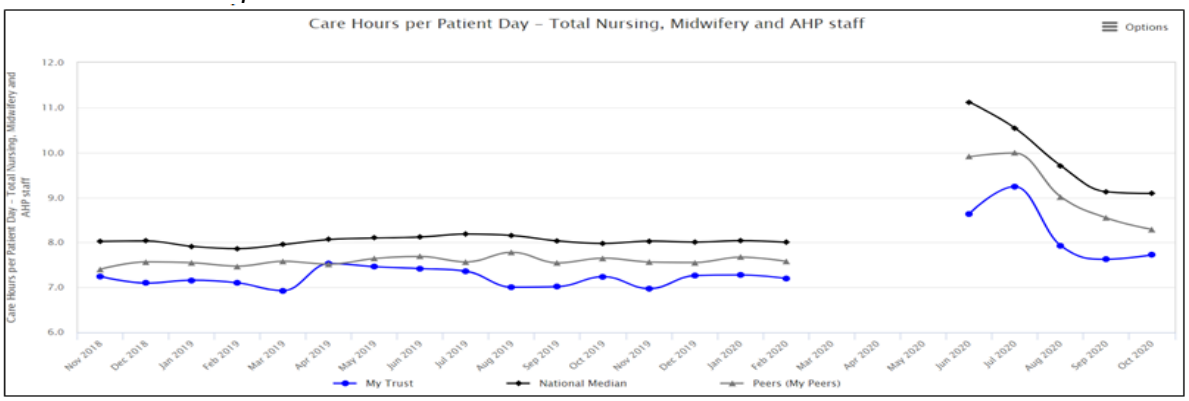


Chart 8 – CHPPD Model Hospital website

		Data			
Financial year	Month	Cumulative count over the month of patients at 23:59 each day	CHPPD - Registered	CHPPD - Care Staff	CHPPD All
2020/21	May	-	-	-	-
	June	14189	4.2	3.5	7.7
	July	13433	4.7	4.1	8.8
	August	13990	4.2	3.5	7.8
	September	13616	4.2	3.3	7.5
	October	14058	4.5	3.2	7.6
2020/21 Total		82096	4.4	3.5	7.9

Monitoring arrangements remain in place to review staffing on a daily basis. The number of staff is triangulated with staffing incidents and 'red flag' events. Further information can be found in appendices 2 and 5. This provides greater assurance and a transparency to the governance processes to ensure adequate safe staffing levels and well as indicators of safety and effectiveness across the organisation.

4.2 Escalation beds and costs

Additional bed capacity has been utilised to support the operational pressures and in particular the COVID-19 pandemic surge planning in the Trust during May 2020 – November 2020. Two additional wards B3 (27 beds) and K25 (18 beds) have been opened and staffed during this time the number of beds occupied has been flexed to meet the demands of the operational pressures within the Trust. The additional beds create a further demand on nurse staffing as these wards do not have a substantive establishment requiring movement from other wards and reliance on temporary staffing to ensure we have the necessary skill mix and experience to meet the need of our patients. The senior nursing team monitor the additional beds and associated staffing costs which are reported monthly to the board.

The table below provides a summary of the costs for the period May to November 2020.

	6 months total			
	June - November			
Ward	**No. Bed Days**	**Additional Costs £**	**Notional Bed Day Cost £**	**Total Cost £**
B3	2395	541,394	0	541,394
K25	1872	423,169	0	423,169
Totals	**4267**	**964,562**	**0**	**964,562**

Funding included in trust plan for 2020/21

Staffing levels are reviewed daily to determine the additional staffing required in the escalation areas to ensure patient safety as part of the daily operational staffing plans.

5. Use of Temporary Staffing

The expansion of ICU was undertaken using national and local best practice guidance. Caring for a critical care patient requires staff with a specific skill set and expertise which isn't used in any other part of the Trust. Therefore in order to expand the critical care unit into the theatre footprint, WHTH accessed off-framework agencies Thornbury Nursing Services and Greenstaff Medical Agency. In normal circumstances the Trust do not use off-framework agencies as they do not provide the same assurances as on framework agencies which have stringent criteria set by recognised framework providers. Therefore the senior nursing team review demand and usage of these agencies on a weekly basis with a focus on reducing the number of shifts requested as soon as activity permitted. Maximum shift bookings were seen week commencing 21st and 28th April 2020 which corresponded with the planned peak of COVID 19 in the North West region. Since this time we have gradually seen a reduction in the Thornbury Nursing bookings and this remains an area of focus for the senior nursing team.

NHS professionals (NHSp) is the agreed supplier of temporary staffing to the Trust, providing registered nurses and health care assistants as requested via the e rostering interface. There is an information cascade in place to agencies when shifts are unable to be filled by NHSp workers. NHSp like many NHS organisations also reported staffing challenges during the COVID-19 pandemic response. WHTH and NHSp worked in

collaboration during this time to introduce a number of initiatives to support the increase of staff joining NHSP and improvements in fill rates and availability of staff.

This included

- A local call to arms recruitment drive
- A rapid response recruitment process
- NHSp representation at the daily nurse staffing meetings
- Review of cancelled shifts
- All successful applicants for positions at WHH are offered to join NHSP as soon as they are successful at interview.
- Enhanced rates and incentive initiative

The above initiatives supported staff fill rates and saw a number of staff join the Trust under the rapid recruitment response (98 registered nurses and 38 unqualified staff). This initiative was recognised at the recent Nursing Times Workforce Summit Awards which saw WHTH and NHSp awarded the winner in the Best Recruitment and Experience category at the awards.

Overall we have seen a reduction in the overall fill rates at Warrington and Halton Hospitals during the last 6 months. Fill rates across the North West and Cheshire and Merseyside have also seen a reduction during this time frame however Warrington and Halton have the lowest fill rates by NHSP at 75.8% compared with 78.5% for North West Acute Trusts. There is recognition that the COVID-19 pandemic adversely affected fill rates during the last 6 months due to many temporary staff needing to self-isolate or were unavailable for work due to COVID 19 related issues.

These metrics are reported and monitored monthly at the NHSp meetings with the deputy chief nurse and Workforce Group chaired by the Chief Nurse and Deputy Chief Executive.

Table 3

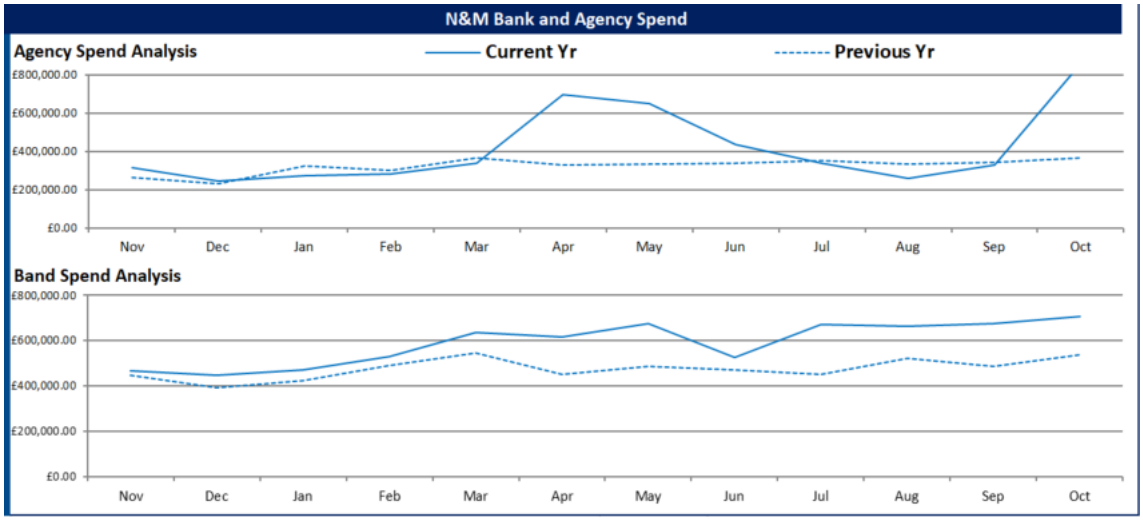
May - October 2020	% Hours Filled by NHSP	% Hours Filled by Agency	% Hours Unfilled	% Overall Fill
North West Trusts - Acute	66.9%	11.6%	21.5%	78.5%
Cheshire & Mersey - Acute	64.2%	13.2%	22.6%	77.4%
Warrington	61.2%	14.6%	24.2%	75.8%

Chart 9 below shows agency use and bank spend analysis for the current financial year. Bank / agency spend has increased during April to June 2020 and again in September 2020. Both of these increases are related to the COVID-19 pandemic response to support the Trust with improving fill rates as staff absences increased. In order to increase NHSP fill rates and decrease agency spend WHH implemented an initiative payment scheme with NHSP in October – November 2020. After the introduction of the initiative scheme over a 4 week period we saw an increase in registered nurse fill rate by 10.8%. Fill rates for health care assistant staff also increased by 16.8%.

Agency reduction is a priority and we continue to undertake deep dive reviews led by the deputy chief nurse for the high spending wards. There is recognition that a reliance on temporary workers including agency staff is required during the COVID 19 pandemic response and this is reviewed and monitored monthly with the clinical teams at the NHSP meetings. We have a pro-active approach for any WHTH staff to join the

NHSp bank to enable us to reduce overall high cost agency spend. As we recruit more nurses, we would expect to see a further reduction in this spend.

Chart 9



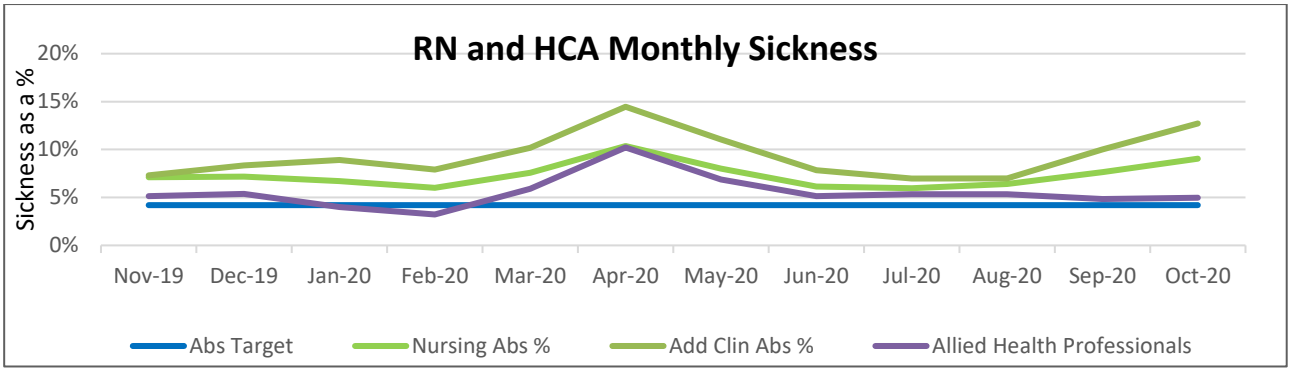
During the COVID-19 pandemic, in order to ensure that safe staffing levels were maintained there has been a requirement to use off framework nursing agencies. The two agencies that WHTH used and continue to use are Thornbury Nursing Services and Greenstaff Medical Agencies. In normal circumstances the Trust do not use off framework agencies as they do not provide the same level of assurance as on framework agencies which have a stringent criteria set by recognised framework providers. Staff supplied through these providers comply with NHS recruitment standards and adhere to set regulatory policies and pricing agreements. Non framework agencies do not offer these assurances and as such are not routinely utilised.

6. Monthly Sickness Absence

Sickness absence levels for registered nurses and health care assistants has been above the Trust target of 4.2% during the last 6 months which impacts on the overall staffing available in the Trust.

From chart 10 it is clear that there has been an increase in sickness absence during April and May 2020 and a further increase commencing in August 2020. These increases have seen nursing absence peak above 10% and health care assistants above 14%. Both of these peaks of absence directly correlate with waves 1 and 2 of the COVID 19 pandemic. Any shortfalls in staffing are reviewed and managed daily at the operational staffing meetings chaired by the associate chief nurse to ensure all wards and departments have sufficient staff to meet the acuity and activity needs of the wards.

Chart 10



7. Women and Children

7.1. Paediatrics

Nurse staffing levels for Paediatrics, including Paediatric Emergency Department, are based on Royal College of Nursing (RCN) Standards from the document 'Defining Staffing Levels for Children and Young People's Services: RCN Standards for Clinical Professionals and Service Managers (July 2013)'. This supports assessing acuity with numbers of staff on shift, patient acuity and dependency needs. Paediatrics use an adapted acuity tool. Patient acuity levels are monitored at 3 different time points through a 24 hr. period against staffing levels on the main ward B11. Acuity and dependency of the patients on the Paediatric wards was monitored over a 4 week period in October 2020 (appendix 6).

During the 4 week monitoring period there were minimal shortfalls of qualified nursing staff identified on the ward at the specific monitoring times. Appropriate action was taken on both occasions with the co-ordinator stepping into the clinical numbers during the day, last minute sickness during the night shift was supported by staff on the NNU to ensure the appropriate skill mix due to have two HDU patients. Therefore during the monitoring period the paediatric department was safe and had appropriate escalation processes in place to manage the peaks in activity and acuity. Following a recent staffing review, the department now ensures a band 6 is allocated to each shift ensuring an appropriate skill mix. The paediatric department is currently fully established.

7.2 Neonatal Unit (NNU)

The Neonatal Unit is commissioned as an 18 cot Local Neonatal Unit supporting intensive care, high dependency and special care baby unit cots.

Number of Neonatal Unit Cots	18
Intensive Care	3
High Dependency	3
Special Care Baby Unit	12

Neonatal unit capacity is planned in coordination with maternity services and the operational delivery network (ODN). This approach anticipates individual care needs and in utero and neonatal transfers within the region.

Neonatal Unit (NNU) staffing levels are defined by British Association of Perinatal Medicine (BAPM) guidance. BAPM staffing recommendations are assessed at two points during a 24 hour period and recorded on the BadgerNet system, a database that determines workload based on acuity.

The actual number of cot days from 01/04/19 – 31/03/2020 was 2792. This is determined from the number of babies and their category of care in each 24 hour period. It is monitored shift by shift.

Annual Care Level Days April 19 – March 20	BAPAM Criteria 2001	BAPAM Criteria 2011
NICU	309	243
HDU	327	361
SBU	2076	2188

Capacity is planned on an average 80% occupancy to meet the demands of the unpredictable nature of neonatal admissions and intensity of care required.

Neonatal Staffing Requirements are detailed below:

- Special care staffing ratio 1:4 (registered nurses : infants requiring special care)
- High dependency care 1:2(registered nurses : infants requiring high dependency care)
- Intensive care 1:1 (registered nurses : infants requiring intensive care)
- A minimum of 70% of nursing staff should be Qualified in Specialty
- A supernumerary shift leader should be available.

Total Number of Nurses	**32.05**
Total Qualified in Specialty	76.13%
Total Registered Nurse or Midwife	87.13%

Neonatal Unit Staff: Providing Direct Care Only		
	WTE BUDGET	WTE IN POST
BAND 7	5.73	5.68
BAND 6	10.35	9.32
BAND 5 QIS	5	3.94
BAND 5	5.65	5.19
BAND 4	5.32	5.22

- A minimum of 3 registered nurses (+1 band 6 shift leader) are on duty at any one time
- There is a supernumerary shift leader in addition to those providing clinical care
- 2 Advanced Neonatal Practitioners (ANNP) support the paediatric medical staff during resuscitation situations on Labour Ward and stabilisation of sick infants on the neonatal unit. ANNP provide additional support to medical staffing rota and are not part of the direct care nursing establishment.

In June 2020, utilising an endorsed neonatal nurse staffing tool (Dinning), a staffing review was completed which assisted in calculating neonatal staffing establishment based on 12 months of historical activity workloads according to BAPM's categorisation of care. The review period was 01/04/19 – 31/03/20.

The Dinning Tool looks at clinical activity only; a separate professional judgement review is required for staffing numbers for specialist roles, mangers and community outreach teams etc.

Utilisation of both the Dinning Tools and professional judgement has facilitated a small change in establishment to facilitate a band 8a matron post in replacement of a band 7 ward manager. The matron role is required to represent the Trust within the Cheshire and Mersey Neonatal Network and at ODN meetings. The matron will further support the development of transitional care services which has a separate staffing requirement.

The ODN also use BadgerNet data to monitor and benchmark activity on the ODN dashboard

Dinning Tool Review April 2019 – March 2020

Suggested skill mix: total nursing establishment available to provide direct care only.			
	BAPM Recommendations 2011 activity based Includes all staff available to give hands on care. This would include specialist roles		Calculation using Dinning. Clinical staff only providing care Band 7 with specialist role excluded from calculation Dinning calculation for direct care
BAND 7	1.30		-4.43
BAND 6	9.47		-0.88
Band 5 QIS	7.28		2.28
BAND 5	5.66		0.01
BAND 4	3.50		-1.82

The service has taken on board recommendation 22 from the MA Desktop Review and will ensure that this is embedded in practice as per the evidence in this report. In addition recruitment processes have been reviewed and will be strengthened to support ongoing rectuitment.

The NNU staffing establishment ensures compliance with commissioned activity and BAPM guidance making us one of the only units in Cheshire and Merseyside to achieve this standard.

7.3 Midwifery Workforce Position

This report provides a review of midwifery and midwifery support worker staffing levels from 01/05/2020 – 31/10/2020 in relation to the safety and quality of care provided.

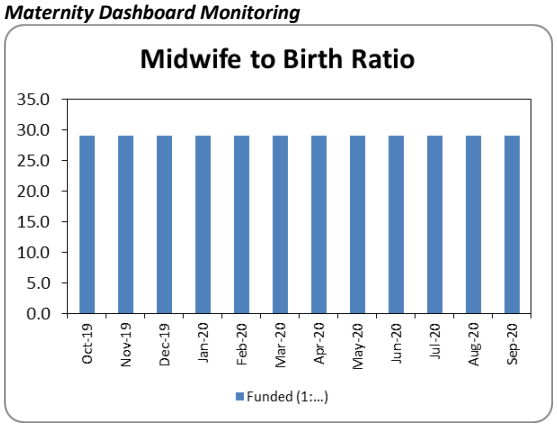
7.3.1 Safe Staffing Reviews

The overall recommended ratio of midwives to women in a maternity service is one midwife per every 28 women (Safer Childbirth, RCOG 2007). A maternity workforce planning desk top review using the nationally recognised Birthrate Plus workforce planning tool was completed in 2017 at WHTH. The Birthrate Plus midwifery workforce planning tool considers the number of births, acuity of the women and babies, type of birth (for instance numbers of caesarean sections and instrumental births), use of analgesia, the location of birth and the number of women cared for by WHTH as well as those women who receive care from other

providers but who choose to give birth at WHTH. An additional percentage is added for specialist roles and managers.

The recommended Birthrate Plus midwifery staffing levels for WHTH in 2017 was found to be 1:29, and this is the midwifery funded establishment. The midwife to birth ratio is monitored through the Maternity Internal Dashboard. The maternity service continues to meet the recommended midwife to birth ratio of 1:29 and provides one to one care in labour. In line with recommendations from the Ockenden Report a desk top review of midwifery staffing levels is currently underway utilising the birth rate plus methodology.

Maternity Dashboard Monitoring



7.3.2 Monitoring of the Maternity Workforce

Weekly staffing meetings take place in order to review staffing levels within the department and support redeployment in anticipation of increased capacity or reduced staffing levels. There is further monitoring of staffing levels daily by the matrons, shift leaders and ward managers. Since August 2020 the weekly staffing meetings have been escalated to daily staffing meetings to help respond to short term changes in staffing as a result of the Covid-19 pandemic. These daily staffing meetings are still in place.

A review of unit capacity, demand and acuity is completed to identify risks from women or babies requiring additional monitoring or 1:1 care and the overall staffing ratios/gaps.

Monthly midwifery staffing numbers are reported to NHS England for the inpatient areas; Labour Ward and combined antenatal and postnatal Ward C23.

7.3.3 NHS England Figures May – October 2020

WARD: Labour Ward	Day		Night	
	Registered Midwives	**Care Staff**	**Registered Midwives**	**Care Staff**

	Total planned staff hours	Total actual staff hours	Total planned staff hours	Total actual staff hours	Total planned staff hours	Total actual staff hours	Total planned staff hours	Total actual staff hours
Total	**14812**	**13443.5**	**2116**	**2279**	**14812**	**12477**	**2110.5**	**2058.5**

Labour Ward reported an average 91 % fill rate against planned midwifery staffing levels during the 6 month period May to October 2020 for day shifts and an 84 % fill rate for nights.

There was an average 74 % fill rate against planned Health Care Assistant staffing levels during the 6 month period May to October 2020 for day shifts and a 75% fill rate for nights. Matrons, shift leaders and ward managers review staffing ratios against unit capacity, demand and acuity on a daily basis to ensure safe staffing levels are maintained.

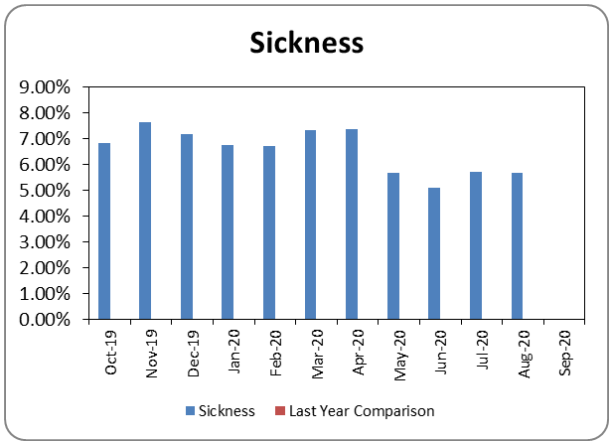
WARD C23	**Day**				**Night**			
	Registered Midwives		**Care Staff**		**Registered Midwives**		**Care Staff**	
	Total planned staff hours	Total actual staff hours	Total planned staff hours	Total actual staff hours	Total planned staff hours	Total actual staff hours	Total planned staff hours	Total actual staff hours
Total	**7038**	**5768.5**	**3519**	**2602**	**3534.5**	**3565**	**3519**	**2656**

Ward C23 reported an average 82 % fill rate against planned midwifery staffing levels during the 6 month period May to October 2020 for day shifts and a 101% fill rate for nights.

There was an average 74 % fill rate against their planned health care assistant staffing levels during the 6 month period May to October 2020 for day shifts and a 75% fill rate for nights. Staffing levels were managed based on acuity and demand on the unit to ensure safety.

7.3.4 Sickness and Absence

Sickness and absence within the maternity department is monitored through the internal maternity dashboard.



- Birth Suite sickness absence rate varied from 4.5% - 11.66 % from May – October 20.
- C23 sickness absence rate varies from 4.3% - 9.5%
- Reasons for sickness and absence included maternity leave, long term sickness and the requirement to shield or self-isolate staff following COVID-19 recommendations.

Shortfalls in staffing were supported by the use of flexible workers from the NHS Professionals Bank. In September 2020 enhanced rates were introduced for staff and agency midwives were engaged through Pulse. In October 2020 the rates for Maternity NHSP were further enhanced to help with fill rates for staffing. This had a positive impact on the shortfall of midwifery hours required to support safe care provision.

7.3.5 Supernumerary Shift Leader for Labour Ward

The Birthrate Plus acuity tool is also used to monitor the supernumerary status of the Labour Ward shift Leader every 4 hours. In addition to the daily staffing meetings, if there is an occasion when the Labour Ward Shift Leader does not have supernumerary status this is escalated to the Matron and mitigating action is taken to address the staffing / acuity issue. A process to formally review the data completeness for the use of red flags will be developed within the governance structure.

7.3.6 Midwifery Staffing Monitoring and Reporting

Monitoring staffing red flags is recommended by NICE guidance NG4 'Safe Midwifery Staffing for Maternity Settings' (2015). Staffing red flags are recorded on the Birthrate Plus acuity tool. Midwifery Red Flags included delays in induction of labour, administration of analgesia etc.

Currently activity, acuity and staffing is recorded on the electronic Birth Rate Plus acuity tool every two hours. A clearer process of describing, recording and escalating midwifery red flags will be developed by 28th February 2021.

Staff also use professional judgements to complete electronic incident forms (Datix) in response to safety concerns impacted by reduced staffing levels and/or increased acuity of activity. All Datix reports are reviewed by matrons or senior managers and concerns addressed. There is a regional Cheshire and Mersey Local Maternity System Maternity Staffing and Escalation Guideline in place which describes the actions staff are to take when staffing levels are significantly reduced or activity/acuity is high.

7.3.7 Maternity Unit Closures

The Maternity Staffing and Escalation Guidelines contain comprehensive information on reasons why a maternity service would be closed to admissions and the process to be followed to ensure the safety of women and babies. During the period 01.05.20 – 31.10.20 (during the Covid-19 pandemic) WHTH maternity unit closed once for a four hour period due to increased activity impacting on safe staffing levels. As a result of the short closure one woman gave birth at another provider unit.

7.3.8 National Maternity Transformation

The National Midwifery Workforce Strategy is outlined in 'Better Births' (2017) and sets out clear recommendations for the rollout of Continuity of Carer (CoC) to support women's choice and improve safety and birth outcomes. Implementation of CoC is mandated and linked to WHTH achieving the requirements of CNST.

To support the future development of the safe and sustainable workforce and the implementation of an effective CoC model, staff were consulted and chose to work within a rostered model. As this model was already in place there was no requirement for a formal consultation. A staffing review of the staff requirements of the CoC team model was carried out, which identified an investment in midwifery staffing of 7.5 WTE was needed.

The CoC programme is progressing well at WHTH with three teams in place, a homebirth team (Team Lunar), a team focussing on women with additional vulnerabilities (Team River) and our first mixed risk team (Team Venus).

Team Lunar are working within a traditional community midwifery model with on-call element to support homebirth. Both Team Venus and Team River work within a rostered model providing 50% of their care in the intrapartum hospital setting and 50% within the community setting. This meets the standards of CoC.

In addition a review of vacancy rates was carried out in September 2020 and 10.2 WTE band 5 and 6 midwives, from current funded establishment, have been recruited. All midwives will be in post by 31st January 2021.

7.3.9 Support for Vulnerable, Black Asian and Minority Ethnic Women and Families

As part of the CoC project, there is a requirement that priority be given to women with additional vulnerabilities and to women from a Black Asian and Minority Ethnic (BAME) backgrounds. Both of these groups are at increased risk of health inequalities and poor outcomes. The WHTH model has prioritised the most vulnerable women using services. Women from BAME background with additional vulnerabilities (e.g. non English speaking, asylum seekers) are allocated and cared for by midwives in team River. By March 2021 all other women of BAME background will be cared for by a continuity team.

The CoC project lead continues to meet with all of these teams regularly to ensure staff are supported working within the new model of care. Supernumery shifts are being allocated to staff when starting to work in unfamiliar areas. In addition staff from Team River receive regular support and safeguarding supervision from the Safeguarding Midwife.

The remaining two mixed risk teams will be implemented in January and February 2021 to ensure we meet our CoC targets. Initial meetings with the staff allocated to these teams are scheduled and will provide an initial opportunity for the staff to co-design the team.

The national CoC target is that 35% of women are on a CoC pathway at 29 weeks of pregnancy. In October 2020 WHTH was at 49.3 % for number of women on a CoC pathway at 29 weeks. This will increase further when the other two teams are rolled out in early 2021. The CoC lead for the region at NHSEI, has praised WHTH CoC model and the progress being made.

7.3.10 Covid-19 Impact and Response

As in other areas of the trust the COVID-19 pandemic has had an impact on maternity staffing through sickness absence and self-isolation. However, the most significant impact has been as a result of our more clinically vulnerable staff undertaking restricted duties and being unable to be in a clinical environment.

The maternity team have used the COVID-19 pandemic as an opportunity to look at how services and activities can be provided and completed in a more agile way. This has included the provision of virtual antenatal contacts, education and hypnobirthing services which has been well received by the women and families. WHTH have also utilised staff working from home to support administration of the elective section list, maternity telephone bookings, completion of computer records on Lorenzo, audits and other non-face to face care.

By working in this way, we have been able to release capacity for staff able to work clinically as well as ensuring those who are unable to complete their normal duties feel able to contribute to the service. This is significant in view of the impact the pandemic has already been shown to have in exacerbating feelings of isolation and in impacting on individual mental health.

7.3.11 Assurance of an Effective System of Midwifery Workforce Planning

Whilst there is effective system of workforce planning in place to ensure safe staffing levels, further work is required to develop:

- a system for monitoring the supernumerary status of the Co ordinator (shift leader)
- reporting of midwifery red flags to monitor staffing
- ensure the last two CoC teams are launched in January and February 2021

8. Overall Conclusions

This report provides an overview of the current position in the nursing workforce, including data from the evidence based staffing review (SNCT) and comparative benchmarking data from CHPPD. It is positive to report that the census data recorded within the SafeCare acuity and dependency system in October 2020 demonstrated that our budgeted nurse staffing WTE is comparable to the safe care data requirements.

This report includes staffing data during waves 1 and 2 of the COVID 19 pandemic which has required a graduated and sustained staffing response within the Trust to ensure patient and staff safety throughout the pandemic.

The report demonstrates that our budgeted nurse staffing WTE (whole time equivalent) is comparable to the safe care census data requirements. Improvements have been made in the overall nurse staffing establishments enabling the Trust to meet the SafeCare acuity requirement of 651.41 WTE nurses (RN & HCA). The actual number of staff in post is currently 570.99 leaving a deficit of 80.42WTE. This figure

includes nursing and HCA vacancies including the additional staffing requirements for ward B3 and K25 which don't have a funded establishment.

Nursing recruitment and retention remains a priority with improvements continues to be made in registered nurse vacancies resulting in the lowest number of registered nurse vacancies at 87 being recorded in November 2020 which is the lowest number for almost 2 years. The introduction of the International Nurse Recruitment Programme will strengthen this position further as we welcome 66 nurses who will be joining our Trust in early 2021. Further improvements have been made over the last 6 months in reducing registered nurse turnover rates which is recorded at 10.59% in November 2020 this is the lowest rate the Trust has seen in over 2 years.

A number of new approaches have been adopted to support staffing fill rates over in the last 6 months one of which being a rapid recruitment process bringing back a number of nurses from our local community into the Trust to support the COVID 19 pandemic response. This project was undertaken in collaboration with NHSP and although did not result in substantive positions in the Trust it did increase both registered and unregistered fill rates at that time. This project was recognised nationally with WHTH and NHSp winning a Nursing Times Workforce Summit Award for "Best Recruitment Experience 2020".

CHPPD is the national reporting metric for safe staffing levels. NHS Choices has recently replaced planned versus actual staffing levels. WHTH ended 2019 with a CHPPD rate of 7.3. During wave 1 of the COVID 19 pandemic, in line with national guidance CHPPD and planned versus actual staffing submissions to unify were paused between April and June 2020. Since June 2020 we have maintained a rate of between 7.7 and 7.6 with a year to date position of 7.9. This is an improvement from the previous 12 months and CHPPD continues to be monitored monthly against the national rate of 9.1 and peer organisations rate of 8.3.

The report demonstrates the progress that continues to be made across the organisation in Nursing and Midwifery staffing. The COVID 19 pandemic waves 1 and 2 presented a number of staffing challenges including increased sickness absence and expansion of critical care and respiratory services which continues to be managed with a robust daily operational staffing process.

9. Recommendations

It is recommended that the Trust Board review the progress to date and receive the contents of the report.

Appendix 1

National context and expectations of the National Quality Board

Boards of Trusts are ultimately responsible for the quality of care they provide, and for the outcomes they achieve. It is well documented that nursing, midwifery and care staff capacity impacts on the ability to deliver a quality experience to our patients and that this has an effect on patient outcomes. Multiple studies have linked low staffing levels to poorer patient experience and outcomes along with increased mortality rates.

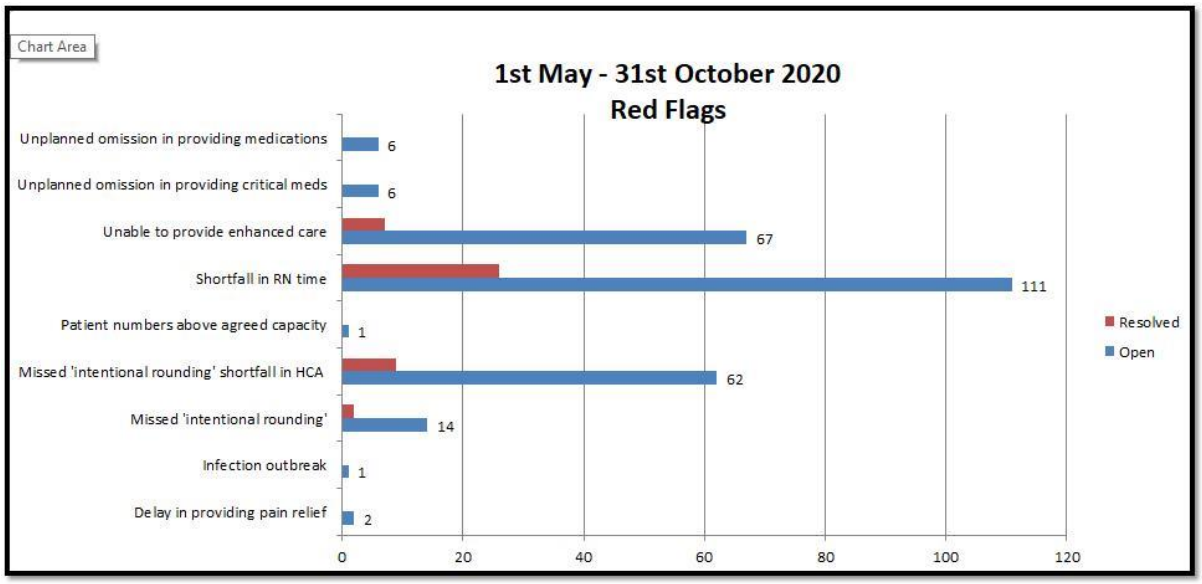
The NQB (2016) described three main expectations of NHS Provider Boards to ensure their organisation has the right culture, leadership and skills in place for safe, sustainable and productive staffing. They are also responsible for ensuring proactive, robust and consistent approaches to measurement and continuous improvement, including the use of a local quality framework for staffing that will support safe, effective, caring, responsive and well led care.

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

Appendix 2

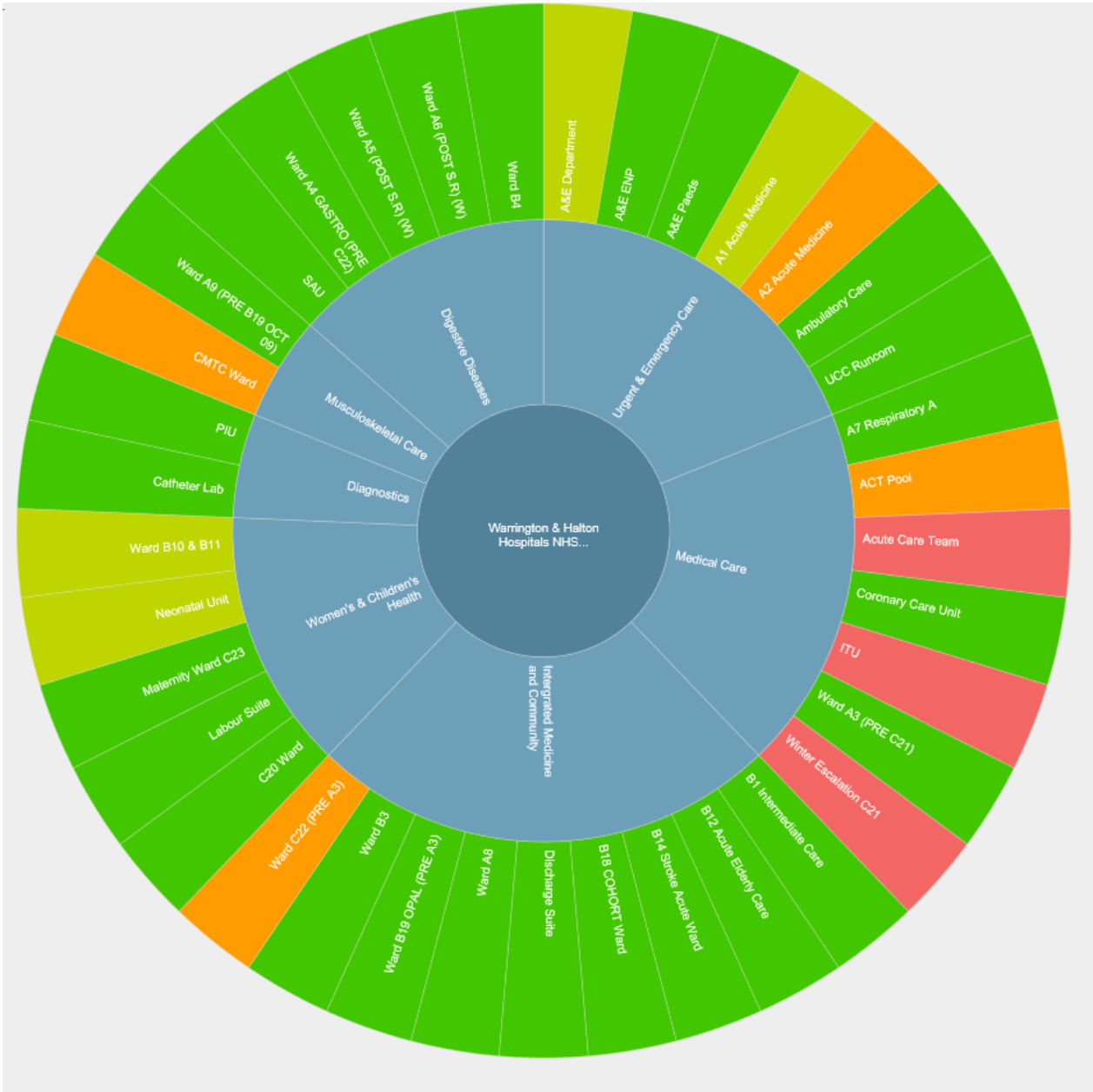
NICE Guidance Red Flags

Red flags can be defined as events that prompt immediate response by the registered nurse in charge of the ward on a given shift to ensure there is sufficient staff to meet the needs of patients on the ward. These events are recorded within the SafeCare™ system, there have been 314 raised in the 6 months between May & October 2020, these are summarised in the chart below. This is comparable in number and nature with the previous report when we had 342 noted in the previous 6 months. Red Flags are one way for our ward staff to escalate staffing related issues to their Matron. However they can be by passed when wards verbally report the issue directly and it is resolved without cause to record within SafeCare™. A recent audit indicated staff were satisfied with the response when a red flag is raised however the senior nursing team need to ensure the process of closing the red flag on the system is undertaken on each occasion.



Appendix 3

Allocate Safe Care "live" output



The above chart is an example of the live report that can, with one click, provide detailed information about staff and patients on all of our wards. Wards highlighted in 'Red' have either got a potential challenge (insufficient staff to provide adequate care) or have not submitted the required patient information.

This is reviewed with senior nurses on a three times daily staffing meeting that occur before patient flow meetings. Areas of concern are addressed and risks to patients and staff are minimised as a result.

Appendix 4

WHH and NHSP COVID-19 Rapid Response.
Workforce Registration and Deployment Service

Summary

NHS Professionals (NHSP) has been working quickly to mobilise a new resourcing model to maximise the availability of Healthcare Professionals to NHS Trusts during the Covid-19 pandemic.

In partnership with the Department of Health and Social Care and NHS England/Improvement the Covid-19 Rapid Response service has been developed to identify solutions that support the Trusts' workforce requirements.

This rapid mobilisation service enables any Healthcare Professional with professional registration or previous appropriate experience to be placed at any NHS Trust rapidly.

Specifically, the service supports the mobilisation of Healthcare Professionals who:

- Have previously worked as a registered Healthcare Professional within the NHS
- Have previously worked as a registered Healthcare Professional outside the NHS
- Final year students studying to become a registered Healthcare Professional.

Please discuss with your NHSP Account Management Team or Business Development Representative, the current Healthcare Professionals in scope.

Individuals will be mobilised through an active attraction campaign and then registered and on boarded though easy online application processes. On boarded Healthcare Professionals will be deployed as agreed with the Trust to support their workforce requirements.

Benefits of the service for Trusts:

- Supports Trusts to quickly access Healthcare Professionals to deal with escalated patient needs
- Enables Trust to easily make their escalated workforce demands available to a wider group of

Healthcare Professionals:

- Deploys mobilised Healthcare Professionals into the Trust
- Delivered through a simple online registration process
- More cost-effective solution than agency
- Full visibility through Business Intelligence
- Easy payment and invoicing process

The NHSP Rapid Recruitment process has been used in the following situations;

- New WHH recruitments
- National Call to Arms
- Local Call to Arms
- Retire and return

Hours worked Qualified and Unqualified

Grade	o of Worke	ours Work	hifts Fille
Qualifed	34	2113.84	232
Unqualifed	19	987.25	108
Total	53	3101.09	340

Breakdown of Shifts worked by Ward

	Qualified		Unqualified		Total	
Ward	Shifts Worked	Hours Worked	Shifts Worked	Hours Worked	Total Shifts	Total Hours
Accident and Emergency	31	287.61	1	7.5	32	295.11
Acute Cardiac Care Unit			5	46.25	5	46.25
Acute Medical Unit (A1) Assessment	13	160.42	6	69	19	229.42
B3	1	6			1	6
Intensive Care and High Dependency Unit	18	191.25	1	11.5	19	202.75
Neonatal Unit	11	110.5			11	110.5
Nurse Pool	1	7.5			1	7.5
Occupational Health	29	218			29	218
Orthopaedic O P D	25	202.03			25	202.03
Theatres Anaestetic Support	9	97.09			9	97.09
Ward A 5	20	185	12	112.5	32	297.5
Ward A 6	3	34.5	8	92	11	126.5
Ward A 7	3	29	10	79.25	13	108.25
Ward A 8	2	17.5	27	201.5	29	219
Ward A2	19	174.5	19	193.5	38	368
Ward A3 (PRE C21)			1	11.5	1	11.5
Ward A4 Gastro (Pre C22)	11	83.5	3	34.5	14	118
Ward B 1	12	73			12	73
Ward B 12	4	23.5	6	36	10	59.5
Ward B 14	2	23	2	11.75	4	34.75
Ward C 20			2	23	2	23
Ward C 23 Maternity Ward			4	46	4	46
Ward C21 (Formerly A9)	2	23	1	11.5	3	34.5
Warrington Theatre	16	166.94			16	166.94
Grand Total	232	2113.84	108	987.25	340	3101.09

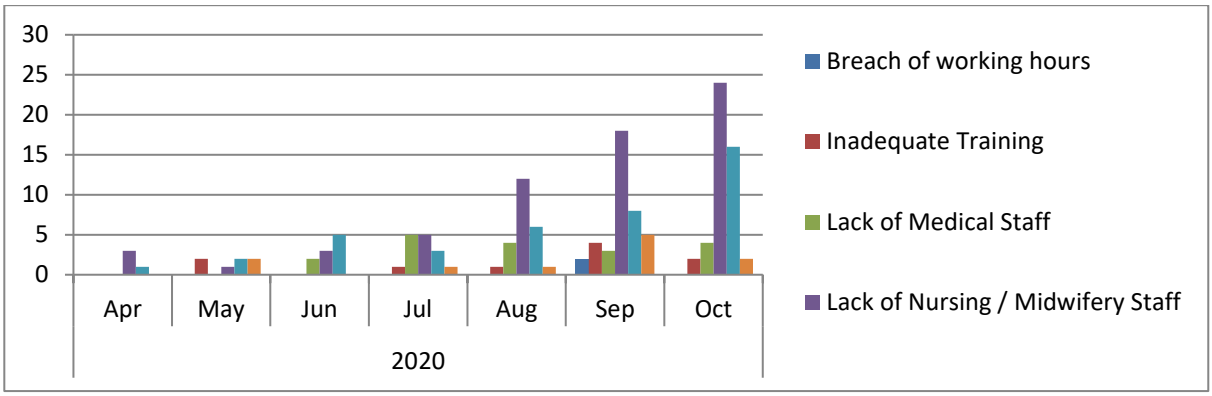
Appendix 5

Reported Staffing Incidents

In order to ensure effective triangulation of data the following information was gathered from the Trust Datix system to understand staff reporting rationales under the heading of staffing incidents.

'Lack of Nursing / Midwifery Staff are highlighted as the largest reason for completing a Datix within this criterion. This does not distinguish between members of the multi-disciplinary team. All incidents are monitored and actioned within the relevant CBU with detail provided in monthly governance reports. Monitoring of staffing incidents takes place on a monthly basis by the senior nursing team.

Number of staffing incidents from April 2020 to December 2020.



This illustrates a slightly improved position in relation to the number of incidents being reported in the previous 6 months were the number of incidents reported in the lack of nursing and midwifery criterion was higher at 28. Staffing incidents continue to be monitored monthly within the CBU's and in the safe staffing group with the senior nursing team.

Appendix 6

Acuity and dependency levels on the Paediatric wards over a 4 week period October 2020.

October 2020	0700	1400	2200	Mitigation
Thursday 1st				
Friday 2nd				
Saturday 3rd				
Sunday 4th				
Monday 5th	0.9			Co-ordinator stepped into numbers
Tuesday 6th				
Wednesday 7th				
Thursday 8th				
Friday 9th			0.4	Last minute sickness and 2 HDU patients, SCBU contacted for support, appropriate skill mix on duty
Saturday 10th				
Sunday 11th				
Monday 12th				
Tuesday 13th				
Wednesday 14th				
Thursday 15th				
Friday 16th				
Saturday 17th				
Sunday 18th				
Monday 19th				
Tuesday 20th				
Wednesday 21st				
Thursday 22nd				
Friday 23rd				
Saturday 24th				
Sunday 25th				
Monday 26th				
Tuesday 27th				
Wednesday 28th				
Thursdays 29th				
Friday 30th				
Saturday 31st				

WHH & We are PROUD to make a difference

NHS Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/21/03/55**			
SUBJECT:	**Infection Prevention and Control Board Assurance Framework Compliance Report**			
DATE OF MEETING:	31st March 2021			
AUTHOR(S):	Lesley McKay, Associate Chief Nurse Infection Prevention + Control			
EXECUTIVE DIRECTOR SPONSOR:	Kimberley Salmon-Jamieson, Chief Nurse & Deputy Chief Executive and DIPC			
LINK TO STRATEGIC OBJECTIVE: ***(Please select as appropriate)***	SO1 We will.. Always put our patients first through high quality, safe care and an excellent patient experience.	x		
	SO2 We will.. Be the best place to work with a diverse, engaged workforce that is fit for the future.	x		
	SO3 We will ..Work in partnership to design and provide high quality, financially sustainable services.			
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): ***(Please DELETE as appropriate)***	#1124 Failure to provide adequate PPE caused by failures within the national supply chain and distribution routes resulting in lack of PPE for staff. #1134 Failure to provide adequate staffing caused by absence relating to COVID-19 resulting in resource challenges and an increase within the temporary staffing domain.			
EXECUTIVE SUMMARY ***(KEY ISSUES):***	To provide the Board of Directors with assurance on actions in place to meet legislative requirements relating to the prevention and control of infection linked directly to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.			
PURPOSE: ***(please select as appropriate)***	Information	Approval	To note ✓	Decision
RECOMMENDATION:	The Board of Directors are asked to receive the report			
PREVIOUSLY CONSIDERED BY:	**Committee**	Quality Assurance Committee		
	Agenda Ref.			
	Date of meeting			
	Summary of Outcome			
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None			

REPORT TO BOARD OF DIRECTORS

SUBJECT	IPC Board Assurance Framework	AGENDA REF:	BM/21/03/55

1. BACKGROUND/CONTEXT

Guidance on the required infection prevention and control measures has been published, updated and refined to reflect learning. Further guidance and mitigating guidance has been advised as new variants of the virus have emerged.

This assessment framework provides assurance on actions in place to meet legislative requirements relating to:-

- *Health and Social Care Act 2008 Code of Practice on the Prevention and Control of Infections and Related Guidance* (2015), which is linked directly to *Regulation 12 of the Health and Social Care Act 2008*
- Personal Protective Equipment at Work Regulations 1992
- Workplace (health, safety and welfare) Regulations 1992

In the context of COVID-19, there is an inherent level of risk for NHS staff that are treating and caring for patients. Within the healthcare setting, transmission risks can arise from: patient to staff, staff to staff, staff to patient and patients to patient. Robust risk assessment processes are central to ensuring that these risks are identified, managed and mitigated effectively.

The risk assessment process will be continuous alongside review of emerging information to ensure that as an organisation the Trust can respond in an evidence-based way to maintain the safety of patients, services users and staff.

This Assurance Framework and Action Plan will be reviewed monthly by the Infection Prevention and Control Team and submitted to Infection Control Sub-Committee, with an action plan to address any emerging areas of concern identified.

2. KEY ELEMENTS

1. Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks posed by their environment and other service users			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure:			
• Infection risk is assessed at the front door and this is documented in patient notes	• Where patients are conveyed by the Ambulance Service with possible or confirmed infection risk for COVID-19 they are risk assessed pre-hospital by the Ambulance staff to inform destination decision. Government guidance for Ambulance Trusts is used for decision making https://www.gov.uk/government/publications/covid-19-guidance-for-ambulance-trusts/covid-19-guidance-for-ambulance-trusts • ED are pre-alerted by the Ambulance Service of suspected Covid-19 cases	• Some COVID-19 positive individuals present at the hospital as asymptomatic patients	• Patient placement government guidance flow chart in place Mandatory surveillance\ncv2019\COVID-19 information\COVID-19 - Effective Patient Placement v2.1.docx • ED reorganized to have Hot and Cold respiratory assessment areas to segregate patients presenting with suspected Covid-19 from other attendees • All patients admitted via ED are screened for Covid-19, data reviewed daily
	• Electronic infection risk assessment tool in Lorenzo (Electronic Patient Record)	• Compliance with completion of infection risk assessments	• Audit of compliance with admission infection risk assessments planned
	• Covid-19 Alert added to Lorenzo for all patients with a positive SARS-CoV-2 swab and updated with additional swab results • **>2100** Covid-19 alerts added to individual patient records on Lorenzo (11/02/2021)		• IT surveillance system in place to track day of admissions, day 3 and day 5 screening. Matrons and Lead Nurses review result daily to ensure Trust Covid-19 screening SOP is adhered to

1. Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks posed by their environment and other service users			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure:			
	• Covid-19 shielding Alerts added to Lorenzo		• Re-audit of screening compliance planned
	• Alerting system in place for other healthcare associated infections: (MRSA; CDT; GRE; CPE; MDROs)		
• Patients with possible or confirmed COVID-19 are not moved unless this is essential to their care or reduces the risk of transmission	• SOP for patient placement. Patients are assessed for location of care according to Clinical Frailty Score and WHO Performance Status and clinical specialty need • The Trust is following PHE national guidance with admission screening and repeat swabbing undertaken 3 and 5 days post admission or sooner if initial test was negative and patient exhibits symptoms. Further repeat screening if symptoms develop • Screening data • Safe transfer systems in place, including a transfer team and security escort with corridor clearance to limit exposure risks	• Potential incorrect or change in placement requirements identified • Guidance for 2 negative results before moving patients is under review and implementation plan being developed	• SOP for patient placement in place which is in line with PHE national guidance • Operational Manager/Silver Command oversight of patient placement at Bed Meetings (4 times per day and frequency increased at times of increased activity/demand)
• Compliance with the national guidance around discharge or transfer of COVID-19 positive patients	• In-house discharge screening is in place prior to transfer to care homes to facilitate timely and appropriate discharge of patients • The Trust is following PHE national guidance with repeat swab undertaken 48 hours prior to discharge/transfer • Included in Covid-19 screening SOP and Transfer to Care Home Pathway	• Assurance of full compliance with the Trust guidance for discharge screening • Update to discharge SOP required to incorporate latest guidance on not undertaking repeat	• Audit of compliance with discharge screening planned • Care Home process in place to request screening results prior to transfer • Care Homes request evidence of screening prior to accepting patients

1. Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks posed by their environment and other service users			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure:			
		screening on patients with Covid-19 positive result within 90 days	
• Monitoring of IPC practices, ensuring resources are in place to enable compliance with IPC practice	• Hand hygiene audits • PPE audits • Environmental audits • High impact intervention audits • Supplies monitoring of PPE levels daily		
• Monitoring of compliance with PPE, consider implementing the role of PPE guardians/safety champions to embed and encourage best practice	• PPE audits AGP/non-AGP • PPE champions implemented with role defined		• Refresh PPE champions role in February 2021
• Staff testing and self-isolation strategies are in place and a process to respond if transmission rates of COVID-19 increase	• Staff screening in place for: symptomatic staff and asymptomatic staff in outbreaks • Occupational Health Service monitor staff cases and areas where clusters of cases are identified are reported to the IPC team • Self-testing – lateral flow implemented November 2020 with guidance on action to take according to results. Compliance monitored at Tactical meetings • Review underway and plan in progress for introducing LAMP testing		

1. Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks posed by their environment and other service users			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure:			
• Training in IPC standard infection control and transmission-based precautions are provided to all staff	• Local induction and mandatory IPC training includes standard infection control and transmission-based precautions	• Level 2 Training attendance figures are less than 85%	• Training session is being recorded and information on Covid-19 added to face to face mandatory training session. E-learning session is also being updated.
• IPC measures in relation to COVID-19 should be included in all staff Induction and mandatory training	• Mandatory IPC training updated to include guidance on COVID -19	• IPC induction is currently via e-learning	• Training session is being recorded and information on Covid-19 added to face to face mandatory training session. E-learning session is also being updated.
• All staff are regularly reminded of the importance of wearing face masks, hand hygiene and maintaining physical distance both in and out of work	• PPE booklet (version 2) distributed in Dec 20 • Sharing of learning from incidents including social distancing in break areas and car sharing • PPE posters in all clinical areas • Desk top messages • Daily (weekdays) Covid-19 Safety huddle		• PPE posters revised 02/2021 • Use of electronic desk top messages on hands, face, space, clean workplace • Safety briefings • Daily Covid-19 safety huddle
• **All staff (clinical and non-clinical)** are trained in putting on and removing PPE; know what PPE they should wear for each setting and context; and have access to the PPE that protects them for the	• PPE guidance included in the Covid 19 Policy is line with PHE national Guidance • PPE Trust Board paper • Trust wide risk assessment • Local risk assessments in place for the use of PPE • Infection Prevention and Control Team support staff education for PPE • PPE training records		• PPE champions (58) support staff education/face to face training • Updates on changes to guidance communicated as and when received • PPE audit tool developed for aerosol/non-aerosol generating procedures – weekly audit

1. Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks posed by their environment and other service users			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure:			
appropriate setting and context as per national guidance	• PPE Audit records • Face Masks distributed to all Non-clinical areas on Friday 12th June ahead of the change in guidance for PPE to be worn in non-clinical areas • Risk assessments include details on Covid-19 secure and when face masks are required • PPE training for visitors where compassionate visiting requirements are indicated • PPE safety Champions		• Covid-19 PPE staff information booklet (x2) • PHE PPE training video website links shared and compliance monitored • Supplies including PPE is a standing agenda item at the Tactical Meetings and estimated usage rates have been added to all Recovery Plans • A protocol is in place for both in and out of hours access to PPE • Further PPE training with PPE champions in July and August 2020
• National IPC guidance is regularly checked for updates and any changes are effectively communicated to staff in a timely way	• Subscription and daily review of Gov.UK email updates. Covid-19 Policy is updated as updates are received (currently version 7) shared at Trust Wide Safety Briefing (TWSB) and via Covid daily Bulletin • Control Room with dedicated email address receives national updates which are distributed as and when received for timely action • Compliance framework tracking compliance with national guidance under clearly defined work streams with nominated leads	Update required and in progress in line with latest guidance published 01/2021	• Coronavirus Assessment Pod decontamination SOP • Coronavirus Policy version 7. Updates shown in different coloured font to support staff more easily identify latest changes/ updates • SOP for patient placement during Covid-19 pandemic • Quantitative Fit Testing SOP • Qualitative Fit Testing SOP

1. Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks posed by their environment and other service users			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure:			
			• Reusable PPE Decontamination SOP • Covid-19 Screening SOP • Hospital onset Covid 19 and Outbreak Management SOP • Staff screening SOP • Review of compliance against national guidance • Policies, guidelines and SOPs and updates are distributed by Trust Wide Safety Brief
• Changes to guidance are brought to the attention of boards and any risks and mitigating actions are highlighted	• Covid-19 Tactical Group Meetings and Recovery Board Meetings in place with clear escalation route to Trust Board • Tactical meetings (initially daily (weekdays) from 18/03/20 and stepped down to 3 times per week 01/05/20 and then to weekly from 06/07/20 • Recovery Board Meetings twice per week starting on 05/05/20 feed into Strategic Executive Oversight Group (SEOG) meeting and this feeds into Board. The Associate Director of IPC attends Tactical and Recovery meetings as do the DIPC and Deputy DIPC/Consultant Microbiologist Infection Control Doctor • COVID Non-Executive Director Assurance Committee (COVNED)		

1. Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks posed by their environment and other service users			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure:			
• Risks are reflected in risk registers and the Board Assurance Framework (BAF) where appropriate	• A Covid-19 specific Risk Register has been created with risks escalated to the corporate Risk Register and Trust BAF as appropriate. Updates are discussed at the Quality Assurance Committee • Corporate Risks include impact on activity • Local risk assessments in place for the use of PPE • 2 risks on the BAF linked to: - national shortage of PPE - oxygen supply		• PPE is a standing agenda item for monitoring levels at the Tactical Meetings and estimated usage rates have been added to all Recovery Plans • Oxygen daily SitRep continued beyond national reporting requirements to provide local assurance • HSIB interim bulletin on oxygen January 2021 is under review
• Robust IPC risk assessment processes and practices are in place for non COVID-19 infections and pathogens	• Existing IPC policies in place: - Chickenpox - Clostridium difficile - Scabies - Shingles - Meningitis - MRSA - Multi-drug resistant organisms - Influenza - TB/ MDR TB - Viral Gastroenteritis - Viral haemorrhagic fevers - Isolation of immunosuppressed patients • SOPs for rapid testing for CPE/ MRSA and enteric and respiratory pathogens		• Clostridium difficile Guidelines (2018) in place and all patients with a C. difficile toxin positive or PCR positive result are isolated • Ribotyping of all community onset healthcare associated and hospital onset healthcare associated cases • Root Cause Analysis investigation for all hospital apportioned cases • Compliance with Mandatory HCAI reporting requirements • Distribution of HCAI surveillance data weekly

1. Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks posed by their environment and other service users			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure:			
	• Isolation for other infections and pathogens is prioritised based on transmission route		• Re-establishing the C. difficile Cohort Ward is included in Recovery Plans • GNBSI reduction Action Plan has been revised and work stream is being reinstated
• Trust CEO or the executive responsible for IPC approve and personally signs off, all data submissions via the daily nosocomial sitrep. This will ensure the correct and accurate measurement and testing of patient protocols are activated in a timely manner	• Sign off process in place for daily nosocomial SitRep • Data validation process for new admissions and inpatient Covid-19 tests prior to forwarding for sign off		
• Ensure Trust Board has oversight of ongoing outbreaks and action plans	• Information on outbreaks included in daily executive summary and discussed at the daily Senior Executive Oversight Group Meeting • Learning from Outbreaks included in Nosocomial Board Paper 01 2021		

2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure:			
• Designated teams with appropriate training are assigned to care for and treat patients in COVID-19 isolation or cohort areas	• SOP for patient placement (agreed ward and critical care locations). Patients are assessed for location of care according to Clinical Frailty Score and WHO Performance Status. Respiratory Step Down Unit SOP • Simulation training • Availability of rapid SARS-CoV2 testing	• Revision to SOP to agree placement of suspected Covid-19 cases according to clinical speciality as cases decrease with Recovery Team oversight • Response where unexpected sickness occurs	• Ongoing discussion at Nursing and Midwifery Forum, Medical Cabinet and Allied Health Professionals Forum as mitigation • Discussed at the Unplanned Care Group Meeting and action agreed to update guidance • The Matrons provide oversight of staffing levels to ensure all areas are appropriately and safely staffed
• Designated cleaning teams with appropriate training in required techniques and use of PPE, are assigned to COVID-19 isolation or cohort areas	• Task Team and Domestic Assistant training for Covid-19 cohort ward areas has been carried out • Fit Testing for FFP3 masks undertaken for Domestic Assistants in areas where aerosol generating procedures are performed • Task Team support areas where there are Domestic Assistant shortfalls		• Four additional HPV decontamination machines purchased and training on use provided
• Decontamination and terminal decontamination of isolation rooms or cohort areas is carried out in line with PHE and other national guidance	• Terminal cleaning and Decontamination polices in place including guidance on environmental disinfectant required to decontaminate the environment. Decontamination included in the Covid-19 policy		

2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure:			
	• All policies are used in conjunction with any updates provided by COVID-19 national guidance • Terminal Cleaning Guidelines 2018 • Decontamination Policy 2019 • Novel Coronavirus Policy (version 7) • Additional HPV machines purchased		
• Increased frequency, at least twice daily, of cleaning in areas that have higher environmental contamination rates as set out in the PHE and other national guidance • Attention to the cleaning of toilets/bathrooms, as COVID-19 has frequently been found to contaminate surfaces in these areas • Cleaning is carried out with neutral detergent, a chlorine-based	• Cleaning of frequently touched surfaces is included in cleaning policies • Toilets and bathroom cleaning carried out in all areas at least twice a day. Increased to 3 times per day in January 2021 • Domestic staff document when areas have been cleaned • Frequencies detailed in Trust Cleaning standards policy • Staff training records • Alternative disinfectant used in CT scanning room. Chlorine based disinfectant diluted to 1,000ppm available chlorine is used for terminal cleaning, wards where C. difficile	• Cleaning audits were halted for the initial stages of the pandemic with escalation in place from Wards and Departments in the event of any concerns regarding standards • Compatibility issue with CT scanner	• Cleaning audits have been re-instated and are carried out by staff in the Cleaning Monitoring Team • Additional monitoring carried out during outbreaks • Ward/Department audits findings are emailed to the Ward/ Department Managers for action • Domestic Supervisory team ensure standards are adhered to • CT Manufacturer provided alternative decontamination guidance

2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure:			
disinfectant, in the form of a solution at a minimum strength of 1,000ppm available chlorine, as per national guidance. If an alternative disinfectant is used, the local infection prevention and control team (IPCT) should be consulted on this to ensure that this is effective against enveloped viruses • Manufacturers' guidance and recommended product 'contact time' must be followed for all cleaning/ disinfectant solutions/products as per national guidance: • 'Frequently touched' surfaces, e.g. door/toilet handles, patient call bells, over-bed tables and bed rails, should be	cases are cared for or Hydrogen Peroxide Vapour for cases of C. difficile • Consultant Microbiologists and IPCNs included in discussions on alternative products to ensure effective against coronaviruses • Information on contact time is included in the decontamination policy • Domestic staff record when they have cleaned areas		

2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure:			
decontaminated at least twice daily and when known to be contaminated with secretions, excretions or body fluids • Electronic equipment, e.g. mobile phones, desk phones, tablets, desktops and keyboards should be cleaned a minimum of twice daily • Rooms/areas where PPE is removed must be decontaminated, timed to coincide with periods immediately after PPE removal by groups of staff (at least twice daily)	• Information on cleaning of workstations is included in the Environmental Action Plan • Domestic staff time cleaning activity when areas are vacant		
• Linen from possible and confirmed COVID-19 patients is managed in line with PHE and other national guidance and the appropriate precautions are taken	• Process for managing linen is included in the COVID-19 policy. All linen from COVID-19 possible and confirmed positive patients is treated as infectious and placed in alginate bags which are tied and then placed in a white plastic bag	• Occasional reporting of alginate bag shortage (which are provided by the laundry contractor)	• Guidance received from the Laundry Contractor to double bag used linen in white bags

2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure:			
	• No DATIX reports on non-compliance with double bagging of used/infected linen		
• Single use items are used where possible and according to Single Use Policy	• Decontamination Policy in place which includes single use/single patient use guidance used in conjunction with any updates provided by National Guidance in response to COVID-19 • Chlorine releasing agents are the nationally advised method of decontamination • Hydrogen Peroxide Vapour has been used for environmental decontamination as part of a deep clean programme for vacant patient rooms/wards		• An SOP for decontamination of reusable PPE is in place
• Reusable equipment is appropriately decontaminated in line with local and PHE and other national guidance	• Decontamination Policy in place used in conjunction with any updates provided by National Guidance in response to COVID-19	• Decontamination Meetings suspended	• Date scheduled to reconvene meetings from 17/08/20
• Ensure cleaning standards and frequencies are monitored in non-clinical areas with actions in place to resolve issues in maintaining a clean environment	• Cleaning monitoring programme in place • Monitoring result are circulated to managers for corrective action where standards are not met at time of auditing • Housekeepers accompany monitoring officers where on duty and corrective action is taken at time of auditing or as soon as possible		
• Ensure the dilution of air with good ventilation e.g. open windows, in admission and waiting	• Windows within the waiting space are opened to ventilate the area and any space having forced ventilation is adequate to keep	• Not all areas will be provided with ventilation or have	• These areas are ventilated by keeping doors and windows open where possible/ patient comfort allows

2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure:			
areas to assist the dilution of air	the area ventilated so windows can be kept closed • Signage on social distancing, hand hygiene and face coverings is displayed in ED waiting areas	the ability to open windows	
• There is evidence organisations have reviewed the low risk COVID-19 pathway, before choosing and decision made to revert to general purpose detergents for cleaning, as opposed to widespread use of disinfectants	• Currently Trust wide use of Chlorine based disinfectants in green, amber and red pathway areas		

3. Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure:			
• Arrangements around antimicrobial stewardship are maintained	• Consultant Medical Microbiology Virtual Ward Round in Critical Care • Ward based Pharmacist support • Prescribing advice available by telephone (in and out of hours)	• Reduction in antibiotic ward round activity initially • C difficile MDT was on hold in early stages of the pandemic and	• Antibiotic ward rounds re-established (2 ward rounds / week) • Critical Care daily ward rounds recommenced • Infection Control Doctor presentations to Medical Cabinet

3. Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure:			
	• Antibiotic prescribing guidelines for COVID suspected patients have been published	Cohort ward was disbanded with no single consultant covering C difficile patients	• Review as evidence/guidelines are updated • Antimicrobial Management Steering Group Meetings will be reconvened from September • C diff outliers ward rounds recommenced in July • **November Point Prevalence compliance audit 94%**
• Mandatory reporting requirements are adhered to and boards continue to maintain oversight	• Mandatory reporting of HCAIs has continued • Data on HCAIs is included on the Quality Dashboard • DIPC reports HCAI data at Trust Board • Information on Data Capture System • Distribution of HCAI surveillance data weekly	• RCA face to face meetings suspended due to COVID-19	• RCA meetings now undertaken via Microsoft Teams • Review evidence/guidelines are updated

4. Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure:			
• Implementation of national guidance on visiting patients in a care setting	• Restricted visiting implemented 17 March 2020; Visiting suspended from 26 March 2020; Compassionate visiting arrangements agreed 09 April 2020. Paper on visiting arrangements taken to SEOG	• Visitor arriving on site without knowledge of visiting arrangements	• Environmental Safety Plan includes site lock down to restrict access • Compassionate visiting arrangements agreed for the following patient groups where

4. Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure:			
	• Visiting the dying guideline in place with training provided by the Palliative Care Team • Trust wide Communication via email on visiting restrictions then cessation		close family and friends visiting may be admitted: - Patients in critical care - Vulnerable young adults - Patients living with Dementia - Autism - Learning difficulties • Loved ones who are receiving end of life care • Signage at entrances
• Areas in which suspected or confirmed COVID-19 patients are where possible being treated in areas clearly marked with appropriate signage and have restricted access	• Coronavirus posters displayed outside areas where patients with suspected or confirmed COVID-19 are cared for • Family Liaison service in place to keep relatives (virtually) updated on care of loved ones		
• Information and guidance on COVID-19 is available on all Trust websites with easy read versions	• Information on COVID-19 is available on the Trust Web Site and at entrances		
• Infection status is communicated to the receiving organisations or department when a possible or confirmed	• Covid-19 Alert added to Lorenzo for all patients with a positive SARS-CoV-2 swab (to date **>2100** alerts added – 11/02/2021) • Covid-19 has been added to e-discharge summary template	• Confusion on the layout of the template	• Changes made to the standard template to clarify results • Discussed at medical cabinet and Safety Alert distributed to all Consultants

4. Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure:			
COVID-19 patient needs to be moved			• Information added to medical staff induction training
• There is clearly displayed and written information available to prompt patients' visitors and staff to comply with hands, face and space advice	• Information on the Trust website (updated 16/10/2020) • Signage at all entrances • Hand gel and face masks provided at hospital entry points • Entrances are manned (part time) to support visitor compliance – visiting restrictions are currently in place		

5. Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure:			
• Screening and triaging of all patients as per IPC and NICE Guidance within all health and other care facilities must be undertaken to enable early recognition of COVID-19 cases	• Triage in ED includes questions on Covid-19 symptoms/ pre-admission testing results where available • Information provided prior to attending Outpatient Departments and further symptom screening in place on arrival	• Revised Guidance on returning travellers from Denmark and Mink Variant; Brazil and South Africa	• Plan to meet with ED Team to implement screening at Triage • SOP being updated to reflect requirement to transfer returning travellers from countries with SARS-CoV-2 variant and positive result to the Regional Infectious Disease Unit

5. Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure:			
• Front door areas have appropriate triaging arrangements in place to cohort patients with possible or confirmed COVID-19 symptoms and to segregate them from non COVID-19 cases to minimise the risk of cross-infection as per national guidance	• Patients conveyed to hospital by Ambulance are pre-assessed to determine where they are taken to in ED • ED reorganised to have Hot and Cold respiratory assessment areas to segregate patients presenting with suspected Covid-19 • Triage in ED and segregated areas for patients suspected to have COVID-19 • Environmental Safety Action Plan with proposal to lockdown 25% of entrances • Manned mask stations at main entrance Warrington site (part time) and mask available at other entrances with access to hand sanitisers	• Asymptomatic patients subsequently identified as COVID-19 positive	• Process in place to isolate and close the bay to admissions when exposure incidents occur
• Staff are aware of agreed template for triage questions to ask	• Questions are asked of patients at booking in ED	• Awaiting copy of template	• Plan to meet with ED Team to implement screening at Triage • SOP being updated to reflect requirement to transfer returning travellers from countries with SARS-CoV-2 variant and positive result to the regional Infectious Disease Unit
• Triage undertaken by clinical staff who are trained and competent in the clinical case definition	• Senior ED staff are rostered to carryout Triage		

5. Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure:			
and patient is allocated appropriate pathway as soon as possible			
• Face coverings are used by all outpatients and visitors	• Observational checks carried out in Departments	• Patient refusal or inability to wear a face covering due to an underlying condition	• Social distancing maintained where patients and anyone accompanying them cannot wear a face mask • SOP required to support staff decision making in relation to continuing with procedure with reasonable adjustments to ensure staff safety where patients are exempt
• Face masks are available for patients with respiratory symptoms	• Face masks available for all patients	• Some patients are unable to tolerate face masks	• Social distancing maintained where patients and anyone accompanying them cannot wear a face mask
• Provide clear advice to patients on use of face masks to encourage use of surgical facemasks by all inpatients in the medium and high-risk pathways if this can be tolerated and does not compromise their clinical care	• Masks are offered to patients where O_2 therapy is not required and 2 metre distancing is not possible • Mask use is recorded in Lorenzo and on care and comfort rounds • Masks are worn when transferring between wards/departments	• Some patients are unable to tolerate face masks	• Use of clear curtains to create a physical barrier

5. Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure:			
• Ideally segregation should be with separate spaces, but there is potential to use screens, e.g. to protect reception staff	• Estate work has been carried out to install additional doors within ED • Where available, doors are closed on ward corridors to separate Covid and non-Covid areas • Perspex screens have been installed in a number of reception areas		
• For patients with new-onset symptoms, isolation, testing and instigation of contract tracing is achieved until proven negative	• Symptomatic screening is advised after 48 hours if admission screen result was negative • Routine swabs for Covid have been added to the sepsis screening packs • Isolation facilities are prioritized for patients with suspected infections transmitted by the respiratory route • Contact tracing is including in the Covid-19 Hospital Onset and Outbreak Investigation SOP	• Low number of available side rooms	• Patients are isolated where possible. Clear curtains are used as barriers where isolation rooms are not available • Patients are socially distanced as far as reasonably achievable
• Patients with suspected COVID-19 are tested promptly	• Admission screening has been updated in line with national guidance and currently includes all admissions • IT surveillance system in place to track day of admissions day 3 & day 5 screening. Matrons and Lead Nurses review result daily & ensure Trust Covid-19 screening SOP is adhered to • Rapid screening swabs are available, limited number (6 -7 per day). On site testing is in place with same day turnaround of results for routine specimens	• RCA investigation findings are demonstrating a small number of day 3 and day 5 swabs have been omitted	• Additional control measures put in place to ensure compliance including reminders via daily safety brief, emails to senior staff, electronic monitoring system

5. Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure:			
• Patients that test negative but display or go on to develop symptoms of COVID-19 are segregated and promptly re-tested and contacts traced promptly	• Repeat patient testing in place where there are on-going concerns about COVID-19 and initial swab was negative • SOP on Covid-19 screening and isolation and PPE in place • Contact tracing is including in the Covid-19 Hospital Onset and Outbreak Investigation SOP • Letter in place for follow-up of discharged patients who have had contact with Covid-19	• Low number of available side rooms	• Patients are isolated where possible. Clear curtains are used as barriers where isolation rooms are not available • Patients are socially distanced as far as reasonably achievable
• Patients that attend for routine appointments who display symptoms of COVID-19 are managed appropriately	• Rapid testing available 7 days per week • Routine appointments have been stepped down. Social distancing measures are in place in Outpatient Departments • Recovery plan for Outpatients (28/05/2020) includes providing information not to attend if unwell with Covid-19 symptoms • Risk rated appointment schedule based on clinical priority • Virtual 'attend anywhere' clinics • Rooms identified for shielding patients	• Public compliance with social distancing measures	• Social distancing measures are in place in Outpatient Departments • Signage in place to keep left on corridors, walk in single file and socially distance • Seating arranged in Outpatient waiting areas to support social distancing

6. Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure:			
• Separation of patient pathways and staff flow to	• Environmental Action plan in place • Keep left signage in place for internal walkways		

6. Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure:			
minimise contact between pathways. For example, this could include provision of separate entrances/exits (if available) or use of one-way entrance/exit systems, clear signage, and restricted access to communal areas	• Restricted key codes/controlled entry in place • Green pathway for surgical patients at CSTM building • Wards identified for care of patients with Covid-19 as per Trust escalation plan		
• All staff (clinical and non-clinical) have appropriate training, in line with latest national guidance, to ensure their personal safety and working environment is safe	• PPE Champions (58), roving training on donning and doffing of PPE • Links to PHE videos have been distributed. Individual booklets on COVID-19 and PPE produced and distributed • Training records from all CBUs that staff have read the Covid-19 policy, receive the PPE booklet, watched the PHE videos, received face to face training, read the Covid-19 swabbing SOP	• Staff returning to work, including after pregnancy, shielding or long term sick leave may not be fully informed with the latest guidance	• Action plan in place with Unplanned and Planned Care Groups to ensure all staff return to work receive appropriate level of training • Action plans in place with CBUs where there are shortfalls in staff training • IPC Team provide ongoing training to PPE champions on donning and doffing of PPE • Links to PHE videos are available and distributed

6. Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure:			
• All staff providing patient care are trained in the selection and use of PPE appropriate for the clinical situation and on how to don and doff it safely	• Links to PHE videos have been distributed. Posters are displayed in clinical areas on donning and doffing • Information recirculated to Planned and Unplanned Care Groups • Information circulated on Trust Wide Safety Brief	• Posters not displayed in all areas • Staff returning from absence may not be fully informed/updated with latest guidance • PPE to be maintained on CBU Governance agenda's	• Additional posters ordered and site survey to be completed by IPCNs with PPE champions for each area • IPC team provide ongoing training on donning and doffing of PPE. Links to PHE videos are available and distributed • Request addition via Governance Teams
• A record of staff training is maintained	• Record of training	• Follow up of staff training records required and identify shortfalls	• Action plan in place with Unplanned and Planned Care Groups to ensure all staff return to work receive appropriate level of training • Action plans in place with CBUs where there are shortfalls in staff training
• Appropriate arrangements are in place that any reuse of PPE in line with the MHRA CAS alert is properly monitored and managed	• Reusable (laundered gowns) introduced as part of contingency as per national guidance as a temporary measure during national shortage of gowns • PPE paper submitted to Trust Board and Risk Assessment in place		

6. Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure:			
	• Decontamination SOP for reusable equipment including replacement of filters for respiratory protective equipment		
• Any incidents relating to the re-use of PPE are monitored and appropriate action taken	• To date 19 incidents reported relating to Covid-19 - Communication of suspected infection status - Distribution of non-fluid repellent gowns • Reusable FFP3 respirators labelled as latex free – however do have latex content		• Non-fluid repellent gowns withdrawn from use • Trust wide alert and email sent to users to complete Latex questionnaire and return to Occupational Health or return for alternative mask fit testing
• Adherence to PHE national guidance on the use of PPE is regularly audited	• Observational audits completed and feedback received from PPE Champions • Electronic Audit Tool developed and launched 15/05/20 • Audits are carried out weekly and repeated in a shorter timescale where issues are identified	• Trust wide over view of compliance	• Dashboard being set up
• Hygiene facilities (IPC measures) and messaging are available for all patients/ individuals, staff and visitors to minimise COVID-19 transmission such as: - hand hygiene facilities including instructional posters	• Hand washing signage – wash hands more frequently & for 20 seconds • Catch it Bin It Kill Posters displayed throughout the Trust		• Hand washing technique posters to be refreshed

6. Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure:			
- good respiratory hygiene measures - maintaining physical distancing of 2 metres wherever possible unless wearing PPE as part of direct care - frequent decontamination of equipment and environment in both clinical and non-clinical areas - clear advice on use of face coverings and facemasks by patients/individuals, visitors and by staff in non-patient facing areas	• Social distancing signage in place Trust-wide • Ring the bell cleaning initiative implemented • Office risk assessments in place including use of masks if not in a single person office		
• Staff regularly undertake hand hygiene and observe standard infection control precautions	• Programme of hand hygiene audits in place – carried out weekly in areas operational. Overall compliance • April =98%; May=98%; June=98%, July=98%, August=99%, September=98%, October 98%, November=98%, December=98%, January=98%		
• The use of hand air dryers should be avoided in all clinical areas • Hand dryers in toilets are associated with greater risk of droplet spread than	• Hand air dryers not in place in clinical areas • Removal of hand driers in public toilets (none in clinical areas) has taken place as part of the environmental action plan		

6. Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure:			
paper towels. Hands should be dried with soft, absorbent, disposable paper towels from a dispenser which is located close to the sink but beyond the risk of splash contamination, as per national guidance	• Hand towel dispensers have been installed and waste collection schedule put in place		
• Guidance on hand hygiene, including drying, should be clearly displayed in all public toilet areas as well as staff areas	• Signage on hand washing technique is displayed on all soap dispensers. • HM Government signage has been displayed detailing 20 second handwashing		
• Staff understand the requirements for uniform laundering where this is not provided for on site	• Guidance on home laundering is included in the COVID-19 PPE information leaflets • Scrub Suits have been offered as an alternative to uniforms and are laundered centrally • Trust wide emails with guidance on laundering		
• All staff understand the symptoms of COVID-19 and take appropriate action (even if experiencing mild symptoms) in line with PHE national guidance and other if they or a member	• Staff shielding and screening for COVID-19 is undertaken in line with national guidance • Monitored by the Occupational Health and Wellbeing Team and overseen by the Workforce and Organisational Development Team		

6. Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure:			
of their household display any of the symptoms			
• A rapid and continued response through ongoing surveillance of rates of infection transmission within the local population and for hospital/ organisation onset cases (staff and patients/ individuals)	• Local statistics included in Tactical meetings agendas • Surveillance on hospital onset patient cases included on the Integrated Performance Report • Information on staff cases/outbreaks reported at Senior Executive Oversight Group by DIPC		
• Positive cases identified after admission that fit the criteria for investigation should trigger a case investigation. Two or more positive cases linked in time and place trigger an outbreak investigation and are reported	• Root Cause analysis investigation requested for all cases ≥ day 8 of admission • Outbreak reporting protocol in place including to: - Trust board - NW.ICC; PHE; CCG; CQC; NHSE/I via web-based reporting system		Process in place for RCA review with IPCT and Governance Department
• Robust policies and procedures are in place for the identification of and	• Daily surveillance in place of ≥ day 8 cases and location tested to promptly identifying clusters and initiate outbreak investigation accordingly • Occupational Health and Wellbeing Team monitor for clusters of staff cases		

6. Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure:			
management of outbreaks of infection			

7. Provide or secure adequate isolation facilities			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure:			
• Restricted access between pathways if possible, (depending on size of the facility, prevalence/ incidence rate low/high) by other patients/individuals, visitors or staff	• Green pathway for Surgical cases at CSTM building • ICU expansion into theatre for non-Covid ICU cases in theatre pods and use of recovery for patients with Covid-19		
• Areas/wards are clearly signposted, using physical barriers as appropriate to patients/individuals and staff understand the different risk areas	• Signage in place stating Covid-19 cases on wards • Barriers in place to support - Keep left - Distancing in waiting areas	• Signage review	• Signage review to clearly state areas are Red, Amber of Green and written information to state what this means
• Patients with suspected or confirmed COVID-19 are isolated in appropriate	• SOP for patient placement. Patients are assessed for location of care according to Clinical Frailty Score and WHO Performance Status	• Limited number of single rooms for isolation (65)	• Cohorting in place as advised by the Infection Prevention and Control Team

7. Provide or secure adequate isolation facilities			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure:			
facilities or designated areas where appropriate			• Operational Manager/Silver Command oversight at Bed Meetings (4 times per day and frequency increased at times of increased activity/demand)
• Areas used to cohort patients with suspected or confirmed COVID-19 are compliant with the environmental requirements set out in the current PHE national guidance	• Additional hand washing facilities in anterooms on ward A7 • Side rooms in use for non-clinical activity converted back for clinical inpatient use - 2 single rooms on A2 - 1 single room on A7 - Plans in place for 4 additional single rooms: 2 between A5 and A6; and 2 between A8 and A9 - 3 single room pods built in AMU		
• Patients with resistant/alert organisms are managed according to local IPC guidance, including ensuring appropriate patient placement	• Isolation Policy in place • Elective surgery/Endoscopy including pre-operative assessment SOPs including (advice on self –isolation and Covid testing before surgery). Staff temperature/ symptoms screening in elective care areas to minimise transmission • Provision of seating with social distancing in out-patient areas and availability of face masks for patients in addition to staff • All patients in waiting areas will wear a mask / face covering unless it compromises their breathing and for that there would be	• Limited number of side rooms further reduced by ward closures • Potential non-compliance of patients with shielding pre-operatively	• Isolation priority protocol in place based on transmission based precautions

7. Provide or secure adequate isolation facilities			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure:			
	alternative arrangements (as per published FAQs)		

8. Secure adequate access to laboratory support as appropriate			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
There are systems and processes in place to ensure:			
• Ensure screens taken on admission given priority and reported within 24hrs	• In house testing with aim to report results within 6 hours (routine screen and rapid test within 90 minutes • Laboratory operating hours expanded to 24/7 w/c 25/01/21 for 3-week period	• Updated requirement for 2 negative results before moving patients	• Protocol implemented 05/02/21 describing screening methods for patients in ED
• Regular monitoring and reporting of the testing turnaround times with focus on the time taken from the patient to time result is available	• Audit data on Covid-19 testing turnaround times is reported to Silver IPC Cell		
• Testing is undertaken by competent and trained individuals	• Training on swabbing technique provided verbally and by video	• Small number of samples rejected due to insufficient cellular material or incorrectly labelled	• Swabbing SOP and training provided • Competency assessment tool launched
• Patient and staff COVID-19 testing is undertaken promptly and in line with PHE and other national guidance	• Updates to guidance provided in light of swab availability changes to national guidance • Swabbing SOP in place covering day of admission, day 3, day 5, weekly thereafter if previous results negative, symptomatic, pre-admission elective and discharge screening		

8. Secure adequate access to laboratory support as appropriate			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
• Regular monitoring and reporting that identified cases have been tested and reported in line with the testing protocols (correctly recorded data)	• LION BIS used to monitor testing in line with guidance and follow-up of omitted tests on admission/ day 3 /day 5/ weekly from day 5 • Documentation of IPC advice on receipt of positive results • RCA requests for cases ≥ day 8 of admission, with monitoring system in progress • Daily data validation process for Sit Rep signoff		
• Screening for other potential infections takes place	• Other routine admission screening (CPE,MRSA,VRE) in place		

9. Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure that:			
• Staff are supported in adhering to all IPC policies, including those for other alert organisms	• PPE Champions in place • Clinical advice for management of patients with suspected infections continued • IPC 7 day and on call service		
• Any changes to the PHE national guidance on PPE are quickly identified and effectively communicated to staff	• Subscription and daily review of Gov.UK email updates. Covid-19 Policy is updated as updates are received (currently version 7). TWSB and Covid daily Bulletin used to communicate updates	Update required and in progress in line with latest guidance published 01/2021	• Subscription and daily review of Gov. UK email updates • Control Room inbox is monitored 7 days per week and guidance issued over

9. Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure that:			
			the weekend- out or of hours is escalated for action • Additional posters ordered Links to PHE videos are available on the Trust Hub and distributed
• All clinical waste related to confirmed or suspected COVID-19 cases is handled, stored and managed in accordance with current national guidance	• Guidance included in Covid-19 Policy. Early guidance adhered to when initial classification of a HCID. Waste was quarantined and disposed of by incineration • Guidance included in the Coronavirus Policy	• Some delays in waste collection from site	• Additional waste storage capacity to ensure securely stored away from the public whilst awaiting collection
• PPE stock is appropriately stored and accessible to staff who require it	• Stock control in place • In and out of hours access protocol in place • Specialist PPE equipment office with access available 7 days/week		

10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Appropriate systems and processes are in place to ensure:			
• Staff in 'at-risk' groups are identified and managed appropriately including ensuring their physical and	• An integrated risk assessment has been produced for staff who are 'extremely vulnerable', at 'increased risk', pregnant and Black, Asian and Minority Ethnic (BAME) staff.		

10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Appropriate systems and processes are in place to ensure:			
psychological wellbeing is supported	For BAME staff, based on the number of BAME staff recorded on ESR, there is 93.5% compliance. All BAME staff risk assessments will be quality checked and a sample audit will take place in July 2020 to ensure agreed actions have been undertaken • Chief People Officer and Chief Executive Officer and Chairman attended the BAME Staff Network Group in June 2020 to receive feedback • Individual letters have been sent to BAME members of staff, outlining support available • Named midwife contact within Maternity Department provided for pregnant staff • All staff who are considered clinically extremely vulnerable are supported by robust workforce support and the Trust are in the process of having one to one discussions to agree support and adjustments • All staff working at home have been provided with a 'working from home pack', including access to mental health support • Enhanced Occupational Health Service to 7 days per week with additional staffing both administration and clinical • An enhanced wellbeing offer has been developed, linked to learning from Wuhan, Italy and the British Psychological Society		

10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Appropriate systems and processes are in place to ensure:			
	• Electronic system in place for Covid-19 Workforce risk assessment • Access to face to face counselling		
• Risk assessment(s) is (are) undertaken and documented for any staff members in an at risk or shielding groups, including Black, Asian and Minority Ethnic (BAME) and pregnant staff	• Process in place for electronic self-assessment followed by manager assessment if risks are identified – compliance with completion of risk assessments is monitored by the HR Department		
• Staff required to wear FFP reusable respirators undergo training that is compliant with PHE national guidance and a record of this training is maintained and held centrally	• Fit testing programme, including quantitative and qualitative testing, in place • Qualitative Fit testing SOP • Quantitative Fit testing SOP • Records are added to a central database • Powered Hoods are offered as an alternative where it has not been possible to Fit close fitting face masks • Only EN 149:2001 compliant masks are accepted as fit for use for Aerosol Generating procedures		
• Staff who carry out fit test training are trained and competent to do so	• Programme of Fit Testing in place which is only carried out by trained Fit testers • An accredited Fit2Fit company or the Department of Health virtual training provided staff training		
• All staff required to wear an FFP respirator have	• Programme of Fit Testing in place		

10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Appropriate systems and processes are in place to ensure:			
been fit tested for the model being used and this should be repeated each time a different model is used	• Compliance with Fit testing is monitored. Paper submitted to QAC in February 2021		
• A record of the fit test and result is given to and kept by the trainee and centrally within the organisation	• Spreadsheet with Fit testing details included	• Data not held on ESR	• Action in place to review use of ESR for recording Fit Testing records
• For those who fail a fit test, there is a record given to and held by trainee and centrally within the organisation of repeated testing on alternative respirators and hoods	• Spreadsheet with Fit testing details included	• Data not held on ESR	• Action in place to review use of ESR for recording Fit Testing records
• Members of staff who fail to be adequately fit tested a discussion should be had, regarding re deployment opportunities and options commensurate with the staff members skills and experience and in line with nationally agreed algorithm	• Alternative respiratory protection is offered i.e. powered hood • Staff are redeployed to green pathway areas or amber areas where aerosol generating procedures are not performed • Provision of specialist PPE equipment is recorded including advice on decontamination of re-usable PPE		

10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Appropriate systems and processes are in place to ensure:			
• A documented record of this discussion should be available for the staff member and held centrally within the organisation, as part of employment record including occupational health	• Provision of specialist PPE equipment is recorded	• Documented evidence of discussion and central holding of this record	• Process under review to capture this data
• Following consideration of reasonable adjustments e.g. respiratory hoods, personal reusable FFP3, staff who are unable to pass a fit test for an FFP respirator are redeployed using the nationally agreed algorithm and a record kept in staff members personal record and Occupational health service record	• Provision of specialist PPE equipment is recorded	• Documented evidence of discussion and central holding of this record	• Process under review to capture this data
• Boards have a system in place that demonstrates how, regarding fit testing, the organisation maintains staff safety and provides safe care across all care settings. This system	• Spreadsheet with Fit testing details included • Compliance with Fit testing is monitored. Paper submitted to QAC in February 2021	• Data not held on ESR	• Action in place to review use of ESR for recording Fit Testing records • Information on Fit testing figures is reported at Tactical meetings and

10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Appropriate systems and processes are in place to ensure:			
should include a centrally held record of results which is regularly reviewed by the board			included at Senior Executive Oversight Group Meetings • Report to QAC 02/2021
• Consistency in staff allocation is maintained, with reductions in the movement of staff between different areas and the cross-over of care pathways between planned/elective care pathways and urgent/ emergency care pathways, as per national guidance	• Staffing reviews undertaken for all COVID areas • Staff movements managed by the senior nursing team at daily meetings • Senior Nurse presence 7 days per week 8am-8pm to support staffing management • Planned elective areas have designated teams, who are not moved to any other area in the Trust • Where it is necessary to move staff between different areas to support patient safety, this is discussed with the Infection Control Team. This cross over has not occurred between Elective and Emergency Care pathways		
• All staff adhere to national guidance on social distancing (2 metres) wherever possible, particularly if not wearing a facemask and in non-clinical areas	• Signage in place along corridors to socially distance, keep left and walk in single file • Risk assessments of all areas to achieve Covid-19 Secure spaces • IPC Team and/or Health and Safety Team review where concerns have been raised		
• Health and care settings are COVID-19 secure workplaces as far as practical, that is, that any workplace risk(s) are	• Risk assessment in place to reduce risk • Agile working policy		

10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Appropriate systems and processes are in place to ensure:			
mitigated maximally for everyone			
• Staff are aware of the need to wear facemask when moving through COVID-19 secure areas.	• Guidance on PPE distributed by email, PPE booklet, posters		
• Consideration is given to staggering staff breaks to limit the density of healthcare workers in specific areas	• Requirement to stagger breaks is included in the Covid-19 Environmental Safety Plan		
• Staff absence and well-being are monitored and staff who are self-isolating are supported and able to access testing	• Managers have been supported to record absence in 'real time'. Daily and weekly absence reporting is in place		
• Staff that test positive have adequate information and support to aid their recovery and return to work	• A COVID-19 Occupatinal Health advice line has been created, to provide a range of advice and guidance to the workforce • The OH Service has also developed the co-ordination and advice service for staff testing (for symptomatic staff) • Enhanced Occupational Health Service to 7 days per week with additional staffing both administration and clinical • Occupational Health and Wellbeing advise staff of test results and provide further wellbeing support as and when required	• Test and Trace Service hours of operation	• National guidance for 16 hour per day service (cover in place for 11.5 hours per day) • Notifications from Test and Trace are received in the Control Room and forwarded to the Occupational Health and Infection Control Teams for action

10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Appropriate systems and processes are in place to ensure:			
	• Retesting is in place as appropriate and is set out in Staff Testing SOP		

3. ACTIONS REQUIRED/RESPONSIBLE OFFICER

- Include in cycle of business for Infection Control Sub-Committee and keep under continuous review to identify any emerging information that would require addition to the action plan
- Monitor the action plan to address gaps in assurance until completion

4. IMPACT ON QPS?

- **Q**: Visiting restrictions due to risk of infection may have a negative impact on patient experience. A number of communication mechanisms have been implemented

- **P**: Risk to staff health and wellbeing from anxiety associated with the unknown situation and risk of infection of self and family members. Risk from continuous high pressure/demand on healthcare services. A number of staff are absent from work due to Clinically Extremely Vulnerable (CEV) requirements

- **S**: Financial impact of a global pandemic and major interruption to business as usual

5. MEASUREMENTS/EVALUATIONS

- Incident reporting
- IPC BAF Action plan monitoring
- Environmental Action Plan monitoring

6. TRAJECTORIES/OBJECTIVES AGREED

- To ensure compliance with the Code of Practice on prevention of Healthcare Associated Infections

7. MONITORING/REPORTING ROUTES

- Infection Control Sub-Committee
- Quality Assurance Committee
- Senior Executive Oversight Group
- Trust Board

8. TIMELINES

- For the duration of the Covid-19 pandemic at all stages which is yet to be determined

9. ASSURANCE COMMITTEE

- Infection Control Sub-Committee

10. RECOMMENDATIONS

- The Board of Directors is asked to receive the report

APPENDIX ACTION PLAN for IPC BAF

Ref No	Action required	Target date	Date met	Supporting action	Lead	Supported by	Evidence/ Current position	RAG status
Criterion 1 Systems are in place to manage and monitor the prevention and control of infection								
1	Guidance requires 2 negative results before moving patients	Feb 21		Meetings with UEC Triumvirate	UEC	DCN	PCR testing: review underway to introduce LFT and meeting held to discuss resource requirement	
2	PPE champions role refresher	Mar 21		Teams meeting with PPE champions	IPCNs	DCN	58 nominated PPE champions	
3	Improve compliance with level 2 IPC training	May 21		Provision of additional training sessions	IPCN	ACNs Planned & Unplanned Care	Currently less than 85% compliance	
4	Revision to Trust Covid-19 Policy	Mar 21			ADIPC	CMMs		
Criterion 2 Provide and maintain a clean and appropriate environment								
5	Training of core group of staff to use the HPV decontamination machines	Mar 21		Provision of training by the supplier	ADE	DCN IPCNs	Training provided to Warrington site task team members	
Criterion 3 Ensure appropriate antimicrobial use to optimise patient outcomes								
6	Re-establish C. difficile MDT	Aug 20	Aug 20		CMMs	AMD Unplanned Care Group IPCNs	MDT meetings recommence date 17/08/20 however not being scheduled as planned in early 2021	
7	Re-establish HCAI RCA Review meetings	Feb 20			ADIPC	CMMs	CDT reviews have commenced	

Ref No	Action required	Target date	Date met	Supporting action	Lead	Supported by	Evidence/ Current position	RAG status
Criterion 5 Ensure prompt identification of people who have or are at risk of developing an infection – Nil action Required								
8	Triage SOP in ED requires updating to include questions on travel to countries with variant SARS-CoV-2 strains	Nov 20		Draft triage template provided for implementation	AC/ SR/ SFD	CMM	SOP updated by IPC Team, Awaiting evidence of triage documentation from ED Team	
9	Template to be implemented and shared with all appropriate staff	Dec 20		Education of all staff on the revised Covid-19 triage process	AC/ SR/ SFD	CMM	Example template shared with ED	
10	SOP to support decision making in relation to provision of treatment where patients are unable or refuse to wear a face mask	Dec 20			ADG	ADIPC	Decision taken at individual department level Datix completed when patients refuse to wear a mask	
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 infection								
11	Handwashing signage to be refreshed	Mar 21		Obtain posters from the Soap supplier	IPCNs			
12	Education on Covid-19 PPE for staff returning to work, including after pregnancy, clinically extremely vulnerable or long-term sick leave	Apr 21		Awaiting Occupational health guidance. Clinical areas not classed as Covid secure.	ADIPC	ACNs Unplanned & Planned Care Groups	Clinically extremely vulnerable staff are currently excluded from the workplace	
13	Dashboard to be developed to provide a Trust wide overview of PPE training records	Dec 20			ADIPC	ACNs Unplanned & Planned Care Groups	In progress	
14	Site Survey to be completed of all clinical areas to ensure posters for donning and doffing are displayed on all bay/ side room doors	Mar 21			ADIPC	IPCNs	In progress	

Ref No	Action required	Target date	Date met	Supporting action	Lead	Supported by	Evidence/ Current position	RAG status
15	Audit hand hygiene signage is in all public toilet locations	Dec 20			ADIPC	IPCNs	In progress	
Criterion 7 Provide or secure adequate isolation facilities								
16	Clear signage for different risk areas	Mar 21					Signage that clearly demonstrate red, amber, green areas awaiting implementation	
Criterion 8 Secure adequate access to laboratory support as appropriate								
17	Dashboard to be developed to provide a Trust wide overview of compliance with Covid-19 swabbing training	Jul 20			ADIPC	IPC Admin	In progress	
Criterion 9 Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections – Nil Concerns								
18	Requirement to have 2 negative swab results before moving patients	Feb 21					Advice and guidance provided on requirement; review of additional resources is underway	
Criterion 10 Have a system in place to manage the occupational health needs and obligations of staff in relation to infection								
19	Centralised records of FFP3 Fit Testing	Dec 20		Add records to ESR	DCN Patient Safety	DCPO	Spreadsheet includes all staff records	
20	Documented (centrally held records) process for supporting staff who fail fit testing including redeployment options. Records should be held centrally of discussions with employees	Dec 20			DCPO		Alternative respiratory protection (powered hoods). Redeployment Hub established for vulnerable staff	
21	Review updated Guidance to ensure timely response to Test and Trace service referrals and develop SOP	Nov 20			DD HR & OD	OHWB Manager	Draft SOP under review	

RAG Legend	
Action not commenced	
Action in progress	
Action completed	

Key Personnel

ACNs	**Associate Chief Nurses**
ADIPC	**Associate Director of Infection Prevention and Control**
ADG	**Associate Director of Governance**
AMD	**Associate Medical Director**
CBU	**Clinical Business Managers**
CMM	**Consultant Medical Microbiologists**
DCN	**Deputy Chief Nurse**
DCOO	**Deputy Chief Operating Officer**
DCPO	**Deputy Chief People Officer**
DD HR	**Deputy Director of Human Resources and Organisational Development**
IPC Admin	**Infection Prevention and Control Administrator**

Completed Actions

Ref No	Action required	Target date	Date met	Supporting action	Lead	Supported by	Evidence/ Current position	RAG status
Criterion 1 Systems are in place to manage and monitor the prevention and control of infection								
1	Audit completion of admission infection risk assessments	Aug 20	Aug 20	Report from Informatics Team	ADIPC	Information Team	Variable compliance. Data requires further review	
2	Audit of compliance with discharge screening	Aug 20	Aug 20	Report from Informatics Team	ADIPC	Information Team	Some discharge screening samples taken before 48 hours	
3	Re-establish Clostridium difficile Cohort Facility	Aug 20	Aug 20	Agree location	ADIPC	ACN Unplanned Care Group	C. difficile cohort facility established on ward B19 w/c 27/07/20	
Criterion 2 Provide and maintain a clean and appropriate environment								
5	Revision to Patient Placement SOP Update: Further revision required as local case incidence is escalating	Jul 20 Sep 20	Aug 20	SOP reviewed and updated	CMMs	IPCNs	Revised SOP on the HUB Revised to include Mink Variant	
Criterion 4 Provide suitable accurate information on infections to service users								
7	Safety Alert on completion of the E-discharge summary	Jul 20	Jul 20		AMD Unplanned & Planned Care Groups	ADIPC	Safety Alert Medical Cabinet Minutes Email audit trail from Consultant Leads	
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 infection								
14	Dashboard to be developed to provide a Trust wide overview of PPE Audits	Dec 20	Dec 20		ADIPC	IPC Admin	Locally held dashboard by IPC Team	

Ref No	Action required	Target date	Date met	Supporting action	Lead	Supported by	Evidence/ Current position	RAG status
16	Audit exact location of hand towel dispensers in public toilets	Dec 20	Dec 20		ADIPC	IPCNs	OEM confirmed dispensers are located away from sinks	
18	Review of daily side room survey to optimise use of side rooms	Sep 20	Sep 20		DCOO	ADIPC	Meeting held with UEC CBU & Transformation Manager current audit tool revised	
21	Monitoring and reporting of testing turnaround times	Nov 20	Nov	Agree reporting route	CMM	Laboratory Manager	Reporting plan in place and plan to monitor via IPC Silver Cell	
Criterion 10 Have a system in place to manage the occupational health needs and obligations of staff in relation to infection								
22	Named Midwife for pregnant staff	Nov 20	Nov 20				AGJ is nominated Midwife	
25	Guidance on risk assessments for staff who have been shielding returning to work in clinical areas	Nov 20		Awaiting Occupational health guidance. Clinical areas not classed as Covid secure.	DD HR & OD	ADG; DCN; AMD; DCOO; CMM; ADIPC	Self and manager risk assessments in place, Updates reported at Tactical meetings	

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/21/03/56**	
SUBJECT:	**Freedom to Speak Up**	
DATE OF MEETING:	31 March 2021	
AUTHOR(S):	Jane Hurst, Deputy DoF & Commercial Development	
EXECUTIVE DIRECTOR SPONSOR:	Kimberley Salmon-Jamieson, Chief Nurse & Deputy Chief Executive	
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	SO1 We will.. Always put our patients first through high quality, safe care and an excellent patient experience. SO2 We will.. Be the best place to work with a diverse, engaged workforce that is fit for the future. SO3 We will ..Work in partnership to design and provide high quality, financially sustainable services.	x x
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): **(*Please DELETE as appropriate)***	#1135 Failure to deliver an emergency and elective healthcare service caused by the global pandemic of COVID-19 resulting in major disruption to service provision. #1124 Failure to provide adequate PPE caused by failures within the national supply chain and distribution routes resulting in lack of PPE for staff. #115 Failure to provide adequate staffing levels in some specialities and wards. #134 Financial Sustainability a) Failure to sustain financial viability, #1134 Failure to provide adequate staffing caused by absence relating to COVID-19 resulting in resource challenges and an increase within the temporary staffing domain. #1114 Failure to provide essential, optimised digital services in a timely manner in line with best practice governance and security policies, caused by increasing and competing demands upon finite staffing resources whom lack emerging skillsets, sub-optimal solutions or a successful indefensible cyber-attack, resulting in poor data quality and its effects upon clinical and operational decisions / returns and financial & performance targets, reduced operational efficiencies, denial of patient access to services, inferior quality of care including harm, failure to meet statutory obligations (e.g. Civil Contingency measures) and subsequent reputational damage. #224 Failure to meet the emergency access standard. #125 Failure to maintain an old estate caused by restriction, reduction or unavailability of resources resulting in staff and patient safety issues, increased estates costs and unsuitable accommodation. #145 a. Failure to deliver our strategic vision. #145 b. Failure to fund two new hospitals. #1126 Failure to potentially provide required levels of oxygen for ventilators caused by system constraints resulting in lack of adequate oxygen flow at outlets. #241 Failure to retain medical trainee doctors in some specialties by requiring enhanced GMC monitoring resulting in a risk service disruption and reputation.	
EXECUTIVE SUMMARY *(KEY ISSUES):*	From the 1st April 2020 to 28 February 2021 the FTSU team has managed 39 disclosures. The majority of which relate to culture, allegations of bullying and relationship issues within teams. The FTSU team continues to work closely with HR and OD to support individuals and teams to resolve the issues that are highlighted. The FTSU team continues to engage with medical students and	

	preceptorship nurses as they join the Trust to make them aware of FTSU. The wellbeing services across the Trust offer a good resource for FTSU to sign post staff to access further support.			
PURPOSE: ***(please select as appropriate)***	Information	Approval	To note	Decision
RECOMMENDATION:	The Board is asked to note the progress of Freedom To Speak Up.			
PREVIOUSLY CONSIDERED BY:	**Committee**	Strategic People Committee		
	Agenda Ref.	SPC/21/03/34		
	Date of meeting	24.03.2021		
	Summary of Outcome	Noted		
FREEDOM OF INFORMATION STATUS (FOIA):	Choose an item.			
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	Choose an item.			

REPORT TO BOARD OF DIRECTORS

SUBJECT	Freedom to Speak Up	AGENDA REF:	BM/21/03/56

1. BACKGROUND/CONTEXT

The purpose of this paper is to update the Board on the activity of the Freedom To Speak Up (FTSU) Team. From the 1st April 2020 to 28 February 2021 the FTSU team has managed 39 disclosures. The majority of which relate to culture, allegations of bullying and relationship issues within teams. The FTSU team continues to work closely with HR and OD to support individuals and teams to resolve the issues that are highlighted.

2. DISCLOSURES

In 2020/21 (1 April to 28 February 2021) the FTSU team received the following disclosures.

Table 1 Disclosures in 2020/21

Quarter 1	9
Quarter 2	8
Quarter 3	12
Jan and Feb 2021	10
Total	**39**

The cases can be grouped as follows:-

Table 2 Types of disclosures in 2020/21

Behaviour, culture and relationships	28
Communication	4
Staff safety	2
Process	2
Patient safety	1
Environment	1
Staff levels	1
Total	**39**

Nearly a third of the issues raised have related to Women's and Children's CBU. The issues are being managed with support from HR, OD and escalation to the Executive and Non-Executive Directors responsible for FTSU. A FTSU questionnaire was circulated to W&C staff and reported back to the Executive lead, included in the Trust Board in September 2020 and used to inform the Organisational Development action plan.

There has been 1 patient safety concern raised relating to the Women's and Children's CBU, which was investigated by the Deputy Chief Nurse and Head of Midwifery and was included in the review.

Communication, staff safety and process issues have been dealt with through HR and the environment issue dealt with through the Estates and Facilities Team. The staffing levels query was highlighted and checked with Deputy Chief Nurse.

The 39 disclosures have been across a variety of operational and corporate areas, with some areas having 3 or 4 people speak up about the same issue. The professional groups of staff who have spoken up can be broken down as follows:-

- 10 midwives
- 10 administration / managers
- 4 nurse
- 4 medical staff
- 4 therapies AHP staff
- 3 Health Care Support Workers
- 4 other / anonymous.

3. ACTIVITY

Face to face training has been limited during 2020/21 due to COVID-19 pandemic. During the year, the team has presented to Year 3, 4 and 5 Medical Student inductions and at the Student Physician Associates induction in June (feedback was scored as “good” by 95%). The team held a drop in day in July and the FTSU Guardian attended and introduced FTSU to the newly formed the BAME and LGBTQA+ groups. FTSU Champions also attend induction for new student nurses and the international nurses to raise awareness.

The fourth annual survey has been published and can be found at ftsug_survey_report_2020.pdf (nationalguardian.org.uk). Key recommendations are noted below and these will be reviewed and considered over the coming weeks.

Recommendation 1: Leaders should appoint Freedom to Speak Up Guardians through fair and open competition
Recommendation 2: Leaders should assure themselves that there are no barriers to anyone who may want to apply for the Freedom to Speak Up Guardian role.
Recommendation 3: Leaders should take steps to assure themselves that existing arrangements have the confidence of the workforce.
Recommendation 4: Leaders should provide Freedom to Speak Up Guardians with ring-fenced time for the role, taking account of the time needed to carry out the role and meet the needs of workers in their organisation. Leaders should be able to demonstrate the rationale for their decisions about how much time is allocated to the role. CQC consider the commitment to the Freedom to Speak Up Guardian role, including the provision of sufficient ring-fenced time, as an important element in their assessment of well-led.
Recommendation 5: Freedom to Speak Up Guardians must, with the necessary support of their leaders, including provision of sufficient ring-fenced time, gather feedback on their performance.

Recommendation 6: Leaders should provide effective speaking up training for all workers, ensuring this meets the expectations set out in the national guidelines published by the NGO.
Recommendation 7: Leaders should work with their Freedom to Speak Up Guardian(s) to identify potential groups that face barriers to speaking up, and work towards addressing those barriers.
Recommendation 8: Leaders should seek assurance that their speaking up arrangements are effective for workers.
Recommendation 9: Leaders must communicate that detriment will not be tolerated, act to prevent detriment occurring and look into cases of detriment when it is reported.

4. LESSONS LEARNT

The ability to signpost staff to the various wellbeing offers has been key to providing support to staff who are struggling during this difficult year. Many who have spoken up have said that they will access the services highlighted to them.

5. RECOMMENDATIONS

The Trust Board is asked to note the progress of Freedom To Speak Up.

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/21/03/57**	
SUBJECT:	Mortality Review Q3	
DATE OF MEETING:	31st March 2021	
AUTHOR(S):	Layla Alani, Deputy Director of Governance. Alison Talbot, Head of Clinical Effectiveness. Phil Cantrell, Mortality Lead.	
EXECUTIVE DIRECTOR SPONSOR:	Alex Crowe, Executive Medical Director	
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	SO1 We will.. Always put our patients first through high quality, safe care and an excellent patient experience. SO2 We will.. Be the best place to work with a diverse, engaged workforce that is fit for the future. SO3 We will ..Work in partnership to design and provide high quality, financially sustainable services.	x
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): **(*Please DELETE as appropriate)***	SO1: We will... Always put our patients first through high quality, safe care and an excellent patient experience.	
EXECUTIVE SUMMARY *(KEY ISSUES):*	This paper represents the scheduled 'Learning from Deaths' report in compliance with National Guidance requirements. The Q3 report for 2020/2021 provides a report for awareness and scrutiny in line with National Guidance and the required National Reporting Criteria; and details learning following reviews. Key points to note are; • During Q3 2020/21 372 deaths have occurred within the Trust. • 55 have met the criteria to be subject to a structured judgement review (SJR). • 0 were to subject to investigation using root cause analysis (RCA) methodology. • HMSR is as expected at 105.22 and is not an outlier. • SHMI is expected at 106.54 and is not an outlier. • The Mortality Review Group has completed a focus review of Cardiac dysrhythmia deaths from August 2019 – March 2020. Information from the Health Evaluation Data (HED) system reported that Warrington and Halton Teaching Hospitals NHS Foundation Trust is an outlier for Cardiac Dysrhythmias deaths. The patients included in this review were all identified by Health Evaluation	

<table>
<tr><td></td><td colspan="4">Data (HED) system i.e. those admitted with a primary diagnosis in the group ‘Cardiac Dysrhythmias’ that later died whilst inpatients. Twelve patients have been reviewed and the learning noted.
• The Trust were notified by NHS England that they will no longer be funding the Mortality Datix platform used nationally. The Trust has created the Structured Judgement Review (SJR) form locally and it is available on the Trusts Datix system. Incorporating the form into the Trusts’ system will allow an easier reporting process and the ability to link mortality reviews with the other modules in Datix such as incidents and complaints.
• The roll out of the Datix mortality module may cause a delay to completion of the SJR’s as additional training and demos will be required. As a result of the delay in completion, the team will continue to manually review SJRS.
• Attached as appendices are the MRG themes of the month for noting.
• Attached as appendices is the latest Healthcare Evaluation Data report for information.</td></tr>
<tr><td>PURPOSE: (please select as appropriate)</td><td>Information</td><td>Approval</td><td>To note
x</td><td>Decision</td></tr>
<tr><td>RECOMMENDATION:</td><td colspan="4">The Board of Directors is asked to note the contents of the briefing paper.</td></tr>
<tr><td>PREVIOUSLY CONSIDERED BY:</td><td colspan="2">Committee</td><td colspan="2">Quality Assurance Committee</td></tr>
<tr><td></td><td colspan="2">Agenda Ref.</td><td colspan="2">QAC/21/03/65</td></tr>
<tr><td></td><td colspan="2">Date of meeting</td><td colspan="2">2 March 2021</td></tr>
<tr><td></td><td colspan="2">Summary of Outcome</td><td colspan="2">Noted</td></tr>
<tr><td>FREEDOM OF INFORMATION STATUS (FOIA):</td><td colspan="4">Release Document in Full</td></tr>
<tr><td>FOIA EXEMPTIONS APPLIED: (if relevant)</td><td colspan="4">None</td></tr>
</table>

1. BACKGROUND/CONTEXT

Guidance states that all Trusts are required to review their processes and to implement systems to review, understand and learn from deaths that occurred. National Guidance set the requirements of this:

- Governance and capability.
- Improved data collection and reporting.
- Death certification, case record review and investigation.
- Engaging and supporting bereaved Families and carers.

The Trust is committed to learning from both positive and negative aspects of patient's care, with a clear process for completing mortality reviews. Learning identified during mortality reviews allows specialities to review and improve their processes, with collated learning providing corporate themes for larger quality improvement projects. The Trust is committed to systematically investigating, reporting and learning from deaths.

The content of this report provides an overview of the process and systems that are in place to ensure that deaths are reviewed appropriately, and that learning has occurred

2. KEY ELEMENTS

The Trust use the HED (Healthcare Evaluation Data) system to asses our overall mortality data, highlighting any themes or trends that support the requirement for focused reviews. This also enables benchmarking against other Trusts.

Using both the HED and the Datix Risk Management system to obtain data, this report will include;

- The total number of deaths of patients.
- The number of reviews of deaths.
- The number of investigations of deaths.
- The themes identified from reviews and investigations.
- The lessons learned, actions taken, improvements made.

3. MEASUREMENTS/EVALUATIONS

3.1 Total number of deaths and investigation levels.

During Q3;

Month	Number of Deaths	Number of those which required SI
October 2020	131	0
November 2020	121	0
December 2020	119	0

Whilst no SIs were identified there are multifactored reviews undertaken by clinical governance which include rapid reviews and concise investigations.

3.2 Investigations of deaths

Structured Judgement Reviews of deaths - Structured Judgement Reviews are presented to the Mortality Review Group (MRG), an assessment of problems in care is made and any actions or lessons to be learned are sent to the appropriate forum. Particular groups of patients are reviewed at the MRG:

- All deaths of patients subject to care interventions with elective procedures. These are identified using the electronic patient record which provides a daily update as to patients that have died.
- Patients undergoing an emergency laparotomy.
- SHMI/HSMR outliers identified using the HED system.
- Deaths where learning will inform existing or planned improvement work, for example if work is planned on improving sepsis care, relevant deaths should be reviewed, as determined by the Trust;
- Death of a patient with mental health needs (this covers Inpatients who are detained under the Mental Health Act) identified via the Trust Patient Safety Manager. If the death may have been due to, or partly due, to problems in care including suspected self-inflicted death it will be investigated as a serious incident.
- Trauma deaths will be reviewed and presented at MRG on a quarterly basis.
- Patients who have died aged between 18 and 55 years.
- Patients who have died with no DNACPR in place.
- Once a quarter, a further sample of other deaths will be selected that do not fit the above identified categories, to ensure we take an overview of where learning and improvement is needed most overall.
- All Coroners' reports received post-inquest will be triangulated with the SJR to enhance the learning.
- Any concern that a member of staff may have in relation to a patient death will be reviewed through the mortality process.
- At the request of the Medical Director or Chief Nurse.

3.3 SJR reviewed

During Quarter 3, 55 Structured Judgement Reviews were completed by members of the MRG **Table 1** below details their overall care rating;

Q3	Overall Assessment Care Rating Following SJR					Total
	1: Very Poor	2: Poor	3: Adequate	4: Good	5: Excellent	
	0	**0**	21	32	2	55

Cases rated as *1:* ***Very Poor*** or *2:* ***Poor*** are reviewed by MRG and then referred to the Governance Department for further discussion and possible further investigation. Consideration is also given to external reporting via StEIS where appropriate.

Cases rated as *3:* ***Adequate*** are referred to MRG for further discussion and cases rated as *4:* ***Good*** and *5:* ***Excellent*** are disseminated for learning through the Mortality & Morbidity Meetings.

3.4 samples of learning identified:

- 3 trauma deaths were discussed at MRG. The identified learning was included in the 'themes of the month' newsletter and circulated to the Clinical Speciality meetings and the Medical Cabinet meeting (see appendix 1).

- **M7791 –** 51 year old patient admitted from a local mental health unit where the patient was treated under section 3 of the Mental Health Act. The patient had a fungating tumour through her mastectomy scar. On admissions the patient had a working diagnosis of possible COVID-19. The patient was referred to the palliative care team when they failed to respond to treatment. The background, medical history, family, legal and psychiatric aspects of the patient's management were not available on admission and were obtained much later into clinical care. The information was only acquired when the hospital contacted the psychiatrist in the community.

Learning:

Background information was not presented on admission and was obtained when staff contacted the psychiatrist in the community. If this information had been acquired earlier this could have streamlined the process for both the patient and the next of kin. This information obtained included the following:

The patient had previously been diagnosed with schizophrenia and learning difficulties and 2:1 care by staff from the mental health unit was in place. The patient had previously been diagnosed with ductal carcinoma of the breast. A CT scan was completed 6 weeks prior which confirmed progression of the cancer with new lung and liver metastases. The patient

had started palliative chemotherapy in September 2020. The section 3 could be rescinded by the community psychiatrist as the patient was recognised as dying meaning a coroner's referral was not required.

Action taken to address: A passport is being developed to support patients with mental illness who are admitted directly from mental health units. This will ensure that the medical/nursing team have a full understanding of the patients needs.

- **M8119 –**79 year old man who was admitted with 3 and half stone weight loss and was found to have a bowel tumour with significant pre-op pathology and a number of post-op complications. Whilst the overall care was deemed to be good with this patient and his EOL care was very good: although it was not possible to discharge the patient to his preferred place of death, confirmation of the patients diagnosis does not appear to have been communicated to the patient and his family in a timely fashion. Although the patient was told on day 5 post op that cancer was the likely cause, nobody confirmed the diagnosis with them until day 65 when the patient had a seizure, and cerebral metastases were diagnosed.

Learning:

Timely conversation of poor prognosis and diagnosis as soon as it is available.

Action taken to address: Surgeon was contacted and agreed that communication was not the standard that they would normally expect. The case was discussed in detail at mortality and morbidity meeting to ensure learning from experience.

3.5 Focused Reviews

The MRG analyses data in relation to Mortality and where is it indicated that there is a high SHMI/HSMR (i.e. greater than expected number of deaths) in a diagnosis group (Cardiac Dysrhythmias), a request is made for a Focused Review to be undertaken. **Table 2** details the current review completed:

Table 2

	Overall Assessment Care Rating Following SJR					
Cardiac Dysrhyrhmia	1: Very Poor	2: Poor	3: Adequate	4: Good	5: Excellent	**Total**
	0	**0**	4	8	0	**12**
	End of Life care (EOL) care rating					

	1: Very Poor	2: Poor	3: Adequate	4: Good	5: Excellent	
	0	**0**	4	7	1	

Overall findings of the review were that care was found to be good in majority of cases. Themes were picked up to explain analysis data;

- Poor documentation;
- Coders unable to use the working diagnosis;

- Referral Handover;
- EOL decision making;
- Multi FCE in a short period.

**A detailed report will be presented at the next MRG and will be shared in the next learning from deaths report for completeness.*

3.6 COVID-19 Deaths:

COVID-19 Focus Review has been completed. The review findings were presented at the November 2020 MRG meeting. The reviewers analysed 30 randomly selected cases from 1st April 2020 to 18th June 2020 (wave 1 COVID-19 pandemic), where COVID-19 appeared anywhere on the death certificate. This process identified 4 cases where care was considered poor in accordance with the MRG descriptors (See appendix 2 for details and learning shared). Whilst, poor care was identified for the 4 cases, the discussion at MRG was that the overall care in all 4 cases was adequate and the outcome would not have changed but that there were elements of care for learning by the specialty. The overall care in the other 26 cases was rated as either good or adequate. This report was presented at Quality Assurance Committee and Trust Board (2.21).

An COVID-19 nosocomial mortality paper is in process of being completed (wave 2 and 3 COVID-19 pandemic).

4. TRAJECTORIES

HMSR is as expected at 105.22 and is not an outlier and are within expected range.

SHMI is expected at 106.54 and is not an outlier and are within expected range.

5. MONITORING/REPORTING ROUTES

Learning from Deaths is monitored by the MRG which reports monthly to the Patient Safety and Clinical Effectiveness Committee, Quarterly to the Quality Assurance Committee and annually in both the Quality Account and to the Clinical Commissioning Group via the Clinical Quality Focus Group.

6. IMPACT ON QPS?

The learning from deaths helps us to make changes that will ensure high quality, safe care and an excellent patient experience.

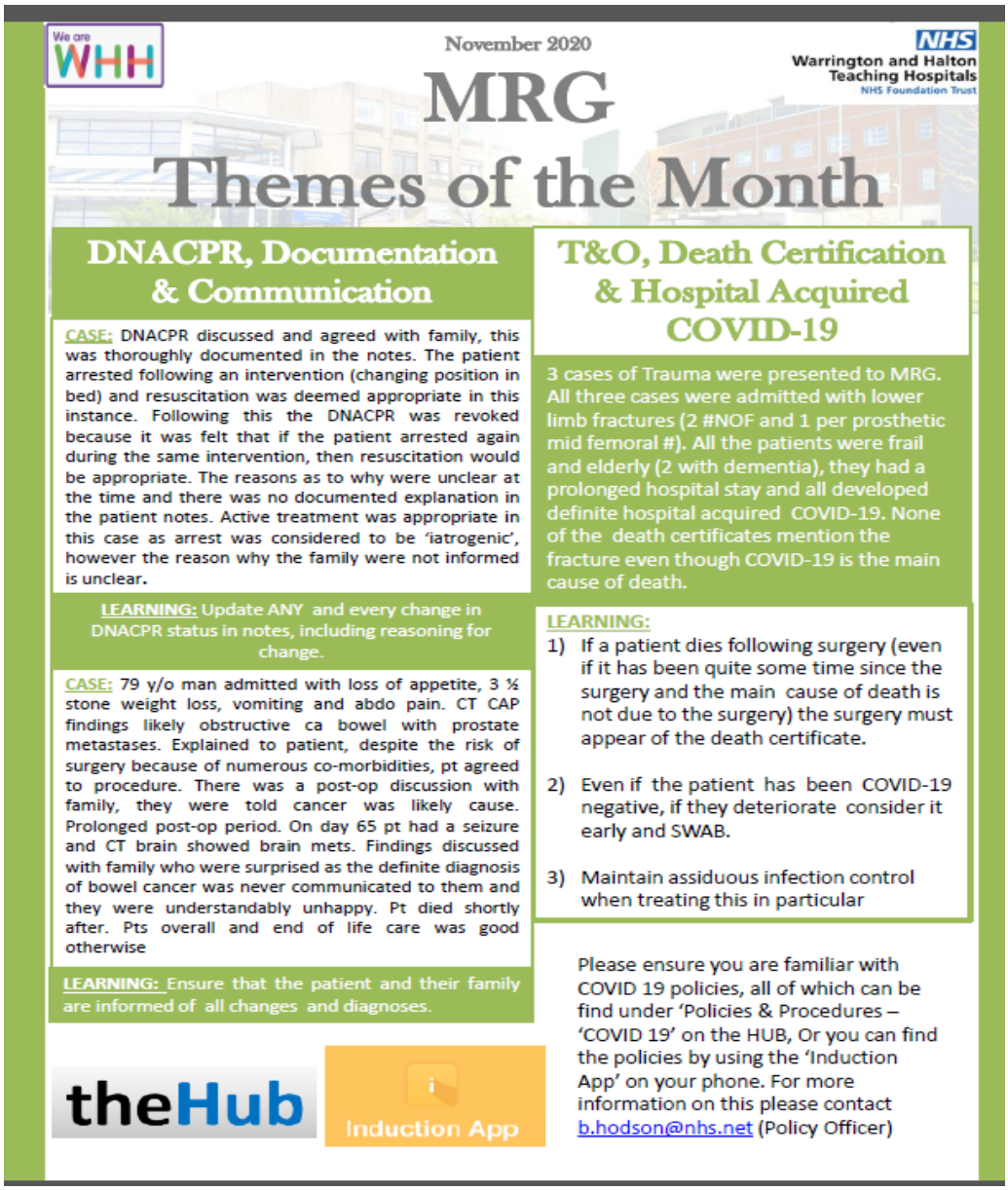
7. TIMELINES

Ongoing, the Mortality Review Group meets monthly to review deaths that have been subject to a Structured Judgement Review.

8. RECOMMENDATIONS

The Board of Directors are asked to note this report.

Appendix 1



November 2020

MRG Themes of the Month

DNACPR, Documentation & Communication

CASE: DNACPR discussed and agreed with family, this was thoroughly documented in the notes. The patient arrested following an intervention (changing position in bed) and resuscitation was deemed appropriate in this instance. Following this the DNACPR was revoked because it was felt that if the patient arrested again during the same intervention, then resuscitation would be appropriate. The reasons as to why were unclear at the time and there was no documented explanation in the patient notes. Active treatment was appropriate in this case as arrest was considered to be 'iatrogenic', however the reason why the family were not informed is unclear.

LEARNING: Update ANY and every change in DNACPR status in notes, including reasoning for change.

CASE: 79 y/o man admitted with loss of appetite, 3 ½ stone weight loss, vomiting and abdo pain. CT CAP findings likely obstructive ca bowel with prostate metastases. Explained to patient, despite the risk of surgery because of numerous co-morbidities, pt agreed to procedure. There was a post-op discussion with family, they were told cancer was likely cause. Prolonged post-op period. On day 65 pt had a seizure and CT brain showed brain mets. Findings discussed with family who were surprised as the definite diagnosis of bowel cancer was never communicated to them and they were understandably unhappy. Pt died shortly after. Pts overall and end of life care was good otherwise

LEARNING: Ensure that the patient and their family are informed of all changes and diagnoses.

T&O, Death Certification & Hospital Acquired COVID-19

3 cases of Trauma were presented to MRG. All three cases were admitted with lower limb fractures (2 #NOF and 1 per prosthetic mid femoral #). All the patients were frail and elderly (2 with dementia), they had a prolonged hospital stay and all developed definite hospital acquired COVID-19. None of the death certificates mention the fracture even though COVID-19 is the main cause of death.

LEARNING:

1) If a patient dies following surgery (even if it has been quite some time since the surgery and the main cause of death is not due to the surgery) the surgery must appear of the death certificate.

2) Even if the patient has been COVID-19 negative, if they deteriorate consider it early and SWAB.

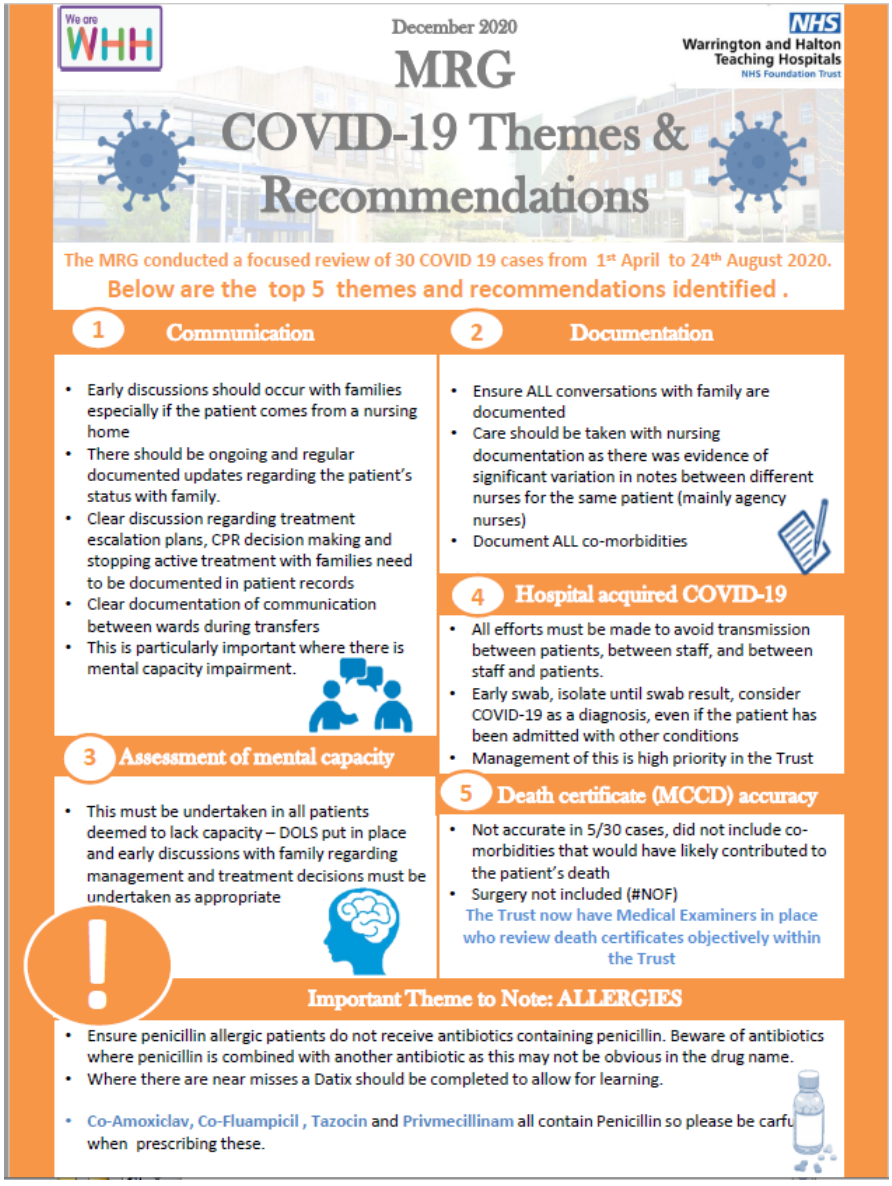
3) Maintain assiduous infection control when treating this in particular

Please ensure you are familiar with COVID 19 policies, all of which can be find under 'Policies & Procedures – 'COVID 19' on the HUB, Or you can find the policies by using the 'Induction App' on your phone. For more information on this please contact b.hodson@nhs.net (Policy Officer)

theHub

Induction App

Appendix 2


We are WHH
December 2020
MRG
NHS
Warrington and Halton Teaching Hospitals
NHS Foundation Trust
COVID-19 Themes & Recommendations
The MRG conducted a focused review of 30 COVID 19 cases from 1st April to 24th August 2020.
Below are the top 5 themes and recommendations identified .
1 Communication
Early discussions should occur with families especially if the patient comes from a nursing home
There should be ongoing and regular documented updates regarding the patient's status with family.
Clear discussion regarding treatment escalation plans, CPR decision making and stopping active treatment with families need to be documented in patient records
Clear documentation of communication between wards during transfers
This is particularly important where there is mental capacity impairment.
2 Documentation
Ensure ALL conversations with family are documented
Care should be taken with nursing documentation as there was evidence of significant variation in notes between different nurses for the same patient (mainly agency nurses)
Document ALL co-morbidities
3 Assessment of mental capacity
This must be undertaken in all patients deemed to lack capacity – DOLS put in place and early discussions with family regarding management and treatment decisions must be undertaken as appropriate
4 Hospital acquired COVID-19
All efforts must be made to avoid transmission between patients, between staff, and between staff and patients.
Early swab, isolate until swab result, consider COVID-19 as a diagnosis, even if the patient has been admitted with other conditions
Management of this is high priority in the Trust
5 Death certificate (MCCD) accuracy
Not accurate in 5/30 cases, did not include co-morbidities that would have likely contributed to the patient's death
Surgery not included (#NOF)
The Trust now have Medical Examiners in place who review death certificates objectively within the Trust
Important Theme to Note: ALLERGIES
Ensure penicillin allergic patients do not receive antibiotics containing penicillin. Beware of antibiotics where penicillin is combined with another antibiotic as this may not be obvious in the drug name.
Where there are near misses a Datix should be completed to allow for learning.
Co-Amoxiclav, Co-Fluampicil , Tazocin and Privmecillinam all contain Penicillin so please be carfu
when prescribing these.

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/21/03/58**			
SUBJECT:	**Digital Update Report**			
DATE OF MEETING:	2021			
AUTHOR(S):	Alex Crowe, Executive Medical Director			
EXECUTIVE DIRECTOR SPONSOR:	Alex Crowe, Executive Medical Director			
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	SO1 We will.. Always put our patients first through high quality, safe care and an excellent patient experience. SO2 We will.. Be the best place to work with a diverse, engaged workforce that is fit for the future. SO3 We will ..Work in partnership to design and provide high quality, financially sustainable services.			X X
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): **(*Please DELETE as appropriate)***	#1114 Failure to provide essential, optimised digital services in a timely manner in line with best practice governance and security policies, caused by increasing and competing demands upon finite staffing resources whom lack emerging skillsets, sub-optimal solutions or a successful indefensible cyber-attack, resulting in poor data quality and its effects upon clinical and operational decisions / returns and financial & performance targets, reduced operational efficiencies, denial of patient access to services, inferior quality of care including harm, failure to meet statutory obligations (e.g. Civil Contingency measures) and subsequent reputational damage.			
EXECUTIVE SUMMARY *(KEY ISSUES):*	The purpose of this report is to provide Board oversight of performance of the Digital Services Department.			
PURPOSE: *(please select as appropriate)*	Information	Approval	To note x	Decision
RECOMMENDATION:	The Trust Board is asked to note the: • Digital Board Standing Items highlights; • EPR Procurement status; • Maternity EPR status including preferred supplier status; • National Infrastructure Incident – 13th/14th January 2021. • Plans for Chief Information Officer.			
PREVIOUSLY CONSIDERED BY:	**Committee**			
	Agenda Ref.			
	Date of meeting			
	Summary of Outcome			
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: *(if relevant)*	None			

REPORT TO BOARD OF DIRECTORS

SUBJECT	Digital Update Report	AGENDA REF:	BM/21/03/58

1. BACKGROUND/CONTEXT

The purpose of this report is to provide Board oversight of performance of the Digital Services Department.

The report summaries assurances tabled through the Finance And Sustainability Committee, complemented with pertinent additional information.

2. KEY ELEMENTS

Digital Services governance focuses upon two key forums, the Digital Board and the Information Governance Sub-Committee whom report respectively to the Finance & Sustainability Committee and Quality Assurance Committee.

Ad-hoc reports regarding areas of interest are submitted at the request of the committee chairs.

Digital Board Standing Items

Digital Programme

- Reported progress remains limited to priority schemes due to COVID with E-Observations and E-Rostering the main beneficiaries;
- Warrington Care Record / Shared to Care go live providing access to GP letters across Cheshire & Merseyside STP;
- 0-19s Health Visitor notifications scheme agreed as high priority due to its care impact;
- Results & Reporting scoping work and Audiology upgrade are being raised in priority, utilising resources directed away from projects paused due to COVID pressures;
- Next tranche of Paperless Care programme prioritisation started, resource plans and programme timeline expected end of April.

DXC Vendor Management Meeting

- The work to migrate Lorenzo EPR to a new cloud platform, key to improving performance, is replanned to summer 2021.

IT Services Update

- Service Desk and change requests performance remains stable;
- 3 of 8 deployments reporting amber due to resources and acting upon lessons learnt;
- Capital investments are on track with 5 additoinal due to be brought forward from 21/22.

Digital Analytics Programme

- The reporting backlog remains stable with plans in place to close down delayed requests including resolving design issues with stakeholders;
- The workload prioritisation process is now being expanded to the entire Digital Services department to address interdependencies. Terms of Reference are being developed in support of 3rd party engagement.

Digital Compliance & Risks

- The status of audits remains stable whilst a deep dive of audit actions has been submitted to FSC and proposes safe, pragmatic means to closing legacy actions;
- Risks continue to be regularly reviewed resulting in fewer risks of lower scores but with additional actions;
- An oversight report of the quality/safety impact of open risks and their actions timescales was submitted to QAC in January 2021.

Clinical Safety and Risk Review

- EPR Customer Safety Notices and Product Alert Notices remain under control.

EPR Procurement

- Following approval of the Strategic Outline Case, Pre-Market engagement has not started due to COVID Wave 3. Replanned to start late April / early May to secure involvement of frontline colleagues and soon to be appointed Principle and Associate CCIO's;
- Potential EPR collaborations continue to be explored;
- Benefits development for the Outline Business Case continues;
- Contract schedules for the new Tactical Lorenzo contract on hold due to DXC requesting changes to termination by convenience;
- Lorenzo Theatres decision on hold until after Pre-Market engagement.

Maternity EPR

- Procurment stand still period ended 23 March. BadgerNet selected as preferred supplier, preparation plans being drafted;
- Tactical reporting including offline remote working pilot progressing;
- CTG Monitoring and archiving has been assessed by the supplier and continues to require further resolution activity;
- Digital Midwife recruitment appointment made;
- High priority Electronic 0-19s notifications development with Local Authority and Community stakeholders in final testing stages.

National Infrastructure Incident – 13th/14th January 2021

A national Digital infrastructure issue occurred at approximately 23.00 on 13th January 2021 and continued to 05.30 on 14th January 2021, resulting in operational challenges for frontline personnel:

- The issue affected a number of national digital services including SMART card access;

- The Trust suffered loss of access to Lorenzo EPR including Electronic Prescribing And Medication Administration;
- The Senior On-Call Manager co-ordinated the immediate response with support from IT Support, Chief Pharmacist and Executive On-Call;
- The Senior On-Call Manager and Chief Pharmacist supported the revertion to business continuity processes at ward level;
- The ongoing incident was esclataed to Senior Digital Management at approximately 03.30 by the Executive On-Call;
- An urgent review meeting was chaired at 05.30 by the Executive On-Call just prior to the resolution being declared;
- Two Emergency Preparedness reviews have been subsequently conducted by the EPRR Team with support from Clinical Governance with lessons learnt formally recorded and resulting actions agreed;
- Immediate infrastructure reliability assurances were gleaned from NHSX. The formal Root Cause Analysis report is to be received whilst a new management escalation process has been provided for the remainder of the pandemic in response to national service desk communications feedback submitted to NHSX;
- A formal Datix incident was recorded and no patient harm reported;
- An executive report will be formulated when the Root Cause Analysis report has been received and the Datix Incident finalised;
- The incident highlighted the reliance the Trust places upon its Digital infrastructure for safe and efficient care.

Plans for Chief Information Officer

- Business case development for interim and substanstive (band 9) CIO approved;
- Interim CIO for 6 months with a target start date of 30 March 2021 to 30 September 2021;
- Band 9 CIO anticipated to start September 2021, subject to successful applicant notice period.

3. ACTIONS REQUIRED/RESPONSIBLE OFFICER

None required.

4. IMPACT ON QPS?

Modern Digital Health infrastructure now has a clear link to the quality and safety of patients and performance and sustainability of services.

Programme prioritisation has enabled E-Observations and some ePMA deployments to continue during the COVID-19 response, thus contributing to quality and safety improvements to patient care.

The contribution of the Trust Digital infrastructure to efficient care processes, including the Patient Administration System / Electronic Patient Record and ePMA, was prevalent throughout the incident period.

5. MEASUREMENTS/EVALUATIONS

With performance trends now available in respect of planned activities and service desk operations, industry standard benchmarks will be considered for future reporting.

Staffing resources are benchmarked against the model hospital data.

6. TRAJECTORIES/OBJECTIVES AGREED

Target delivery timescales are managed via the Digital Programme Of Works and encompass the activities of all Digital Services Departments.

7. MONITORING/REPORTING ROUTES

Digital Governance is described in section 2.

8. TIMELINES

Target delivery timescales are managed via the Digital Programme Of Works and encompass the activities of all Digital Services Departments.

9. ASSURANCE COMMITTEE

Assurance for Digital Services responsibilities is sought by the Finance And Sustainability Committee with support from the Quality Assurance Committee.

10. RECOMMENDATIONS

The Trust Board is asked to note the:

- Digital Board Standing Items highlights;
- EPR Procurement status;
- Maternity EPR status inc;luding preferred supplier status;
- National Infrastructure Incident – 13th/14th January 2021.